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Senate

The Senate met at 10 a.m. and was called to order by the Honorable JON TESTER, a Senator from the State of Montana.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Almighty God, the true light of life, whose power no earthly force can challenge and whose reign no alien god can shake, open our hearts to what You have done for us, what You are doing even now, and what You promise for us in the future. May the gifts of each sunrise and sunset remind us of Your goodness and make us more determined to please You with our words and deeds.

Draw near to our lawmakers as they work. Let the consciousness of Your presence fill their minds with peace. Use them today to defend those who are helpless and have lost all hope. Quicken their memories to recall the many times You have intervened to keep our Nation safe. Let the warmth of Your divine solace scatter the shadows of perplexity and doubt, as You encircle them with the wonder of Your love.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable JON TESTER led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, July 31, 2007.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable JON TESTER, a Senator from the State of Montana, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mr. TESTER thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Mr. President, this morning the Senate will be in a period of morning business for 1 hour, with the time divided equally between the majority and the minority. The minority will control the first half of the time and the majority will control the second half.

Following morning business, the Senate will proceed to the consideration of H.R. 976, and I expect the majority manager, Senator BAUCUS, to call up his amendment at the desk, which will be the text of the SCHIP legislation reported overwhelmingly by the Senate Finance Committee last week.

Today the Senate will recess at 12:30 for its respective policy work periods.

UNANIMOUS CONSENT REQUEST—S. 849

Mr. REID. Mr. President, I ask unanimous consent that the majority leader, following consultation with the Republican leader, may at any time proceed to the consideration of Calendar No. 127, S. 849, the Openness Promotes Effectiveness of Our National Government Act of 2007, sponsored by Senators LEAHY and CORNYN, and that the bill be considered under the following limitations: that there be a time limit of 2 hours of general debate on the bill, with the time equally divided and controlled between the chair and ranking member of the Judiciary Committee or their designees; that the only amendment in order be a Leahy-Cornyn technical amendment, which is at the desk; that upon the use or yielding back of the time, the amendment be agreed to, the bill, as amended, be read the third time, and the Senate vote on passage of the bill, with the above occurring without further intervening action or debate.

The ACTING PRESIDENT pro tempore. Is there objection?

Mr. KYL. Mr. President, reserving the right to object, and I will object, I believe it will be possible, with the sponsors of the bill, to reach an agreement that will obviate the necessity for a great deal of floor time or amendments on the floor. I have met with the sponsors of the bill and have presented ideas about ameliorating some of the deficiencies the Department of Justice brought out about the legislation. Last week, I had a long conversation with Senator CORNYN, who is here. I believe if we can continue those discussions, in a very brief period of time—perhaps by the end of this week—it would not be necessary to devote a great deal of time to the consideration of the bill. Because of that, at this time, I will object to that particular procedure, but I hope we can report back to the majority leader that we have reached an agreement on the bill in the near future.

Mr. REID. I would be satisfied if the junior Senator from Arizona could work on this. I hope there can be an agreement reached that we can take this bill up maybe when we get back, with a limited amount of time and amendments. It is very popular legislation—the Freedom of Information Act—which our friends in the press

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

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love, and other organizations around the country. It is very important. I hope we can move forward on this bipartisan piece of legislation.

The ACTING PRESIDENT pro tempore. Objection is heard.

Mr. REID. I thank the Chair.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period of morning business, with Senators permitted to speak therein for up to 10 minutes, with the time equally controlled between the two leaders, and Republicans controlling the first half of the time, and the majority controlling the second half of the time.

The Senator from Texas is recognized.

ORDER OF PROCEDURE

Mr. CORNYN. Mr. President, I ask unanimous consent to speak during our allocation of morning business for up to 20 minutes, with the Senator from New Hampshire, Senator GREGG, being reserved the last 10 minutes of that time.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

INFORMED CONSENT

Mr. CORNYN. Mr. President, before I talk about the topic that brings me to the floor, I express my gratitude to the majority leader, Senator REID, for bringing up the freedom of information reform bill that Senator LEAHY, the Senator from Vermont, and I have been working on for a number of years. When I was attorney general of Texas, it was my responsibility to enforce our open Government laws, and I became a big advocate of greater transparency, more openness in Government, because I believe that only a public that is truly informed can give their consent. It has to be informed consent. That is, after all, the very fundamental basis for the legitimacy of all of our laws.

When I came to the Senate, I was pleased to see that Senator LEAHY, chairman of the Senate Judiciary Committee, had been very active in this area. We joined efforts in a bipartisan way to work on these reforms. I know Senator KYL has some concerns. He expressed those this morning. He has been good about working with us to try to work our way through that. I share his hope and aspiration that we can work through the differences and perhaps complete our work on those Freedom of Information Act reforms this week before we break for August. I think that would be a very positive development and one that is certainly worthy of the Senate.

QUALITY HEALTH CARE

Mr. CORNYN. Mr. President, I want to turn to the topic that will engage us for perhaps most of the remainder of the week, and that is ensuring that quality health care is available to the next generation. This is, and should be, a top public policy priority for the Congress. Certainly, it is one of mine.

I think there will be a lot of attention paid to the reauthorization of the State Children's Health Insurance Program that will be on the floor shortly. It is noteworthy that SCHIP, so called, was created by Congress in 1997 to fill a gap in our health insurance system. It was targeted at working poor families who had too much income to qualify for Medicaid but could not afford regular health insurance. This program has been enormously successful nationwide, lowering the uninsured rate by nearly 25 percent, and especially in my State of Texas, where we have about 25 percent of our total population currently uninsured. So this has gone a long way to make sure people got access to quality health care. Interacting with Medicaid, insurance coverage has been extended under this program to more than 1 million Texas children who would have otherwise not been covered. So SCHIP deserves reauthorization and renewal.

Unfortunately, the Senate Finance bill that will come to the floor seems to take us on a path toward a major step that failed in 1994, and that is a federally funded takeover of national health care. The Senate Finance Committee is proposing a near quadrupling—that is four times—of SCHIP funding that would increase taxes, weaken private insurance coverage, and create a new de facto entitlement program for middle-class families, all courtesy of the beleaguered American taxpayer. A close analysis demonstrates that, if enacted, the Senate bill would actually have the unintended impact of degrading health care for many children and will not be as nearly beneficial to Texas as a more modest alternative, which I intend to support.

The original SCHIP program—again, it is worth spelling out the acronym—State Children's Health Insurance Program—was limited to those families at up to 200 percent of the official poverty level or $40,000 for a family of four. But some States have found a way to expand coverage from first children, then to parents, then to childless adults, and then to families with much higher incomes. Some States, such as New Jersey, now use SCHIP funds to cover families with income of up to 400 percent of the poverty level—up to $82,600 a year for a four-person family. So that is what I mean when I say that SCHIP is now being transmogrified, transformed into a middle-class entitlement, if this finance bill were to pass.

Minnesota, instead of using the State Children's Health Insurance Program to target relatively low-income children, as Congress intended, spends 61 percent of SCHIP funding on adults; and Wisconsin spends 75 percent of their SCHIP funding on adults. If this were the U.S. military, we would call this ''mission creep.'' The Senate bill would encourage these distortions further. Nearly a third of the newly covered, some 2 million children, already have private insurance.

So let me be clear. What this bill, if enacted, would do would take some people who currently have private insurance and substitute taxpayer-paid-for insurance under this program because, of course, why would anybody pay for something that the Government starts giving away for free? They will drop their private insurance and many of the parents will decide to drop theirs as well, transferring these expenses to the American taxpayer.

But many SCHIP programs pay physicians at Medicaid rates; that is, the reimbursement for physicians—a reimbursement rate that is so low that many doctors simply cannot afford to take patients based on those Medicaid rates and, thus, they are refusing new patients. Ironically, the switch to Government-paid SCHIP could mean reduced health care for those recipients who decide to give up private insurance to get free insurance. But where reimbursement is at the Medicaid rate, where there are so few doctors who can afford to treat patients at those rates, children will end up with actually less care in some instances and not more.

Many supporters are happy because funding for this expanded program will be paid by tobacco users, through a 61-cent per pack cigarette tax increase. But the accounting is fundamentally flawed. To make it balance, the Senate bill pretends spending on this accelerating program will go from $8.4 billion in 2012 to only $400 million in 2013.

As our Republican leader notes, ''Does anyone seriously think Congress will decide to cut SCHIP by $8 billion in one year, so that millions who rely on it will lose their health insurance?'' Of course not. This is phony accounting. No business in America could run its operations this way, and the Federal Government should not try.

Supporters of the finance bill claim a badge of fiscal responsibility because this bill only uses $35 billion of the $50 billion budget authority it was given during this year's budget reconciliation. But the finance bill gets that additional $15 billion in budget authority by setting aside billions of dollars for a so-called incentive fund. The SCHIP program was designed as one huge incentive already for the States. The creation of this program says to the States: Go cover children; Congress will give you more money for doing that than we will for covering anyone else.

So why are we creating an incentive on top of another incentive? And these

incentive payments, of course, will be used to go beyond covering children, which is, of course, Congress's original stated intent.

This goes from what I would call mission creep to another incremental step toward a federally controlled, Washington-dictated health care system, paid for by huge tax increases on the American taxpayer. Perhaps the answer is that this fund exists to provide expanded coverage for nontargeted populations; that is, populations Congress did not intend—adults, for example. After all, States, under the Finance Committee bill that is coming to the floor, will have relative freedom to use these funds as they see fit. Where, I ask, is the accountability? Where is the responsibility?

The finance bill also puts aside at least $2 billion in a so-called contingency fund. First an incentive fund, then a contingency fund—both slush funds. But this contingency fund will only be drawn down by $400 million total over 5 years. This represents less than 1 percent of overall spending. I think this blatantly shows the level at which this bill is overfunded. So while the bill is only claiming to spend part of the budgetary authority it is given, it is still creating two budgetary slush funds. I think it is there for another purpose. I think this is another attempt, as I said, to incrementally federalize health care.

There will be some of us who will join together, with our leader and Senator LOTT, Senator KYL, and others, to offer a scaled-down alternative called Kids First, which refocuses SCHIP on its intended purpose. It concentrates on outreach—locating and enrolling eligible children. Some 75 percent of uninsured children already qualify for either Medicaid or SCHIP. Kids First aims to sign them up. It also subsidizes eligible families to keep their private coverage and doesn't provide an incentive for them to drop their private coverage to get free coverage courtesy of the American taxpayer.

The Senate bill increases spending by $35 billion over 5 years—I should say so far because I know there are amendments that will be offered, and I think I have read Senator KERRY and others will offer amendments to bump that figure to $50 billion, and we have seen even larger figures suggested on the House side. So no telling what a conference committee will ultimately come back with. But Kids First, the alternative which will be offered by this side of the aisle, will cost only $10 billion more than the current SCHIP program.

Ironically, under Kids First, the children in my State, Texas, would come out far ahead over the Senate Finance Committee version. SCHIP, as we know, is a joint Federal-State effort involving matching Federal funds. After cutbacks for budget reasons a few years ago, Texas is now ramping up its SCHIP program, enrolling additional eligible children. However, the Senate Finance Committee bill would confiscate about $660 million that Texas has so far left unspent from prior years because we have been responsible, because we haven't used the money that was designated for children to cover adults, as 14 other States have. Under Kids First, we would keep access to all unspent funds for 2 more years so we can locate and recruit and sign up more children—the designated target for this Children's Health Insurance Program.

But here is the bottom line: Texas would have $1.6 billion in SCHIP Federal matching funds available next year under Kids First and only $1.06 billion under the Senate bill. In other words, we would be better off under the alternative rather than the Senate Finance Committee bill, and so would the children, who would be the beneficiaries of those funds. Additionally, any matching funds left unspent after that would go back to the U.S. Treasury, and that would not be used to subsidize other States that game the system and distort the program beyond Congress's original intent.

One alternative provides the prospect of better health care for Texas children, plus lower taxes, a fiscally responsible government, and more money and more control for my State. For this and other reasons I have stated, I will vote for the Kids First Act, the alternative we will offer, and not the Senate Finance Committee bill.

Mr. President, I yield the floor and reserve the remainder of our time for the Senator from New Hampshire.

Mr. GREGG. Mr. President, how much time remains?

The ACTING PRESIDENT pro tempore. Sixteen minutes and twenty seconds.

Mr. GREGG. Mr. President, I wanted to rise to carry on the discussion which the Senator from Texas has so eloquently begun relative to the proposal that is coming forward to the Senate today called SCHIP. Under the cloak of trying to address the issue of health care for children, we are seeing an explosion in cost, the purpose of which is not necessarily to cover children who need coverage because many of the children who are going to be covered here are already covered under private plans, but the purpose is actually to dramatically expand the role of government in the area of limited health care in this country, and it is openly acknowledged as being an effort to move down the road toward universal health care.

Independent of the substantive policy of how we approach insuring and making sure children get health insurance in this country, there is the ancillary policy of fiscal discipline. This Congress, so far, under its Democratic leadership has abandoned the concept of fiscal discipline. They are spending money on all sorts of initiatives around here that go well beyond even the extraordinarily high numbers which were put in the budget under this Democratic Congress. We have returned, without question, to the days of tax and spend. In fact, it was interesting today that there was an article in the Wall Street Journal, an editorial that listed I think it was ten different areas where there have been proposals to dramatically increase the tax burden on the American people, to gather up funds by the Democratic Party so they can then be spent on other initiatives.

This proposal, this SCHIP proposal as it comes forward to us under the auspices of the liberal leadership of the Senate, is a classic example of spending which can't be afforded and spending which uses gimmicks in order to mask its real costs.

This chart reflects the fact that the spending in this proposal jumps $35 billion—$35 billion—over a 5-year period, taking a program that could be fully funded today for about a third of that but adding an additional two-thirds on top of that in order to take care of initiatives which basically fund two things: No. 1, they fund adults under a children's health insurance program, and No. 2, they fund bringing children off of private insurance and putting them on the public insurance system so that taxpayers generally have to pay for something which is now being paid for in the private sector.

So the cost of this program jumps radically over the next 5 years, and then, in the ultimate act of fiscal cynicism and fraud, they claim the program will drop back down to being a $3.5 billion program after it has reached a peak of $16 billion in 2012. Are they going to abolish the program in 2013? Of course not. But in order to avoid their own rules of how you have to pay for things around here or are supposed to pay for things around here when you put a new program on the books, in an act, as I said, of fraud and cynicism, the liberal leadership of this Senate has decided to claim that this program, which we will be spending $16 billion on in 2012, we will suddenly only spend $3.5 billion in 2013. Ironically, that number, $3.5 billion, is even less than what the program costs today, which is about $5 billion.

So this whole area in here, this white area, is totally unfunded, unless you assume this program now being put on the books is going to suddenly end 5 years from now—which is, of course, absurd. We don't end programs in the Federal Government. We certainly don't end a program that is focused on trying to fund health care for children. So what happens is that $40 billion over the next 5 years which will be spent on this program, no doubt about it—in fact, a lot more than that if the House bill passes—is treated as if it is a virtual number, as if it doesn't exist, as if it is some sort of nonspending event by an accounting mechanism which claims that actually we are not going to spend that $40 billion, we are just going to spend this $3.5 billion on that program on an annual basis.

The disingenuousness of this reaches a new level of misrepresentation to the American taxpayer as to what the burden is that is going to be put on them as a result of this proposal. Now, why do they do this? Why do they deny there is $40 billion of spending, which they know is going to occur, which my colleagues on the other side of the aisle absolutely know is going to occur? Why do they deny it is going to happen? Why do they use this gimmick where they claim we are going back to a cost of a program which is less than it is today after we put a cost on the books that is three times what it is today? Because they want to avoid something called pay-go—pay-go—which is their representation of how they discipline the Federal budget.

Every time you listen to a colleague from the other side of the aisle talk about disciplining the Federal budget, you will hear those words: I am for pay-go; I am for pay-go. We hear it from the budget chairman incessantly. We hear it from other members of the other side of the aisle. Pay-go is the way we will discipline the Federal budget.

Well, let's see what they have done to pay-go since they have been in charge of the Congress. There is no more pay-go. It should be fraud-go. It is actually Swiss cheese-go since this Congress has been dominated by the Democratic Party.

I will bet you that everybody who ran for election from the Democratic side of the aisle to this Congress said they were going to discipline the Federal deficit using pay-go. Since they have been in office, since they have been running this Congress, they have either waived or gotten around pay-go on about 12 different occasions, representing billions of dollars of cost to the American taxpayer, of which this $40 billion item we are doing today is one of the biggest. With minimum wage, they went around pay-go; with the Water Resources Development Act, they went around pay-go; with PDUFA, they went around pay-go; with immigration reform, they went around pay-go; with the Energy bill, they went around pay-go; with the MILC bill, they went around pay-go; with the county payments or payments in lieu of taxes, at $4 billion, they went around pay-go; with the new mandatory Pell grants, $6 billion, they went around pay-go; and now here, with SCHIP, they are going around pay-go to the tune of $40 billion. Almost $90 billion has been proposed to be spent by the other side of the aisle since they took control of this Congress which should have been subject to pay-go but where they have either waived, ignored, or gimmicked pay-go out of existence. So where is the fiscal discipline? It doesn't exist. It doesn't exist.

The only thing they intend to use pay-go for is to force taxes to go up on American workers. They will use it for that, there is no question about that. When we get to the point where some of these tax issues are raised by expiring, they will say pay-go applies to that and we have to pay for that, so taxes will go up on the American workers and on the American economy. But when it comes to spending money, there is no discipline of pay-go from the other side of the aisle.

Anyone who stands on the other side of the aisle and claims that pay-go is a viable vehicle for disciplining the Federal deficit, well, the next thing they are going to tell you is they have a bridge to sell you in Brooklyn or that the check is in the mail.

The simple fact is, it is a fraud on the American taxpayer when that statement is made. This bill pretty much completes the thought that there is no more pay-go.

Then, on top of that—they are not comfortable enough in this bill to spend $40 billion and claim they are not spending it, which is exactly what they do in the second 5 years—that is not enough for the other side of the aisle. In the House, they put in language repealing one of the most important enforcement mechanisms to discipline the cost of Medicare, which is, if for 2 years the payment for the cost of Medicare from the general fund exceeds 45 percent of the overall cost of Medicare—as we all know Medicare is supposed to be an insurance program that is paid for by the HI insurance, but it also gets support by the general fund—if that cost exceeds 45 percent for 2 years in a row, then we, as a Congress, are supposed to take another look and say that is not the way Medicare is supposed to be funded. It is supposed to be funded through the HI insurance. We go back to look at disciplining Medicare spending and making it more affordable.

No. Not any longer. The House of Representatives not only spends $40 billion they claim they are not spending and don't pay for, they also, in their bill, repeal the 45-percent rule, one of the few disciplines around here which allows this body to stand up and say we are profligate. Let's get this under control.

I think the American consumer needs to know that they get what they pay for. In the last election they got a Congress which has a philosophical viewpoint which has not changed a whole lot in the last 50 years. I was here the last time Congress was dominated by the Democratic Party. I was here when Tip O'Neil ran the House of Representatives. Wow, did we spend money back then. Let me tell you, we are back to that style of governance. Only this time it is being done with the representation that there is discipline because we are using pay-go. Unfortunately, however, pay-go doesn't exist when it comes to spending. It is ''fraud-go,'' it is ''Swiss cheese-go,'' and the American people get stuck with the bill.

Our children and our children's children get stuck with the bill because, in order to address certain political constituencies, the other side of the aisle believes it needs to spend the money, and it does not have the courage to stand up for its own rules, the rules they put forward.

I have always said pay-go was a fraud, but the other side of the aisle marches behind that banner in budget after budget, claiming that pay-go gives us fiscal discipline. Here is $90 billion of spending in just 6 months. They have only been in charge for 6 months—$90 billion. That is a lot of money in 6 months that should have been subject to pay-go, which has been gamed, ignored, or claimed an emergency so that pay-go would not apply.

As a practical matter, let's have no more talk of pay-go in this body. Let's talk about what we are really doing on this SCHIP bill. We are going to spend $40 billion, and we do not pay for it. That is just in the next 5 years. If you extrapolated this, it actually works out to be somewhere in the $2 trillion to $3 trillion range over the life expectancy of the program, the 75-year life expectancy, which is the way we calculate things around here that deal with entitlements.

This is not fiscally responsible, and it is clear, if we continue down this path, we are going to set up a train wreck for those who come after us and have to pay the costs of this type of profligate spending which has no discipline attached to it.

I yield the floor and suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

ORDER OF PROCEDURE

Mr. DURBIN. Mr. President, how much time is remaining on the Republican side?

The ACTING PRESIDENT pro tempore. About 1 minute.

Mr. DURBIN. I ask unanimous consent to preserve that minute, and if one of the Republican Senators wishes, they be given that time.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. DURBIN. I speak now in the 30 minutes I understand is reserved for the majority in morning business.

GENOCIDE

Mr. DURBIN. Mr. President, today is a day which can be historic. Important items will be discussed on the floor of the Senate, including health insurance for literally millions of American kids. At the same time, there is a debate that has been started in New York at the United Nations Security Council. It is a debate about a genocide.

It is, thank goodness, rare that we have to address the issue of genocide in this world, but today we must. We are talking of a genocide today, in New York, at the Security Council, that has caused untold human misery, mass murder, dislocation, torture, rape, and the torching of entire villages. For 4 years the world has watched this tragedy. That's right, for 4 years.

Haven't we learned our lesson when it comes to letting genocide continue without taking action?

There is a great Senate story involving former Wisconsin Senator Bill Proxmire. In 1967, Senator Proxmire began a streak in the Senate that has never been broken. Mr. President, 18 years earlier, in 1949, President Truman had sent the United Nations Genocide Convention to the Senate for advice and consent. In 1967, it was still languishing, held up by a small band of Senators who opposed it. Many Senators just shook their head because of this opposition. Bill Proxmire rose to his feet.

Starting in 1967, Senator Proxmire made a speech every day the Senate was in session, for 19 years, imploring the Senate to adopt the Genocide Convention. All together, he gave 3,211 speeches—each one of them different. In 1986 the Senate gave its consent to the treaty.

Why did Senator Proxmire continue to give all those speeches, day after day, year after year? It wasn't just stubbornness. It was a moral obligation, and because he understood genocide was happening again. At that time it was happening in Cambodia.

Between 1975 and 1979 the Khmer Rouge murdered 2 million people. The United States wisely and bravely led the international effort to hold the Nazi co-conspirators to account at Nuremberg. We and the rest of the world failed to act while Cambodia was being turned into killing fields.

In 1994 we failed to act again when between 800,000 and 1 million people were murdered in Rwanda in 1 month.

Sadly, we have failed to take the necessary action to stop the genocide in Darfur. More than 2½ years have passed since the U.N. commission of inquiry concluded that:

> Crimes against humanity and war crimes have been committed in Darfur and may be no less serious and heinous than genocide.

Earlier this year, President Bush declared:

> For too long, the people of Darfur have suffered at the hands of a government that is complicit in the bombing, murder and rape of innocent civilians. My administration has called these actions by their rightful name: genocide. The world has a responsibility to put an end to it.

Yesterday, the new British Prime Minister, Gordon Brown, said in a joint press conference with President Bush that:

> Darfur is the greatest humanitarian crisis the world faces today.

Yet it is not simply enough to acknowledge genocide. We need to follow Senator Proxmire's example in having the courage, in real time, to act against it.

The crisis in Darfur has been repeated over and over. Paul Salopek, a Chicago Tribune reporter, was captured and jailed by the Khartoum government for 34 days last year. He wrote a haunting description of what one sees when you fly over the villages of Darfur. This is what he wrote:

> Their torched huts seen from the air, look like cigarette burns on a torture victim's skin.

Most recently, Refugees International released a report documenting that:

> Rape on a mass scale is one of the hallmarks of the conflict in the Darfur region of Sudan. An estimated 300,000 people in Darfur have been killed during this genocide; 300,000 people in a country of 40 million. In the United States that would be the equivalent of over 2 million people killed.

Incredibly, the Sudanese Government claims the atrocities are part of their war on terror. At a press conference in Washington earlier this summer, Sudan's Ambassador to the United States compared the slaughter to a family quarrel, and he said:

> Just you and your cousin fighting with you.

Just this last week, Sudanese President Bashir visited Darfur and said:

> Most of Darfur is now secure and enjoying real peace.

People there are ''living normal lives.''

These are lies. This is genocide. It is calculated. It is happening on our watch, in our time.

This week, the global community has a chance to finally make a difference. I am going to join today with Senators FEINGOLD and MENENDEZ in calling for a decisive vote at the United Nations on an expanded peacekeeping force and renewed diplomatic effort in Darfur. The U.N. Security Council will vote this week, maybe even today, on a new United Nations-African Union peacekeeping force that can make a dramatic difference in stemming the violence in Darfur. It also provides an equally important opportunity for peace negotiations.

After years of duplicity in the genocide, Sudanese President Bashir agreed last month to the significant expanded joint United Nations-African Union peacekeeping force. Yet a series of his recent comments contradict that commitment, and a history of involvement in violence makes immediate action all the more important.

The need is simple—rapid deployment of the new peacekeeping force and a renewed diplomatic effort at a long-term political settlement.

I have tried in some small way to urge the members of the United Nations Security Council to act swiftly. I discussed urgency of these matters with U.N. Secretary General Ban Ki-Moon and the Ambassadors of China, Ghana, Republic of Congo, Russia, and South Africa. All were current or permanent members of the Security Council. It is the first time I have ever picked up the phone to call Ambassadors from other countries about a vote in the United Nations Security Council, but I think it is that important. It is my hope that our U.N. Ambassador, Zalmay Khalilzad, will work closely with these nations and Secretary General Ban to make these steps a reality.

I stressed to the Secretary General and to the Ambassadors that the Security Council should be firm in its mandate. We need a force with sufficient resources and numbers; a strong mandate to protect civilians, peacekeepers, and humanitarian workers; a clear U.N. command and control structure, and benchmarks with the threat of sanctions that hold the Sudanese Government accountable; no room for further stalling or delay by the Sudanese Government; a renewed diplomatic effort to bring about a long-term political settlement, including naming a Special Representative of the Secretary General to monitor implementation of a comprehensive peace agreement; and the force must be deployed as quickly as possible.

Congress, the administration, and the private sector—we all need to take action to end the genocide in Darfur. In Congress we have passed the Genocide Accountability Act, which allows the prosecution of genocide committed by anyone currently in the United States, regardless of where the genocide occurred. We have passed language in the Iraq supplemental bill that requires the Treasury Department to submit to Congress a report that lists the companies operating in the Sudanese natural resources industry, and requires the General Services Administration to report to Congress on whether the U.S. Government has an active contract with any of those companies.

Later today the House is expected to pass a bill that would support State and local divestment efforts, require companies to disclose Sudanese-related business activities, investigate whether the Federal Retirement Thrift Investment Board has invested funds in any of these companies operated in Sudan, and bar the U.S. Government from operating with any companies operating to benefit the Sudanese regime.

A few weeks ago, the Senate passed the International Emergency Economic Powers Enhancement Act, which increases civil and criminal penalties associated with violating American economic sanctions such as those against Sudan. I encourage our House counterparts to pass this bill as well.

I have introduced legislation similar to the bill the House is expected to pass today that would support State governments that decide to encourage public funds to divest from Sudan-related investments. That bill has strong bipartisan support, nearly a third of the Senate.

We tried to pass it, but someone in the Senate has put a hold on that bill.

They have decided we should not move quickly to try to divest and discourage genocide. I urge whatever Republican colleague on that side has put a hold on this bill to seriously stop and consider the impact of this political move. We need to make sure the House and the Senate are on record on a bipartisan basis, clearly, unequivocally.

I have also included in the Senate Financial Services and General Government Appropriations Act language requiring the administration to report on the effectiveness of the current sanctions regime and recommended steps Congress can take.

Personally, some of us have decided to divest from Sudan-related investments in our own portfolios as a gesture of solidarity. The administration has taken some important steps. In April of this year, at the Holocaust Museum, President Bush declared rightly that the United States has a moral obligation to stop the genocide in Darfur. Recently the President took the first step toward meeting that obligation by ordering the U.S. sanctions against Sudan be tightened.

The Treasury Department is adding 30 companies that are owned or controlled by the Government of Sudan to a list of firms that are barred from U.S. financial assistance. The Office of Foreign Assets Control within the Treasury Department, working with other agencies, has worked hard to tighten economic and political sanctions.

Although these are important steps, I wish the U.S. Government, the Congress, and the President, had taken these steps sooner. Ultimately, we and the private sector must do all we can to ensure the genocide in Darfur once and for all is brought to an end.

I am going to end today with a quote from Nobel laureate and Holocaust survivor Eli Weisel:

> Take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented.

I see on the floor my colleagues from Wisconsin and New Jersey who join me today in this floor effort, this message to the United Nations. I wish to thank Senator MENENDEZ for his continuing interest in this Darfur genocide. He has carried on in the Senate a tradition started when I first came here by his predecessor, Senator Corzine.

I also wish to thank Senator FEINGOLD, who is chairman of the African Subcommittee of Foreign Relations. He has a special interest in that continent and a special dedication to ending the genocide in Darfur.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from New Jersey.

Mr. MENENDEZ. Mr. President, I wish to thank my distinguished colleague, Senator DURBIN, for bringing us together today to talk about the ongoing genocide in Darfur and, more specifically, the upcoming U.N. Security Council resolution and for his continuing efforts in the Senate.

I am also honored and pleased to be with Senator FEINGOLD, who has been such an incredibly powerful voice on this issue, both in his position as the chairman of the African Subcommittee on Foreign Relations and in his principle position itself. I am honored to join with them in this effort.

Today, as we speak on the Senate floor, the U.N. Security Council is negotiating a new Darfur resolution. So today we are on the Senate floor to send a loud and clear message to the United Nations. The people of Darfur need a strong and meaningful resolution that puts into action the end of the genocide and ensures that a United Nations-African Union troop force gets into Darfur.

Today, we are here to add our voices to those who call for a U.N. resolution with strong authority, for a robust hybrid United Nations-African Union force, and a full mandate and speedy deployment. It has long been clear that the overstretched and underfunded African Union troops cannot end the genocide. If this new force is not allowed in, the carnage and the destruction we have witnessed now for over 4 years will continue.

We have known that a U.N. force is the key to ending the violence in Darfur, and we have tried in the past to put it into place. Over a year ago, when I first came to the Senate, I got the Senate to pass an amendment for $60 million to fund the U.N. peacekeeping force in Darfur. I was joined by my colleagues in that effort.

Almost 1 year ago, the U.N. Security Council passed Resolution 1706, which called for 22,500 U.N. troops and police officers to support the African Union force in Sudan. Yet we still see no hybrid force on the ground. We still hear of attacks on humanitarian workers, we still learn of atrocities against civilians.

The lives of these millions of displaced persons now hang in a delicate balance between life and death. If we were in the refugee camps being attacked, who among us would be content with the counsels of: patience, patience, and delay. Who?

Let's be frank; it has been the Government of Sudan that has kept this force from entering. Now they recently have agreed to allow a force in. Yet we have heard these words before. Words mean little without real action. That is why I am pleased this new U.N. Security Council will likely include the transfer of authority to a hybrid United Nations-African Union mission that will allow the use of force to ensure the security and movement of the mission's personnel and humanitarian workers.

But to be meaningful, this force must be deployed, and it must be deployed as quickly as humanly possible. I am disappointed, however, that after rounds of negotiations, the resolution was ultimately watered down. From what I understand, there will be no reference to sanctions, there will be no right to seize and dispose of illegal arms, there will be no reference to the jingaweit, the brutal pro-Khartoum militia force responsible for many of the atrocities.

While I understand the need to negotiate a resolution that will pass, ultimately, we cannot let this manipulation continue. We cannot let Sudan's Ambassador have veto power over these lives. We cannot let nations with permanent seats and veto power on the Council continue to act irresponsibly. That is where I wish to close.

China says they generally approve, generally approve of the new resolution. They have been working, however, behind the scenes to weaken it. They reportedly helped remove references to sanctions. They reportedly objected to its ''controversial tone'' about genocide. Simply put, they continue to act in their own economic interest. We have seen them take some positive steps in the past, and it is positive that they are reportedly not going to block this resolution and that they may even support it.

But such a small step when China is under public international pressure is simply not enough. That is why I am pleased my resolution on China and Darfur passed the Senate last night. This resolution, which my colleagues on the floor supported, calls on China to use its unique influence and economic leverage to stop the genocide and violence in Darfur.

China has longstanding economic and military ties with Sudan, and they must use their economic leverage to do more than fill their wallet. As China prepares to host the 2008 Olympic Summer Games, we must hold the Chinese Government accountable to act consistently with the Olympic standard of preserving human dignity around the world, including in Darfur.

Once again, the international community finds itself with another opportunity to bring about real change in Darfur. The resolution being passed by the U.N. Security Council will only be meaningful if measures with teeth are included.

As John Prendergast, senior adviser to the International Crisis Group, said recently in testimony before Congress:

> Barking without biting is the diplomatic equivalent of giving comfort to the enemy.

Time has run out for negotiations. Time has run out for the Khartoum Government to balk. Time has run out for watered down U.N. Security Council resolutions. We must get that hybrid force on the ground. We must end the genocide.

If ''never again'' is to have real meaning, if those words we use are to have real meaning, it has to have strong action to stop the genocide, strong action that history will judge as among the righteous, anything less will lend to our collective condemnation, and to the ever-nagging conscience that will not rest as others die.

That is the choice before the U.N. Security Council. I am glad those of us here are making our voices felt so, hopefully, the Council will act and we can have meaningful action to ''never again.''

Mr. FEINGOLD. Mr. President, I am pleased to join my colleagues on the floor today to raise the critical and timely issue of the U.N. Security Council's authorization of an expanded peacekeeping mission for the Darfur region of Sudan. Senator DURBIN has been a stalwart advocate for the people of Darfur for years and I admire and appreciate his dedication to keeping their plight at the top of Congress's agenda and to making sure we finally take strong action to help the more than 2 million displaced Darfuris who are languishing in squalid camps and punish those who continue to be responsible for their plight.

The United Nations Security Council is currently considering a resolution expected to authorize a robust peacekeeping mission to protect the innocent people of Darfur. This is of course a welcome, and overdue, effort. By now, there is little disagreement anywhere in the world that the current force of just over 7,000 courageous but underequipped and beleaguered African Union peacekeepers is not adequately protecting civilians or aid workers from attacks by rebels and government-sponsored militias, nor are they able to sufficiently safeguard humanitarian access to the tens of thousands whose survival now depends upon outside assistance. The AU force in Darfur has repeatedly been deprived of adequate resources and equipment, and yet despite this inconsistent support they have remained committed to the job. Support from the United Nations has been in theory forthcoming, for quite some time. In principle, the roadblocks have been many and the unfortunate result of this hobbled mission transition has been more violence, more displacement, and more death throughout Darfur.

The recent acceptance to expedite the transition of this mission to a more robust U.N.-AU mission is a step in the right direction, but we must bear in mind the number of agreements that have long since been overlooked, ignored, or flat-out rejected by the Sudanese Government.

And while a draft resolution being circulated indicates that the international community is actively moving forward to deploy this hybrid force, I am very disappointed that the resolution's cosponsors have succumbed to pressure from the Sudanese and deleted language which condemned the government for violations of past U.N. resolutions and peace agreements and removed the threat of sanctions in the event of continued noncompliance. The United States Ambassador to the United Nations, Mr. Zalmay Khalilzad suggests that the United States has been ''flexible'' and ''open minded in terms of non-core issues'' when negotiating this resolution, and I can only hope the administration will not .show flexibility when firmness is required. I certainly understand the necessity of diplomatic compromise; however, I feel strongly that the draft resolution being circulated in New York has been unacceptably weakened.

The amended resolution begins by ''Recalling all its previous resolutions and presidential statements concerning the situation in Sudan.'' In fact, however, this new proposal steps back from nearly a dozen Security Council resolutions, dating back to July 2004. Those resolutions were not just addressing the ''situation in Sudan''—they were expressing concern over the rising violence in Darfur and the role of the Sudanese Government in perpetuating the conflict. The distinction here is an important one and should not be overlooked.

The preamble goes on to detail the development and endorsement of the so-called Addis Ababa Agreement, which laid out the three-phased approach to an unprecedented joint United Nations-African Union ''hybrid'' peacekeeping mission. At that time—8 months ago—then-Secretary-General Kofi Annan seemed confident that troops would be mobilizing soon, and the U.S. administration promptly welcomed what it called ''the successful outcome of this historic meeting.''

What appears to have been forgotten in November, and again in the current U.N. debate, is that in August of 2006—just about a year ago—the Security Council passed Resolution 1706, which authorized up to 22,500 U.N. troops and police officers for a robust United Nations peacekeeping force with the power to use all necessary means to protect humanitarian aid workers and civilian populations, as well as to seize and dispose of illegal weapons. The new resolution currently being considered in New York does not reference Resolution 1706 or the Sudanese Government's defiant refusal to comply with its provisions. Nor does it draw the appropriate lessons from the failed attempt to deploy U.N. peacekeepers in Darfur almost a year ago.

Rather than include stronger monitoring and enforcement mechanisms to ensure that the Sudanese Government and other parties to the conflict abide by existing agreements and cooperate with the new peacekeeping mission, the resolution's cosponsors appear to have backed down to Sudanese pressure. Their weakened resolution omits a condemnation of Sudan for failing to ensure humanitarian aid reaches those in need, deletes reference to evidence of violations of the UNSC-mandated arms embargo—which many outside experts have noted has been repeatedly violated with little consequence—drops a request that the Secretary General immediately report any breach of this or previous resolutions and agreements, and removes a threat that the U.N. would take ''further measures''—in other words, sanctions—in the event of noncompliance. How can we believe that individuals will be held accountable for their actions when we have seen such entrenched impunity?

In terms of the peacekeeping mission envisioned for Darfur,this new resolution is much less ambitious than Resolution 1706. The new ''UNAMID'' mission is referred to as an ''operation,'' rather than a ''force,'' and rather than giving peacekeepers the authority to ''use all necessary means'' to protect civilians and aid workers, the new resolution allows them only to ''take all necessary action.'' These semantic distinctions reveal a worrisome retreat from the robust, capable mission authorized in Resolution 1706. And yet, the Sudanese Government has criticized even this diluted resolution. As I said before, diplomatic compromise is important, but not as important as making sure we finally have the tools to punish and put a stop to atrocities.

Sudan's obstruction of this most recent international effort to end the genocide in Darfur should not surprise anyone. After all, this is the same regime we saw attack its own citizens in indiscriminate bombing raids and obstruct humanitarian access during 2 decades of bloody civil war with southern Sudan. These same tactics are being used today in Darfur.

Last week, in its first overall review of Sudan's record for more than a decade, the U.N.'s independent Human Rights Committee said that ''widespread and systematic serious human rights violations—including murder, rape, forced displacement and attacks against the civil population—have been and continue to be committed with total impunity throughout Sudan and particularly in Darfur.'' The only thing more disturbing than the Sudanese Government's practice of organized atrocities as a method of governance is the inability of the international community so far to put a stop to these crimes and secure justice for the victims.

How many more families must be displaced? How many more innocent lives lost? How many more U.N. resolutions, presidential statements, political speeches, and public rallies will be needed? How much evidence of calculated persecution will it take before the international community stands up to the Sudanese Government and the rebels, brings them to the negotiating table, and deploys an expanded peacekeeping mission to protect civilians and ultimately, help secure the peace, in a region that for too long has received much attention but little action?

Although the revised resolution omits the original reference to Chad and the Central African Republic, it does express ''concern that the ongoing violence in Darfur might further negatively affect the rest of Sudan as well as the region.'' The short- and long-term impacts of the crisis in Darfur are real, far-reaching, and very troubling. The humanitarian consequences will require massive logical coordination and rehabilitation assistance. Economically, the rebuilding of infrastructure and livelihoods will demand additional resources and technical support. And this will be required not just for

Darfur but for the whole of Sudan, as well as the broader region.

If this U.N. resolution is passed as it currently stands, we can expect the Sudanese Government to try to evade its requirements and agreements without a single consequence. Should that happen, the toll of the genocide in Darfur will continue to mount—in lives lost, in persons displaced, and in fundamental human values that the international community has failed to uphold.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Illinois.

Mr. DURBIN. How much time remains in morning business?

The ACTING PRESIDENT pro tempore. One minute on the Democratic side and 1 minute on the Republican side.

Mr. DURBIN. I yield back the remaining time on our side and suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BAUCUS. I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

SMALL BUSINESS TAX RELIEF ACT OF 2007

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will proceed to consideration of H.R. 976, which the clerk will report.

The legislative clerk read as follows:

A bill (H.R. 976) to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes.

AMENDMENT NO. 2530

Mr. BAUCUS. I call up my amendment at the desk.

The ACTING PRESIDENT pro tempore. The clerk will report.

The legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH, proposes an amendment numbered 2530.

Mr. BAUCUS. I ask unanimous consent that reading of the amendment be dispensed with.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. BAUCUS. Mr. President, the Senate now has before it the reauthorization of the Children's Health Insurance Program, otherwise known as CHIP. Pending is a substitute amendment that reflects the bill reported by the Finance Committee by a vote of 17 to 4, a strong bipartisan vote.

The bipartisan package Finance Committee colleagues and I crafted will give millions more American children the healthy start they need to lead a long, productive life.

Behind me is a photo of Abigale. Who is Abigale? Abigale is from Missoula, MT. At the time the photo was taken she was 4 years old. Abigale has two siblings, and they live with their mother and father. All three of the children participate in the Montana Children's Health Insurance Program. When Abigale was 2½ years old, she fell down, split her head open and had to have nine stitches. Her medical care was covered by the Children's Health Insurance Program. That same year her 6-year-old brother broke his arm twice and CHIP paid for the surgery, the hospital stay, and all of the medical care he received.

Fawn, Abigale's mother, is thankful to have CHIP not only for the emergency care it provides but also it helps immunize children against childhood diseases and allows them to get the checkups they need for school each year.

Not having health insurance clearly affects a child's life. Uninsured kids do not go to the doctor. They do not have checkups. They remain undiagnosed for serious childhood conditions such as asthma and diabetes. They do not have vaccinations, and they put themselves and their schoolmates at risk for serious illnesses. Kids without health insurance do not have eye exams and are less likely to get glasses, and often cannot see the chalkboard at school. They are not diagnosed with learning disabilities, and they struggle through their classes. Kids who do not have insurance do not see the dentist. They do not get their cavities filled. They do not get braces, and they risk serious illness due to poor dental health. Adequate health care creates a critical foundation for a healthy life.

No one wants innocent children to suffer. Investing in children's health is the compassionate choice, but it is more than that. Insuring our children is a smart economic investment in our Nation's future. Why? Because it is the only choice, if we wish to imbue future generations with strong minds and healthy bodies. It is quite simple. Health insurance has a direct effect on a child's performance at school. Healthy children are more likely to go to school, and they are more likely to do well in school. Then they are more likely to become productive members of the workforce.

Children with health insurance are less likely to receive expensive emergency room care. Parents of children with health insurance are less likely to miss days at work to care for their sick children. When America insures our children, we are all better off, we all benefit.

Health insurance is especially important to the success of minority populations. African-American, Hispanic, and Native American children are all less likely to have health insurance. They are more likely to be poor. Providing affordable coverage is one of the best ways to reduce the gap for these kids.

CHIP has already helped to narrow racial and ethnic disparities in access to care among low-income children. But we can do better. We can continue to narrow that gap.

Health insurance is also a key ingredient to alleviating child poverty. Low-income families without insurance often get stuck in a bitter cycle of medical debt. Parents struggling to make ends meet should not have to choose between buying asthma inhalers for their children and putting dinner on the table.

So I hope my fellow Senators will make the right choice, the only choice. I hope they will join me in making our children's future, and America's future, a brighter one.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Vermont.

Mr. SANDERS. Mr. President, this debate is not just about extending health care to our children. It is about our national priorities. It is about who we are as a nation. It is about which side we are on.

For the last 6 years, we have had a President who has insisted, as one of his major priorities, on more and more tax breaks for the very wealthiest people in our country. People who are worth millions of dollars and people who are worth billions of dollars have, collectively, received hundreds and hundreds of billions of dollars in tax breaks. But when it comes to those people most in need, those people who are most vulnerable, including the children of our country—the kids who are 2 or 3 years of age—who have health care needs, this President, tragically and embarrassingly, has not been there. If you are wealthy and powerful, he is there. If you are a child and vulnerable, AWOL—he is not listening. In fact, he has been in opposition.

It is no secret to the American people that our current health care system is disintegrating. Today, 46 million Americans, including over 9 million children, have no health insurance whatsoever, and tens of millions more are underinsured, with high premiums and copayments. Costs are soaring every single year, and small businesses in my State of Vermont and throughout this country are no longer, in many cases, able to offer any health insurance. Throughout the country today workers are being asked to pay a higher and higher percentage of the cost of their health insurance, and many of them cannot afford to do that because health insurance premiums have been rising four times faster than workers' earnings since the year 2000.

In the midst of all of that—more and more uninsured, costs soaring—we end up spending twice as much per capita

on health care as any other country and remain—we remain—the only Nation in the industrialized world that does not guarantee health care to all our people as a right of citizenship. Today, we are debating about whether we should expand the SCHIP program to 3 million more children. But all over the industrialized world, every child in those countries has health care as a right of citizenship.

Despite the over $2 trillion—$2 trillion—we now spend on health care—money which, to a significant degree, goes to enrich the insurance companies and the drug companies—our health status measures, including infant mortality and life expectancy, rank among the lowest of developed countries. We spend twice as much as other countries per person on health care—with over 9 million children who have no health insurance—and yet health status measures are lower than many of our allies around the world.

There is no question but that in the face of rising costs and a broken health care system, we need to make fundamental changes in the way we do health care in this country. We need to develop a cost-effective national health care program which guarantees health care to all our people, and study after study suggests we can do that without spending any more than we currently spend on our wasteful and bureaucratic nonsystem. That is what we have to do, and that is what I will fight for as long as I am in the Senate.

Today, we are discussing, despite what some may say, what is, in fact, a modest proposal—a modest proposal. We are discussing an expansion of the SCHIP program, which would expand health care to some 3 million more children. Over 9 million American children today are uninsured, and all we are doing today is saying: Let's expand health insurance to one-third of those children. If this bill were passed in 5 minutes, two-thirds of the uninsured children would remain uninsured, and in the United States of America we can do a lot better than that.

As Chairman BAUCUS has said, as Senator OLYMPIA SNOWE said last night, investing in the health insurance of our children is a good investment. It is cost effective. Today throughout this country there are children who are unseen by medical professionals. They are developing illnesses which are undetected. Those illnesses become worse as they get older. They end up in the hospital. It costs significant sums of money to treat these young people, as they age, in hospitals, when we could have eased their suffering and saved money by getting to their illnesses when they were young, if they had the opportunity to see a doctor.

As Chairman BAUCUS also mentioned, there is the issue of dental care in this country. In my own State of Vermont and throughout this country, there are millions and millions of young people who simply cannot gain access to a dentist who have teeth rotting in their mouths in the United States of America, in the year 2007. That is not acceptable to me, and I hope it is not acceptable to my colleagues in the Senate.

Given this sorry state of affairs regarding health care in this country in general, and the needs of our kids in particular, I find it ironic we are having any debate about increasing health insurance coverage for children under the SCHIP program.

Let me be very clear, in terms of providing health insurance to our kids, I would go—and will go—a lot further than this legislation. I have, in fact, recently introduced S. 1564, the All Healthy Children Act of 2007, which would provide health insurance to every child in America. That is where I think we should be going.

Some people, including the President of the United States, are saying: My goodness, this bill will cost $35 billion over a 5-year period; we can't afford that.

But I find it ironic that many of those same people, including the President of the United States, believe, among other things—among many other things—that we can afford to repeal entirely the estate tax, which would benefit only the top three-tenths of 1 percent of the American people. The very richest people in this country would, if the President had his way, receive $1 trillion in tax breaks over 20 years. That is $1 trillion in tax breaks over 20 years going to the wealthiest three-tenths of 1 percent of the American people. That we can afford. But when it comes to spending $35 billion over a 5-year period for the children of our country, we do not have the money.

I find it ironic, if we repealed the inheritance tax, one family, the Walton family who owns Wal-Mart, would receive $32 billion in tax breaks. Yet we are trying to insure 3 million children today for $35 billion. So $32 billion for one family; $35 billion for 3 million children.

To my mind, what this debate is about is getting our priorities right as a nation. I am getting a little bit tired of hearing many of my colleagues, and hearing this President, talk about family values, when we have almost 10 million children in this country uninsured. If you are interested in family values, you are interested in the future of this country, you are interested in the children of this country.

This is a modest proposal. It is a first-step proposal, and it should be passed and passed immediately.

Thank you very much.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, I might ask how much time the Senator from New Jersey would like to consume. I very much appreciate and admire him and thank the Senator from New Jersey for speaking on this amendment. It would be helpful to know how long he would be speaking. He can have whatever time he wishes.

Mr. MENENDEZ. Mr. President, I would say between 15 and 20 minutes.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senator from New Jersey be recognized to speak for 20 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BAUCUS. I thank the Chair.

The ACTING PRESIDENT pro tempore. The Senator from New Jersey.

Mr. MENENDEZ. Mr. President, I thank my colleague, the distinguished chairman of the Finance Committee, not only for making the time available but, more importantly, for his leadership on this critical issue of insuring the Nation's children. There is no stronger voice in the Senate on this issue. I am incredibly proud to have worked with Senator BAUCUS, someone who is keenly interested in this program. I appreciate what he has done in bringing a solid bill to the floor.

I rise today on behalf of our Nation's children and working families. I am reminded every day when I come to the Senate that it is my privilege—privilege—to represent these individuals in the Senate, and with every vote I cast in this great Chamber, I try to always ensure I am protecting and serving our hard-working families.

This week, we are considering a bill to reauthorize our children's health program—a program that affects millions of families across the country. This week, every vote—every vote—we cast will have a direct impact on the health and well-being of our Nation's children and their families.

I cannot overstate how important and how successful this program has been. It currently provides health care to 6.6 million children. Sometimes I think it is important to remember exactly what it means to provide health care for children. It is the immunization shot before school begins. It is a well-child doctor visit that catches early signs of cancer. It is the emergency care coverage after a car accident. It is the new eyeglass prescription to finally see the blackboard. It is an x ray for a broken ankle and a prescription medication for a strep throat. It is about ensuring the well-being of that child so they can fulfill their God-given potential.

Proper coverage can be the difference between life and death, between health and sickness, and between compassion and heartlessness.

In the next few days, we have choices to make, and I hope each of my colleagues ask themselves one question before they cast their vote: Is this good for our Nation's children? Because that should be the only question and the only goal.

I am proud of my home State of New Jersey for always keeping this goal in its mind. Our program, New Jersey FamilyCare, currently covers over 126,000 children and 80,000 parents. These are working families who don't qualify for Medicaid but can't afford

private coverage, and they don't get health care at their job. They work at some of the toughest jobs our State has to offer. They get up every day, 5 days a week—sometimes more—to try to make ends meet for their families, but they don't have health insurance. These are families who, without the children's health program, would yet be another American family cast into the ocean of the uninsured. This program saves them from that fate.

Let me take a moment to humanize what we are talking about, because we talk about these programs in the abstract. They are about lives; they are about people. Elizabeth Geronikos relied on the children's health program for her necessary allergy and asthma medication when her father suddenly lost his job. Jonathan Hale, who discovered a cyst in his brain, was able to get medical attention that his family would not otherwise have been able to afford because of the children's health insurance program. The Cannon family no longer has to worry about their son Jason, who now has a constant supply of asthma medication and has suffered no serious asthma attacks since being on the Children's Health Insurance Program. This is truly a life-changing, if not a lifesaving, program.

But there are also stories of children who were not so lucky. Devante Johnson, who depended on Medicaid for his cancer treatment, died, not for failed chemotherapy, but because his paperwork was never processed. He was 14 years old. Deamonte Driver died because he did not receive treatment for an abscessed tooth—something that, if treated early, would clearly not have been fatal. He was 12 years old. These stories are heartbreaking not only because a child's life was lost but also because it could have been prevented.

We must ensure that no more children go without treatment they need and that no more lives are lost. Our job as Senators is to protect these children. What greater honor and responsibility do we have but protecting our children? As a father, I can't imagine the anguish I would feel if I could not provide health care for my son and daughter. Thus, as a Senator, I feel it is our obligation to provide health care for every single child. I strongly believe we have a responsibility to ensure that no child in America goes to bed at night without proper health care and treatment, and that is why this reauthorization is so crucial.

Under this bill, over the next 5 years we would be able to continue covering the 6.6 million children currently enrolled, and we would be able to reach out and cover an additional 3.2 million children. So the answer to the question, Is this good for the Nation's children, is clearly yes, especially for those 3.2 million children waiting to receive care. That answer is a resounding ''yes.'' There are even more whom we must work to cover.

I want to ask my colleagues who say they may not support this bill, Where are the values we talk about in this institution? Where are the family values voices that so often are heard in this Chamber? Now is not the time to be silent. Now is when families need you most. Now is the time to stand by your values and stand up to protect our future generation.

To these colleagues, I wish to take a moment to answer some questions about New Jersey's effort to reach out and enroll more children. Over the past few weeks, New Jersey has received a lot of attention for covering children up to 350 percent of the Federal poverty level. In our regard, we think we are doing the right thing, and the statistics prove we are right. I can understand that some might think these families have enough money to afford private insurance, but for New Jersey families, that is simply not the case. New Jersey families face higher living costs, and they get less return on their Federal dollar, so we cannot set a policy that suggests that one size fits all.

I did some of the math which I want to share with my colleagues. At the top end, a working New Jersey family, their family budget, shows they have about $4,428 in income. Housing in New Jersey is incredibly expensive, about $1,500 a month. Food for that family is $547; transportation to get to work, or if they happen to have a car to pay for their commutes back and forth, with the high gas prices, $820; child care, if they are not in school, and health insurance. I looked up under the Bureau of Banking and Insurance what is the average health insurance coverage for a family a month—a month. The statistic on the Web site is $2,065. So that puts this family, if they have to be forced to purchase health insurance, in the negative $1,200 a month. That means they can't make ends meet. This doesn't take into account any unforeseen circumstance on the family budget. So it doesn't end up adding up. That is why this program is so important.

That is why, when New Jersey enrolls children up to 350 percent of the Federal poverty level, they do it because without this coverage, we would have thousands more children more without health insurance. Purchasing a private plan, no matter what tax incentives you give—I hear some of our colleagues talk about giving a $5,000 maximum credit per family. Well, that is great. That buys us 2½ months of insurance. What do we do for the rest of the year for that family? Do we roll the dice on their health care? I don't think so—not when we as an institution have some of the best health care in the Nation.

I am grateful to the Finance Committee for recognizing what we already knew on a bipartisan basis: The one-size-fits-all approach doesn't work. Remember, our objective is to cover more children, not less. I can't believe I even need to mention what I am about to say, but in light of some of the comments I have heard over the past few weeks about the President saying: Well, let them go to the emergency room, I think it might be necessary to look at what happens to children without health insurance and how they suffer serious consequences.

Research has shown that uninsured children not only miss regular checkups and visits to the doctors for less serious conditions that ultimately become far more serious in their personal health and far more consequential and far more expensive, but they also receive less than lower quality care. In fact, uninsured children admitted to a hospital due to injuries were twice—twice—as likely to die while in the hospital as their insured counterparts, and that is simply unacceptable.

There is no morality if upon hearing this, every Member of this Chamber does not do everything in his or her power to cover more children. It is, I believe, a moral obligation. I often hear about the value of life and I cherish it as well. Now is the time to honor the value of the lives of these children.

Another way New Jersey has been successful in covering more children is because we also cover low-income and working parents. In New Jersey, we have found a strong correlation between enrollment of parents and enrollment of children. After the State implemented its parent expansion in 2000, not only did it experience rapid enrollment of parents, but it also saw a significant increase in the enrollment of children, which is our goal. In 2002, the State stopped enrolling parents, and what happened? As parent enrollment began to fall, children's enrollment began to level off. Once the State began reenrolling parents in 2005, children's coverage began to rise again. There is clear evidence that by allowing those States that choose to do so to cover parents, you increase the number of children who have health coverage, achieving our ultimate goal of covering more children and, by the way, we end up covering more Americans.

To further prove this point, former Congressional Budget Office Director Peter Orszag recently stated that:

> Restricting eligibility to parents does have an effect on take up among children, in part because when you pick up the parent you are more likely to pick up the child.

Thus, if we stop covering parents under the Children's Health Insurance Program, as some in the Congress and the White House want to do, you end up covering fewer children.

In fact, Peter Orszag said:

> For every three of four parents you lose, you lose 1 or 2 kids.

Based on this, in New Jersey, if we were forced to disenroll all of our parents, over 40,000 children would lose their coverage. This doesn't help us achieve our goal of covering more children.

So again, we have to ask: Is covering parents of eligible children good for our Nation's children? The answer is clearly yes.

As I said at the beginning of my statement, I fully support the legislation we are considering today. Senator

BAUCUS has done an excellent job. I appreciate the bipartisan vote of the committee. I am proud of the reauthorization bill because of what it prioritizes, but also because I know how hard it was to reach this compromise. This is a bipartisan bill that Members of both sides of the aisle support. I know it has taken long nights and serious conversation and many difficult decisions to reach where we are today. I appreciate again Senator BAUCUS's incredible efforts, the members of the committee, as well as Majority Leader REID, for their efforts on behalf of the program.

That being said, I simply want to say that if I had my druthers, I would have sought to achieve a greater height. I understand that so would many of the Members who actually created the compromise. I would have liked to have seen, as I did as a member of the Senate Budget Committee, $50 billion provided. I worked hard to make sure we had that in the budget resolution. I know that is the funding that will be necessary to reach out to the 6 million eligible but uninsured children in America, and it is the funding these children deserve.

Another area of major concern is the lack of language to provide health care for legal immigrant children and pregnant women in the Children's Health Insurance Program. I am a proud cosponsor of the bipartisan Legal Immigrant Children's Health Improvement Act, also known as ICHIA, which would have repealed the morally objectionable law that prohibits new legal immigrants from accessing Medicaid and CHIP until they have lived in the United States for 5 years. I think we should have the flexibility for States to make that decision.

I am proud that in my home State of New Jersey, they have taken it upon themselves to use 100 percent of State funds to cover over 8,000 legal immigrant pregnant women and children at a cost of over $22 million. The State has temporarily fixed the problem, but I had hoped Congress would do the same. How can you tell a 7-year-old child with an ear infection he has to wait 5 years to see the doctor? How can you tell a child who may have the incipiency of some incredibly terrible disease you have to wait 5 years to go see the doctor? It seems to me we can't bar these families from accessing our health care supply simply because they haven't lived here long enough. During the immigration debate, our colleagues emphasized the difference between those who are here legally and those who are not. So it is appalling to me that a legal immigrant child—one whose family waited their time to come to this country, came here legally, obeyed the law, are working, paying taxes—is still subject to the lash of those people who, even for a child who is here legally, seem to punish. It seems to me that is simply wrong.

Let me close by addressing the President's veto threat. He is basically opposed to this bill because he says it covers too many children and families. I don't know how more outrageous and unacceptable a statement can be. I find it embarrassing that some in Washington—those who have the best health care coverage in the world—would propose to cut America's neediest families—neediest families who work hard every day, because if you are poor, you are on Medicaid. These are families who get up and work hard, don't have enough to pay insurance, don't have coverage through work, and can't afford it. Yet the President of the United States, who has the best coverage in the world, and the Vice President of the United States, whom we saw recently in the hospital—happy that everything went well for him—have no worries. They have no worries every night—and for them to say these children are less worthy than them. If the President had his way, over 110,000 New Jerseyans would lose their coverage, and tens of thousands more across the Nation would lose their coverage. I find that morally reprehensible.

I find it ironic that the President doesn't want to cover parents with this program, considering the fact that since 2001, it was his administration that granted 24 waivers for adult coverage in 15 States, including my home State of New Jersey. In fact, when a waiver was issued in 2003 to New Jersey, the administrator of CMS, the Federal agency that supervises the program, said:

> New Jersey is setting an example of how Federal waivers can help them cut into the numbers of citizens with no health coverage.

Tom Scully, Administrator of CMS, the Federal agency overseeing this program, said we are setting an example.

In 2004, President Bush made a promise to insure all of the Nation's children, but his latest proposal would only serve to cut children and increase the number of uninsured. Rather than adding to the ranks of the uninsured, we should be working together to expand access to even more children and families. Mr. President, it is time to make good on your word.

It is time to make good on your promise. It is time to cover all children. At the end of the day, this bill is about low-income and working families getting much needed care. This is about our Nation's children having access to a doctor for preventive care and receiving treatments for more serious conditions. This is about the health and safety of current and future generations.

There is only one question left to be asked: Is this good for our Nation's children? The answer is yes.

Let me close with a great Republican I admire, Abraham Lincoln. He said:

> A child is a person who is going to carry on what you have started. He [and I add she] is going to sit where you are sitting, and when you are gone, attend to those things which you think are important. You may adopt all the policies you please, but how they are carried out depends on him. He will assume control of your cities, states, and nations. All your books are going to be judged, praised, or condemned by him. The fate of humanity is in his hands. So it might be well to pay him some attention.

I ask my colleagues to now pay attention to our children and support this important bill. It is important our children. It is for our families. It is in pursuit of our values, and it is for the well-being of our country.

I yield the floor and yield back the remainder of my time.

(Ms. KLOBUCHAR assumed the Chair.)

Mr. BAUCUS. Madam President, I highly compliment the Senator from New Jersey. He is a tireless advocate to make this legislation even better than it was, especially on behalf of parents. There are other groups in his State that are very deserving. I thank him publicly. He has talked to me many times very earnestly, with a real desire to make sure the people in his State are adequately taken care of. I thank the Senator for his tireless advocacy.

I inquire of the Senator from Arkansas, roughly how much time does she wish to consume?

Mrs. LINCOLN. I hope I can have somewhere between 15 and 20 minutes.

Mr. BAUCUS. I ask unanimous consent that the Senator from Arkansas be recognized to speak for 20 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Arkansas is recognized.

Mrs. LINCOLN. Madam President, I thank Chairman BAUCUS for his tireless effort here in really portraying what I think is a tremendous priority for so many of us in the Senate and certainly in the Finance Committee.

As a mother of twin boys—and I know our Presiding Officer is a mother of a daughter who is a year older than my boys—I know all too well of the importance of reliable health insurance coverage for children. My husband and I have experienced the sleepless nights looking after a sick child. But we also have the comfort of knowing that when dawn comes, we have the opportunity, through health insurance, to seek out health care through a pediatrician or, if it should be worse, to be able to go to the emergency room and know we are covered, to know we can seek that health care for our children when they need it the most, with the confidence that with that health insurance we can continue to care for their needs.

In situations such as these, health insurance coverage is critical not only to the lifelong health of a child but also to a family's peace of mind. I think that is what we are about here today—our ability as Senators to be able to step outside the box of being a Senator and really think about what it means to be a hard-working American, to be a parent, and to not just think of what it means to us and our families as Federal employees and what we have access to in health care but translating that to the needs of all hard-working

Americans and to understand how important it is to them and to their children too.

We have to, in this debate, step outside and put ourselves in the shoes of the hard-working Americans who need health insurance for their children. That peace of mind should not only belong to those families who can afford private health insurance; it should also belong to working families who are struggling to make ends meet in today's world, who are the strength of the fabric of this Nation, those hard-working families who are going to jobs day in and day out—and sometimes more than one job—to keep the needs of their families, as was listed by the Senator from New Jersey, to make sure their families stay whole.

Coming to the bottom of that list and recognizing how expensive health care costs are for their children, we need to make sure the fabric of this Nation stays strong. We do so by not only supporting those working families and their children but by establishing priorities in this country. That is why I rise to speak on behalf of the State Children's Health Insurance Program, or SCHIP, a Federal-State partnership which today provides much needed health care coverage for more than 6 million children across this great country.

In conjunction with Medicaid, CHIP has been tremendously successful in reducing the number of uninsured children in my State and across our country. Since the program's inception 10 years ago, the number of children without health care coverage has dropped by one-third. That is something we can be proud of and that we can build on.

During that time, I am proud that Arkansas has become a national leader in reducing its number of uninsured children from over 20 percent in 1997 to 10 percent today. Now, nearly 65,000 of Arkansas' children currently receive coverage through CHIP or, as we know it in Arkansas, ARKids First.

Despite this success, an estimated 9 million children remain uninsured, nearly two-thirds of whom are already eligible for CHIP or for Medicaid nationwide—9 million children, Madam President. Those children belong to parents just like us. Their parents care for them just as we try to care for our children—yet not having the comfort of knowing their health care needs could be and should be covered.

I am certainly proud that the Senate Finance Committee has recently taken steps to reach more of these children, and I do wish to commend Chairman BAUCUS and Senators GRASSLEY, ROCKEFELLER, and HATCH, as well as their staffs, for their incredible dedication, the vision and leadership they have shown on this issue, their tireless energy in sticking with coming together to bring about a compromise—a much needed compromise—and the extraordinary effort they have put forth particularly over the past few months, which has made renewal of CHIP much more of a reality for America's families.

The CHIP reauthorization package that was overwhelmingly approved in our Finance Committee—by a vote of 17 to 4—applies the lessons of the past 10 years and builds upon the success of the program by giving States more of the tools they need while preserving their flexibility to strengthen their program and ultimately cover more children. In doing so, it would provide an additional $35 billion over 5 years that will allow States to preserve coverage for the children who are currently enrolled, while reaching an additional 3.2 million uninsured low-income children.

This proposal would also provide much needed funding to States for outreach and enrollment efforts to reach many of those who are currently uninsured and yet eligible. It also takes steps to ensure that they get a healthy start by providing care for pregnant women and establishing pediatric quality measures to improve the level and efficiency of the care they do receive. How important that is as we have begun in this country to look at the quality measures of health care, particularly for our elderly. Why is it not equally important to look at the quality measures for the pediatric care that goes to our children?

I have long supported improving access to health care coverage for pregnant women, not only because it is vital to the health of mothers and infants, but it also often reduces future health care costs. What an incredible return on our money—to see expectant mothers going full-term to deliver a child that has a much greater opportunity to perform, to be healthy, and to be less costly later in life due to health care needs. In fact, it was reported in 2005 that the socioeconomic costs—medical, educational, and lost productivity—associated with preterm birth in the United States was at least $26.2 billion. Every year, more than 500,000 infants are born prematurely, an increasing number that now affects nearly one out of every eight babies.

This is of particular concern to me because, in recent reports, more than 13 percent of births in our State of Arkansas were premature, ranking it among the States with the highest incidence of preterm babies. So many of us have been faced with those choices. I know when I served in the House of Representatives and my husband and I were so excited to receive the news that we were expecting twins, I also received the news that at my age, and certainly the work environment I was in and all of the pressures, I was also at risk for a premature delivery. I had the wonderful opportunity to make a decision that I would not run for reelection and that I could minimize my job in order to do everything within my power to bring those children into this world in a safe manner.

I look across this great country, and not all working mothers have that opportunity. They don't have those choices to be able to step aside and do everything they possibly can with the health care they receive to bring their babies into this world in the healthiest fashion. One thing we can do is to provide them the prenatal care they need and the advice and consultation to be able to do what they can to ensure those babies are delivered after a full term.

By taking needed steps to improve access to care for pregnant women, I am confident we can make strides to improve health outcomes for them and for their children. If, in fact, we don't want to do it for the sake of bringing healthy babies into this world, who are going to be future leaders of this country, we should do it as an investment. The long-term investment of a healthier child being born makes so much more sense than the long-term cost of a premature delivery and the health care needs that child would have for the rest of his or her life.

The Finance Committee proposal would also provide the Federal authority and resources to invest in the development and testing of quality measures for children's health care. Of the 146 medical schools in this country, every one of them has a department in pediatrics. We can make an incredible investment in quality measures that would give us not only the outcome we want but also the cost savings in overall health care we so much desire.

This provision would help ensure that States and other payers, providers, and consumers have the clinical quality measures they need to assess and improve the quality and performance of children's health care services.

Additionally, the bill would allow some States to use income-eligibility information from other Federal programs, such as school lunch programs, to speed up the enrollment of eligible children into CHIP or Medicaid. The Senator from New Mexico has done so much hard work on making good common sense out of the mounds and mounds of paperwork people already have to fill out, using the knowledge we already have and those mounds of paperwork to get those children enrolled in the program for which they already qualify. It would simplify the administrative process for States and certainly reduce the paperwork burdens on our families.

The bill would also provide greater access to much needed dental care for lower income children and would ensure that children enrolled in CHIP would have access to mental health care that is on par with the level of medical and surgical care they are currently provided.

As we look at our children and their growth, understanding the unbelievable essentials in dental care, not only so our children can get the nutrition they need but they can pay attention in school, they can get the education they need, which allows them to grow and be a part of this incredible Nation

in a productive way, the success of CHIP over the past 10 years is itself a great example of the things we can accomplish when we reach out across the aisle, when we work in a bipartisan way, when we come together on our priorities and put aside the partisan differences.

This bipartisan proposal we are considering today is another. We should all agree that providing health care for our children is certainly one area where partisan politics should be placed aside. There is no room for partisan politics as we address our children. After all, it is a moral issue, an investment in our Nation's most precious resource—our children; an investment in a future of our country, its leadership, and its productivity. Who can disagree with that?

As we move forward together to reauthorize this successful program, I am hopeful we can do so in the same bipartisan spirit that was demonstrated in the creation of this program, the 10-year implementation of this program, and in the recent reauthorization of this program in the Finance Committee.

It is unfortunate the President and the Secretary of Health and Human Services feel differently. In fact, their proposal to increase the CHIP funding by only $5 billion over the next 5 years falls so short of the funding needed to simply maintain coverage of those currently enrolled in the program. To justify their proposal, the administration actually claimed the number of uninsured children in our Nation was only 20 percent of the estimates calculated by the nonpartisan CBO.

Instead of forcing over a million children—a million children—to be dropped from their current health insurance provider, shouldn't we all agree that at the very least absolutely no child should lose coverage as a result of reauthorization?

The President has been adamant about leaving no child behind when it comes to their education, but shouldn't we apply this to their health care as well? Shouldn't we recognize the reason, or a part of the reason, our No Child Left Behind in education has been less productive is because we failed to provide the resources—the much needed resources—to implement good policies, basic policies? It is fine to talk about these things, but if we don't put our money where our mouth is, the health care doesn't get to the children who need it.

Moreover, shouldn't we all move forward in covering as many of the 9 million uninsured children we possibly can; finding the middle ground, as we have done in the Finance Committee? I wholeheartedly believe so, and that is why I rise in strong support of this legislation.

Some of my colleagues have raised concerns about our efforts to expand this successful program. They have argued the $35 billion compromise that was reached in the Finance Committee is too much money. You know what. It is going to cost us something to cover more children. Let us take a step back and get some perspective on how much money we are actually talking about.

Our current proposal to reauthorize CHIP provides a total of $60 billion over 5 years—$25 billion in the baseline, with an increase of $35 billion. In contrast, our operations in Iraq are now estimated to cost taxpayers $10 billion per month. So for the amount of money, nonbudgeted money, we now spend in Iraq every 6 months, we can cover an estimated 10 million lower-income children with much needed health care for 5 years—5 years. We are talking about money that is completely offset—a program that is completely paid for.

How you spend your money—and this goes for families and for Government—tends to reflect your values and your priorities. We all have to look at where our priorities are in our own family, and we as Senators and stewards of this land and this great country and its resources have to set priorities as well, and they should reflect our values—our values and our priorities. So I ask my colleagues today: What could be a bigger priority than the well-being of our Nation's most precious resource, our children?

Look at our families, the families who are the fabric of this country. One of the things they need the most is time—time to be a family, to sit down to dinner with their children, to be able to go to a PTA meeting or a parent-teacher conference, to take a small vacation, to care for an aging parent. They need time to do that. It is not easy to find that time. If you are a single parent, perhaps a single mom, but even if you are a working family, a lower income working family, working two or three jobs to be able to hit that budget the Senator from New Jersey talks about, to make sure you can hit all those issues you have to deal with, whether it is rent or groceries or certainly any type of health care you could access, it takes time—time away from our families, the time needed to build strong families, to keep their children whole and focused on the good values we want our children to have.

Minimum wage was a great example. Minimum wage was much needed, with over 10 years of not having seen that increase. What an important role it plays in providing our families greater time to be a family. At a time when more and more Americans are struggling to find affordable health care, CHIP has allowed us to make coverage more accessible for millions of children, coverage that is critical to the lifelong health of a child and to a family's peace of mind. I urge each and every one of my colleagues to explore your own conscience, not just thinking about your family but thinking about the millions of American families out there today who want nothing less for their children than what we want for ours.

Let's set aside partisan influences and support this critical effort to invest in the health care of our children, not only for the future of our Nation but for the well-being of millions of American children in working-class, lower income families. They are depending on us, the stewards of this body, the stewards of this country, and it is time we fulfill our commitment to them. I urge my colleagues to join me in supporting legislation to expand health care coverage for children.

I have been proud to work with Chairman BAUCUS and Senator GRASSLEY and others in this effort, and I certainly commend them for their leadership and good work. I look to this body to stand up and to show who it is we are and what it is we are made of on behalf of America's children.

I yield the floor.

Mr. WYDEN. Madam President, before she leaves the floor, let me thank my seatmate on the Senate Finance Committee for a passionate and eloquent address on behalf of this country's children. I commend her for it.

Madam President, I ask unanimous consent that the time between now and 12:30 be divided equally between the Senator from New Mexico, Mr. BINGAMAN, and the Senator from New Jersey, Mr. LAUTENBERG.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico is recognized.

Mr. BINGAMAN. Madam President, would the Chair please advise me when half the time allotted to me has been used?

The PRESIDING OFFICER. Yes.

Mr. BINGAMAN. Madam President, I wish to congratulate the majority leader for taking this time to bring the reauthorization of the Children's Health Insurance Program to the Senate floor. Since this program was created, through a bipartisan effort in 1997, the number of uninsured Americans has grown by millions. At the same time, the percentage of low-income children in the United States without health care coverage has fallen by a third. So this is a remarkable achievement, and this program is a large share of the reason for that achievement.

The program is critically important to my home State of New Mexico. It currently permits the State to cover over 14,000 low-income New Mexicans and will play a critical role in ensuring that all low-income New Mexicans have access to meaningful health care coverage. I strongly support the reauthorization we have reported from the Finance Committee. Of the many issues before the Senate, I believe reauthorizing this legislation needs to be at the top of our list.

Unfortunately, there seems to be a huge gap between what the administration would like to see done on this subject and what in fact is needed. The President has proposed such a small sum of new funding over the next 5 years, $1 billion per year of additional

funding, that if we were to accept that proposal, we would have a significant reduction in the size of the program and the number of children covered by the program.

Instead of reaching a larger percentage of the 9 million uninsured children in our Nation, the President's proposal would not add to the number of children covered. In fact, it would result in hundreds of thousands, if not millions, of low-income children losing their coverage.

I also wish to commend Senator BAUCUS, Senator GRASSLEY, Senator ROCKEFELLER, and Senator HATCH, all four of these individuals, who worked in a selfless and bipartisan way to come up with a proposal they could embrace and they could bring to the full Senate. The Congressional Budget Office estimates the $35 billion over 5 years authorized in this legislation will fill in the shortfalls in funding that have plagued the program for many years. It will allow us to expand coverage to nearly 4 million additional low-income children.

Although I strongly support this bipartisan compromise, there are several aspects of the legislation I hope we can still strengthen as we move forward. First, of course, I would like to see greater funding than the $35 billion over the next 5 years that is called for in this legislation. If we could go to the full $50 billion we provided for in the budget resolution, and that I believe the House is trying to enact, we could expand coverage to an additional 5 million children who would remain uninsured at the bill's current funding levels. So there are ways we can improve this bill.

I am also disappointed in changes that were made to coverage for adult populations in this program. I will not oppose the compromises that were reached on the issue, but I firmly believe the reauthorization program should not result in the narrowing of the flexibility States have had through this program to cover uninsured populations, including adults. In particular, let me discuss a little of the rhetoric that has circulated around this subject.

Coverage of adults is very important to the efforts of my State and other States in our efforts to cover low-income parents and childless adults, but in fact, this program is overwhelmingly a program that is focused on providing coverage to children. Less than 10 percent of the coverage under the SCHIP program currently goes to adults. I believe that has been somewhat taken out of context by many who have discussed the issue.

We should also note States are relying on waivers in covering the adults who are covered under the program. States are relying on waivers, most of which were approved and authorized in this Bush administration, to cover these populations. These are not Democratic-proposed waivers, these are waivers a Republican administration has approved. Tommy Thompson, our former Secretary of Health and Human Services under President Bush, in his first term stated in 2005, upon approving New Mexico's ability to cover adult populations:

> This approval means health coverage for tens of thousands of uninsured New Mexico residents—including many uninsured parents whose children are already covered. By giving States like New Mexico greater flexibility in the way they provide health care to low-income citizens, we are helping millions of people across the country to gain access to quality health care.

Madam President, how much time remains for my half?

The PRESIDING OFFICER. The Senator has 5 minutes remaining.

Mr. BINGAMAN. Madam President, let me also go to one other issue which I think is important to deal with, another shortfall in this legislation, and that is the failure of the program to provide dental coverage.

According to the Children's Dental Health Project, of the 4 million children born each year in the United States, more than a quarter of them will have cavities by the time they are toddlers, and more than half will have cavities by the time they reach second grade. This is concentrated in low-income rural children who suffer disproportionately from these problems.

I believe strongly the Children's Health Insurance Program should be expanded to cover dental care for children across this country, low-income children. This is something we are not able to do as part of this legislation, but I hope we can revisit this issue before final action is taken.

A final issue I wanted to discuss relates to important improvements in legislation I hope we can make for legal immigrant children and legal pregnant women. Under current law, these individuals are prohibited from receiving most CHIP or Medicaid coverage for the first 5 years they are resident in the United States on a legal basis. Very often these children and these legal pregnant women, U.S. citizen children I point out, will become eligible for CHIP and Medicaid. It is counterproductive to prevent these legal immigrants from accessing services at the time they become legal residents of our country.

Today there is a 5-year bar in place to them receiving Medicaid and CHIP coverage. It exists even though the vast majority of these immigrants are working or are in families with working parents and are therefore paying Federal and State taxes. They contribute significantly to the system, but they are barred from receiving the services they are subsidizing. I highlight that legislation to remove this 5-year bar. I want to highlight that this proposal to remove the 5-year bar has bipartisan support. It has passed the Senate as part of the 2003 Medicare Modernization Act. I hope very much that before we complete action and send the bill to the President, we can deal with this issue here.

I urge each Member of the Senate to focus on what is the important work that we can accomplish in the Senate, how we can help the lives of children growing up in this country, and how we can make them more productive citizens in the future. Expanding this health care coverage to cover more children is obviously the first and best thing we can do. I hope very much we can pass this bill, go to conference with the House, and come up with a bill the President can be persuaded to sign.

Again, I congratulate the Finance Committee for the good work they have done bringing the legislation to the full Senate.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. LAUTENBERG. Madam President, I also extend my commendations and thanks to Senators BAUCUS and GRASSLEY for producing this bill. This bill is a long step forward. Although I think it is quite apparent that we need even more than this generous attempt to meet our needs, the fact is, it is a very good bill. But it is surprising to me that we even have to debate this bill.

As we stand here, there are 9 million kids in the United States without health insurance; 250,000 of them live in my State of New Jersey. Every day that we wait to reauthorize and expand the Children's Health Insurance Program we risk more children's illnesses and even permit them to die because they have no health care.

In 2010 there are going to be more than 83 million children, from newborns to 19-year-olds, growing up in America. We have an obligation to make sure those boys and girls have health insurance so they can see their doctor, get a prescription, or visit the hospital if they need to. That is exactly what the CHIP, Children's Health Insurance Program, helps them do. It will ensure that kids have insurance to get regular checkups, to pay for emergencies, or to fight illnesses such as diabetes and other illnesses that afflict children terribly in their lives.

Children without insurance are twice as likely to die from injuries while they stay in the hospital than children who have insurance, and 12 percent of children either delay getting care or do not get any care at all because their families cannot pay for it. It is simply not right. It is those children who need this program the most, but this vital children's health program is set to expire on September 30, just 2 months from now.

The Children's Health Insurance Program is the only way that 6 million of America's children can afford health insurance. Their parents are typically hard-working people, but they simply cannot afford expensive private insurance, and they make too much money to qualify for Medicaid.

For example, in New Jersey, our State program helps to keep 126,000 low-income children in good health. Considering how many kids the program is keeping healthy in New Jersey

and across the Nation, we would expect that President Bush would keep this program healthy, but he has not, and the long-term health of this program hangs in the balance. The President's proposed budget for fiscal year 2008 is $10 billion short of what we need to keep our children healthy. Without more money, we cannot cover the young people who currently get children's health insurance, and we cannot add any new children, no matter how much they need it, to the ranks of the insured.

By 2009, States will be facing more financial shortfalls. They will be forced to cut coverage for our kids. It is unacceptable, so the Senate is offering a better bipartisan plan. I am proud to support the Children's Health Insurance Program Reauthorization Act, which Senators BAUCUS and GRASSLEY introduced and the Finance Committee approved. This bipartisan bill will provide $35 billion in new funding. Most of us would have preferred even higher levels of funding—$50 billion—and I plan to support amendments to increase the funding amount. But there cannot be any doubt that this bipartisan compromise that we have before us is a crucial step forward in improving children's health. It would maintain insurance for the 67 million children who are currently covered, and it would insure more than 3 million new kids who do not have any health insurance at all now.

It would also continue giving States flexibility in covering these youngsters. We know the cost of living and the cost of health care varies from State to State, and that must be a consideration in coverage.

President Bush ran on a campaign pledge to get millions more kids on health insurance. Instead of pledging to sign the bipartisan Senate bill—it is incredible but true—President Bush is threatening to veto it. A veto means putting millions of children at risk for illness and disease. It means going back on the President's pledge, and it shows, by his action more than his words, that the President's priorities are not the same as America's.

President Bush's lopsided tax cuts are projected to cost $252 billion in 2008 alone. We spend $3 billion a week on this war, and we have supplementals in between there. We have already spent more than a half trillion dollars on this war. When you think about it, this bill asks for only $35 billion over 5 years, $7 billion a year, to provide for children's health. It is roughly 2 months of keeping this war going.

In those 5 years we could keep millions of kids healthy and help them become productive members of our American society.

Martin Luther King said:

> Of all forms of injustice, inequality in health care is the most shocking and inhumane.

To let millions of children go without health insurance is an absolute injustice. To stand by while they get sick and cannot afford care is both shocking and inhumane. We are the wealthiest country in the world. We also should be the healthiest country in the world. But we do not seem to be able to tie in these domestic needs with the opportunity that faces us, despite the shortage of revenues because we have become so generous with people who are billionaires, in terms of their taxes. Those who make $1 million a year get tax cuts that are substantial, so it does cut into our revenues. So, as I mentioned before, does the war.

I hope all my colleagues will support this bipartisan Baucus-Grassley bill.

Last, we plead with the President to keep his promise, not to veto it but sign it, to do the best we can for our children and our country.

I yield the remainder of my time. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. LAUTENBERG. Madam President, I ask unanimous consent the quorum call be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LAUTENBERG. I ask unanimous consent now we recess for the caucuses.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 2:15 p.m.

Thereupon, the Senate, at 12:27 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. CARPER).

SMALL BUSINESS TAX RELIEF ACT OF 2007—Continued

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I think we are awaiting the arrival of Senator GRASSLEY. While he is getting ready, I could not be more pleased to have a better partner than Senator GRASSLEY. He and I worked very closely together, and he and I and Senators HATCH and ROCKEFELLER worked very hard to put this current legislation together. I thank the Senator from Iowa for his dedication and public service. He does a good job.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. I appreciate those kind remarks. I obviously have commented many times on this floor in the last 6 years about the close working relationship I have had with him and his efforts, because most everything that came out of our committee in the last 6 or 7 years has been bipartisan.

As we all know, nothing gets through the Senate that is not bipartisan, and so you might as well start at the committee level if you are going to get anything done. I think we have gotten a lot done. I thank the Senator for his kind comments.

Obviously everybody knows we are just beginning, yesterday and today and probably this week, and hopefully completing work this week, on the State Children's Health Insurance Program. So we are going to continually refer to the acronym known as SCHIP.

This, as I said yesterday, is a product back from 1997, now sunsetting 10 years later, by a Republican-led Congress. It is a very targeted program, because too often some people giving speeches on the floor of this body want to leave the impression, or maybe they think it actually is, an entitlement program. This is not an entitlement program. An entitlement program is when a program goes on forever, and if you qualify, there is automatic access to the program, and withdrawal from the Federal Treasury. This program is not an entitlement program because it is based upon a specific amount of money appropriated for the program. That money has got to be divided up among all of the States and among all of the participants. So it is not an entitlement.

I think you are going to hear a lot of debate this week that people want you to think this is an entitlement. This program, targeted as it is, is designed to provide affordable health coverage for low-income children in working families. These families make too much to qualify for Medicaid, which is one of those entitlement programs—and legitimately an entitlement program—but these are families who earn too much to qualify for Medicaid but struggle to afford private insurance.

It is important that we reauthorize this very important program targeted for children. The Finance Committee's bill proposes a reasonable approach for reauthorizing SCHIP that is the product of months of bipartisan work in the committee. I emphasize the word ''bipartisan.'' As I have said so often, this Finance bill is a compromise. I think it is the best of what is possible. Clearly folks on the left wanted to do more, and if you did what they wanted to do, you would have a Democratic bill. My colleagues on the right wanted to do less, and if you did and even go in a different direction, if you did what they wanted to do, you would have a Republican-only bill. So one way or the other, you have got 51 to 49, and nothing is going to get done. You have got to have bipartisanship, because it takes 60 votes around here to shut off debate, to go to finality.

Neither side got what they wanted. I would suggest to you this is the essence of compromise. This compromise bill maintains the focus on low-income, uninsured children and adds coverage for an additional 3.2 million low-income children, children who could presently qualify but not enough money is available or States were not doing their job of outreach to bring these people in.

I have heard some harping from different quarters about the role Senator HATCH and I have played in developing

this important piece of legislation. Some on my side, meaning the Republican side, have suggested our efforts at finding compromise have been inconsistent with advancing the Senate Republican agenda. For a person like me who has been chairman of a committee for the last 6 years, getting a lot of Republican programs through, I take exception to someone who says I am not concerned about Republican principles and getting a Republican program, so I want to put this harping in context. I wish to remind the critics that we would not have made tax relief law if we had not found a way to compromise with Democrats who shared some of our tax reduction goals. The bipartisan tax relief plans of 2001, 2003, 2004, and 2006 could not have passed the Senate on Republican votes only.

During the 4½ years of my chairmanship, we were able to enact almost $2 trillion in broad-based tax relief that was not tax relief as an end in itself but was meant to stimulate the economy, and did stimulate the economy to a point where we have had $750 billion more coming into the Federal Treasury than anticipated as a result, as Chairman Greenspan said, of these tax bills expanding the economy and producing 8.2 million new jobs in recent years.

None of that would have happened if Republicans were working by ourselves, just by ourselves. It took bipartisanship to get that done. So while the temptation is always there for some Members on both sides of the aisle to not engage the other side, rarely if ever will that policy result in sustaining itself.

When it comes to the Republican agenda here, I have not heard any Republicans say to me in the 5 months we have been talking about reauthorizing SCHIP that we should not provide coverage to low-income children. I have not heard anyone say we should not reauthorize this specific bill. Quite to the contrary.

First, the President himself made a commitment to covering more children. I wish to refer to the Republican National Committee in New York City in 2004, and President Bush was very firm in making a point on covering children. Let me tell you what he said.

> America's children must also have a healthy start in life. In a new term [meaning when he was reelected] we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for the Government's health insurance program. We will not allow a lack of attention or information to stand between these children and the health care that they need.

That was back in New York City, early September, 2004. Three months later the President is reelected, with a mandate. It seems to me the President was very clear in his conviction then. Let me repeat his words because I think they are important. He said he would lead an aggressive effort to enroll millions of poor children in Government health insurance programs.

President Bush, this is your friend CHUCK GRASSLEY, helping you keep the promise you made in New York City, and helping you keep your mandate that you had as a result of the last election. But somewhere the priorities of this administration seem to have shifted. The Congressional Budget Office reports that the proposal for SCHIP included in the President's fiscal year 2008 budget would result in the loss of coverage, not an increase of coverage as the administration had been advocating for in the year 2004; and that loss of coverage would add up to 1.4 million children and pregnant women.

Secretary of Health and Human Services Mike Leavitt has also supported expanding SCHIP. Secretary Leavitt is the President's Cabinet member for health care. When Secretary Leavitt was Governor of Utah, he favored expanding SCHIP during a public media availability on SCHIP following a meeting with the President.

Here is what he, now Secretary Leavitt, but then Governor, had to say about that meeting:

> There was a discussion on children's health care. A lot of celebration among governors and the President on the successes that we have had in implementing the Children's Health Insurance Program. Over the course of the last couple of years, it has been a very successful partnership. And we discussed [I assume that ''we'' means the President and the Governors] ways in which that could be expanded.

That is Michael Leavitt.

Also there was a Governor Glendenning at that time representing the Democratic Governors, holding a roundtable with the President.

Now, however, Secretary Leavitt wrote the Finance Committee to say that the President would veto the Finance Committee's SCHIP bill. But even in that letter, he does not call for ending SCHIP. He does not suggest we should not cover kids through SCHIP, not at all. Here is what he said about SCHIP:

> The President and I are committed to reauthorizing a program that has made a significant difference in the health of lower-income children. Through 10 years of experience and bipartisan support the State Children's Health Insurance Program serves as a valuable safety net for children and families who do not have the means to purchase affordable health care. We are committed to its continuation.

I appreciate this support in the past for expanding SCHIP from both the President and Secretary Leavitt. Now, however, some around here say we should not update the SCHIP program regardless of what the President said in the past in New York City, regardless of what Secretary Leavitt said. These people are basically saying the program is fine as it is right now. They want a simple continuation of the current program and current funding.

I will soon say what is wrong with that. But the current program does not work, and the current levels of funding will not do the job everybody says they want to do. Under current law, the current program is authorized to spend $25 billion over the next 5 years. That is if this program were not sunsetting, just continuing on as is. That is what we call a baseline amount. But the Congressional Budget Office says the $25 billion baseline amount will not fully fund the program.

CBO says that without more funding, 800,000 kids would lose coverage. To the chagrin of many Republican Senators and even some Democratic Senators, the administration in the last 6 years—in fact, in one case in Wisconsin, in the last 3 months—has allowed adults to get covered under a program for children. That is not what we intended with the Children's Health Insurance Program. SCHIP is for kids, not for adults. There is no letter ''A'' in the acronym ''SCHIP.'' A simple extension of current law, however, means that adults, about whom everybody is complaining for being on a program only for children, would stay on the program. A simple extension would also mean more adults would be added. Of course, the reason for that is that States will continue in the future to ask for waivers and, be those waivers granted, they would be free to get approval for more childless adults and parents to be on a program that was not intended for anything but children. Covering adults drains scarce resources away from what we consider a priority—children's coverage first.

We may end up having to pass a short-term extension of the current law for a few months before work is finished on this reauthorization. I hope not, but that is a possibility. This is something we have to live with while Congress finishes work on a final version of the reauthorization. If that happens, so be it. But hopefully we can avoid a long-term extension of current law.

The SCHIP formula funding in current law doesn't work either. It actually gives less money to States that get their kids covered. That doesn't make sense. An extension of current law won't fix the formula.

The current formula also penalizes small rural States. That is because uninsured kids are not counted accurately in small rural States. That has resulted in funding shortfalls in those States. An extension of current law means this inaccurate funding formula would continue. That means more shortfalls for these States.

Another problem with current law is that there isn't enough funding. Under a straight extension of current law, there are going to be additional State shortfalls. We dealt with that earlier this year. I believe 14, 15, 16 States had shortfalls. The Congressional Budget Office says those shortfalls would cause 800,000 kids to lose coverage.

When Congress has faced these shortfalls in the past, what have we done? We just handed out more money to the States. Congress did that on three separate occasions. So that would keep those 800,000 kids from losing coverage, but this wouldn't fix any of the other

problems. In fact, it would perpetuate the problems about which everybody is complaining—the funding coverage of adults, No. 1; and No. 2, a fundamentally flawed formula that our legislation takes care of.

That is why an extension of current law won't work. More adults? Think of all the Senators who have been complaining to me because there is no ''A'' in ''SCHIP.'' It wasn't meant to cover adults. It just leaves things as they are—more adults. We have a broken funding formula. We have some States coming up short. So you have to appropriate more money. And most importantly, you have 800,000 kids losing coverage. So what other options are there?

Well, there is the President's proposal. I am not here to bad-mouth the President's proposal or any of my colleagues on this side of the aisle who are working on proposals. I am not going to, obviously, bad-mouth anything Senator WYDEN is doing in the same respect on the Democratic side of the aisle. These policies are good. But I am going to tell the President: Now is not the time.

Going back to the President's program on SCHIP, the President's plan is in his budget. It proposes a $4.8 billion increase in SCHIP, but it does not work either. What many have overlooked is that the President's plan assumes a massive redistribution of about $4 billion in SCHIP funds that States have in reserve. So the President assumes States will willingly relinquish all of those SCHIP reserves. It assumes the Secretary will redistribute those funds to States that currently have SCHIP shortfalls. As someone who was worried about State SCHIP shortfalls before, worrying about SCHIP shortfalls was cool, I tell my colleagues: That dog won't hunt. It is robbing Peter to pay Paul. There is no way a proposal that sucks $4 billion out of State coffers will ever fly around this Senate.

That is not all. Under the President's plan, 1.4 million children and pregnant women would be cut off of the program between now and 2012; 1.4 million would lose coverage, to emphasize. That is the end result of the President's plan: Rob Peter to pay Paul; 1.4 million children losing coverage.

Then we are going to hear about a more comprehensive plan. This is the one I was referring to when I referred to Senator WYDEN and when I was referring to the President having a proposal and some well-meaning people on my side of the aisle. Most of the news is from either Senator WYDEN or from Republican colleagues of mine, a well-meaning approach, a proposal to use the Tax Code to cover many millions of uninsured children and adults through private health insurance. Again, I don't disagree with that policy, but now is not the time for it.

I said during Finance Committee consideration of this bill that I would have liked the debate about SCHIP to focus on a larger effort to address the millions of Americans who are uninsured. I think we are missing an opportunity by only focusing this debate on SCHIP reauthorization. Too many Americans don't have health insurance, and we need to address rising health care costs. That approach will help that as well. I agree that we should be doing more, and I want to see Congress consider proposals to reform the tax treatment of health care to increase coverage for tens of millions of the 46 million people who don't have insurance today. But in terms of this bill and the whole issue of SCHIP reauthorization, that is not realistic.

I continue to be disappointed by the fact that there isn't bipartisan support for trying to do more as part of SCHIP. I urged the administration months ago to get bipartisan support—I emphasize bipartisan support because that is the only way we get things done in the Senate—if they want the President's initiative to be successful. I never saw any effort beyond maybe talking to Senator WYDEN. It just didn't happen. I looked far and wide. I can't find a single Democratic Senator who will support a tax reform alternative to the SCHIP bill. Even though it won't happen with this bill, we still need to work for a broader package to address the more fundamental problems of rising health costs and the uninsured.

Until then, I see SCHIP as a stopgap measure—5 years in duration, 5 years to do something bigger. The $35 billion we are investing in children's health coverage over the next 5 years is a drop in the bucket. When I say $35 billion is a drop in the bucket, somebody will say: You have been in Washington too long. Let me explain. That is one-quarter of 1 percent of the $14 trillion that will be spent on health care in this entire country, public and private expenditures, between now and the end of this authorization, 2012. Economists generally agree that if a condition cannot persist, then it won't persist. The current spending on health care cannot persist.

Members on both sides of the aisle have worked on proposals to address the broader issues of the uninsured and health reform overall. I have already referred to Senator WYDEN as a leader among Democrats on this issue. He has Senator BENNETT of Utah as a Republican working with him. They have been championing a more comprehensive approach to cover the uninsured. Many Republican Senators want to make changes in the Tax Code to help cover tens of millions of Americans of all ages instead of the few million kids whom we do with this legislation. I am looking forward to a fruitful debate on this issue of health reform and the uninsured through the Senate Finance Committee but not until we complete action on this bill. SCHIP must be passed.

Turning back to the Finance Committee bill, meaning the SCHIP bill before us, I am rather surprised at the overheated rhetoric that has emerged from both sides of the aisle. It has really been pretty unbelievable. On one side, I hear that nothing less than $50 billion will do the job, and if that number is not reached, children are at risk of dying. On the other side, I hear maintaining coverage for kids currently on this program and covering about half the kids eligible for Medicaid or SCHIP represents a slippery slope that leads us to the Government takeover of the entire health care system. Both sides need to call time-out to cool down, stop the hysteria, and take a look at what we actually have before the Senate in this Finance Committee compromise.

In 1997, SCHIP was conceived as a capped block grant program, not an entitlement. That was very important to Republicans. It is our model for how a safety net should work. It is not an open-ended entitlement. The Finance Committee bill maintains the block grant. It does not create an entitlement. I warn my colleagues, they are going to hear this too much, and they are going to hear me wake them up that this is not an entitlement. I believe they know better, but we know the game that is played around here.

In 1997, SCHIP was intended to encourage public-private partnerships. The Finance bill improves and strengthens private coverage options. In 1997, SCHIP gave States the tools they needed to control costs. These tools included allowing waiting lists, adding reasonable cost sharing, and limiting enrollment. The Finance bill maintains the flexibility which was in that 1997 act.

In 1997, SCHIP gave States the flexibility to address geographical differences in health care costs. States determine eligibility for benefits and tailor the benefits to their needs. The Finance bill affirms the States' role in managing this program.

SCHIP is also a humble program when compared to Medicaid. Medicaid is the bigger and more expansive entitlement program. Medicaid is a program for low-income individuals, pregnant women, and families. The bill before us today represents a modest update of the SCHIP program created by the 1997 act.

So what does the bill before the Senate actually accomplish? The bill before the Senate extends the program and fixes problems with current law, first, by extending the program that would otherwise expire September 30, doing away with the sunset or extending the sunset 5 years; No. 2, eliminating shortfalls that have plagued the program; No. 3, eliminating enhanced match for coverage of parents and childless adults—in other words, saving money so you spend more on kids; and No. 4, preserving the original SCHIP mission, coverage of low-income children.

The bill before the Senate continues and focuses coverage on low-income children by doing the following: No. 1,

it provides additional resources targeted toward covering low-income children. No. 2, it extends coverage for the 6.6 million children currently enrolled in SCHIP. I want to emphasize, 91 percent of these families have incomes below 200 percent of poverty. No. 3, it covers an additional 2.7 million children already eligible for Medicaid or SCHIP under current law. No. 4, it provides coverage for an additional 600,000 uninsured low-income children.

The Finance Committee bill provides targeted incentives to precisely and, more importantly, efficiently cover the lowest income children. It does this by doing two things: one, by providing precisely targeted incentives that use an incentive fund to encourage enrollment of the lowest income children—in other words, go after those with the most need—and, two, by encouraging States to increase outreach and enrollment.

The Director of the Congressional Budget Office, Dr. Peter Orszag, characterized the incentive fund ''as efficient as you can possibly get per new dollar spent.''

The Finance Committee bipartisan bill also removes childless adults and limits payments for parents. It eliminates coverage under SCHIP for childless adults within 2 years. Those are the people who are already on the program. It eliminates the enhanced match for parents covered under SCHIP. It prohibits new State waivers to expand coverage for parents.

Now, again, I wish to emphasize this point. It does away with State waivers. You get back to every complaint I hear about this bill. You do not hear complaints about covering kids under 200 percent of poverty from Republicans or Democrats. But you hear an awful lot from both Republicans and Democrats about covering adults because there is no letter ''A'' in the acronym SCHIP, and those adults are covered because the law allows waivers. So this bill does away with waivers, so you do not get the adults on the program the way they have gotten there in the past.

Next, it reduces spending on adults by $1.1 billion.

Finally, the Finance Committee bill spends less than the $50 billion authorized in the budget. Now, once again, let me emphasize, there are people around here who say $5 billion in addition to what we are spending now is enough. Then, you have people who say only $50 billion more than what we are spending now is enough. Somewhere in the middle is where you end with compromise.

Now, for Republicans who are irritated because I am here with a bipartisan compromise, along with 16 other members of the Finance Committee—17 to 4 this bill was voted out—we are $15 billion under what a lot of people in this body would like to spend. I think for some people maybe $50 billion would not have been enough.

Continuing SCHIP with static enrollment would cost $14 billion over 5 years over the baseline anyway. At $35 billion, the SCHIP Reauthorization Act will cost $15 billion less than what was included in our budget. This additional funding goes toward coverage of lowest income children.

This bill does not include everything on everybody's wish list. I worked hard for a responsible, bipartisan agreement because I wish to see this bill pass. I think we have done a good job. But I also wish to make one more point very clear. My support for this legislation, in the end, will depend upon the outcome of the floor debate and the conference. I am not going to be able to support a bill that changes significantly from what we have in this proposal.

I appreciate very much the leadership Chairman BAUCUS has provided. I thank him and Senator ROCKEFELLER for what they did to reach a bipartisan agreement.

I also extend my sincere thanks to Senator HATCH for the hours and hours he has put into this effort. Senator HATCH was the main Republican sponsor of the bill that created the SCHIP program 10 years ago. His commitment to the ideals and fundamentals of the program is steadfast, and the program is better for it.

I also have to say I am disappointed by the way the Democratic leadership is handling the process of bringing this bill up for consideration on the floor. It does not bode well for the outcome of the bill. In the Senate, process matters as much as policy, and this process has not been managed in a bipartisan or responsible manner. However, the Finance Committee SCHIP bill is still one I can support. It is a compromise. It is based upon reality. This bill is for kids.

So I will end with an analogy from a child's bedtime story. This bill is not too big, it is not too small. It is not too hard, it is not too soft. It is not too hot, it is not too cold. It is just right.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, since the Senator from Iowa has been talking about the efforts of Senator BENNETT and I and how it relates to the children's health program, I wish to take a few minutes to discuss that relationship.

First, I think Senator BAUCUS, Senator ROCKEFELLER, Senator GRASSLEY, and Senator HATCH—through the hours and hours of effort they have put into making the children's health proposal ready for floor action—have done a great service. They have done a great service, first and foremost, to the country's kids.

It seems to me every single Member of the Senate can say today we cannot afford, in a country as good and strong and rich as ours, to have so many kids go to bed at night without decent health care. As a result of the bipartisan work of four Members of the Senate—two Democrats and two Republicans—we have laid the foundation to take steps immediately to help youngsters who are falling between the cracks.

I have long felt the challenge with respect to health care today is twofold. First, you act immediately to help those who are the most vulnerable in our society. That is, in fact, what four members of the Senate Finance Committee have helped the Senate to promote today. Second, we ought to be taking steps on a broader basis to fix health care in our country.

We are spending enough money on health care today. We are not spending it in the right places. We are spending enough money today on American health care to be able to go out and hire a doctor for every seven families in the United States. That doctor would do nothing except take care of seven families. Pay the doctor $200,000 a year, and my guess is, the distinguished Presiding Officer would probably have physicians in the State of Delaware come to him and say, ''Where do you go to get your seven families?'' because they would all like to be practicing physicians again. So we are spending enough money on health care today. We are not spending it in the right places.

At a time when our population is growing so rapidly, when costs are skyrocketing out of control, we need to fix American health care. But in order to get to the broader health reform effort—an effort that is bipartisan, with Senator BENNETT joining me in the first bipartisan health reform bill in 13 years—you have to take steps to meet the needs of youngsters today.

The Senate has already said that on multiple occasions. We said it first by passing the children's health program, and now, through the reauthorization effort, we say kids will come first. We also said it, in fact, through the budget resolution, where there was an effort to look at the relationship between broader health reform and care for kids, and the Senate, again, said children will come first.

So I am very hopeful. I believe consideration of the children's health program is, essentially, the opening bell of round one in the fight to fix health care. If we can tackle the issue of children's health in a bipartisan way—the way the Senate Finance Committee has done—it ought to be possible, even in this session of Congress, to move on to broader health reform.

Now, I am very hopeful the Administration will join in this bipartisan effort. We have all read about discussions about a possible veto message. I am very hopeful the Administration will join discussions in the Senate, join discussions in the other body, and help us to move quickly on the issue of children's health.

If we do that, it ought to be possible, as the distinguished Senator from Iowa has indicated, to move on to something the Administration feels strongly about, where I happen to think, by and large, they are correct. The Federal tax

rules, as it relates to health care, are a mess. Essentially, they reward inefficiency. They disproportionately favor the most affluent. If you are a ''high flier'' in our country, you can go out and get every manner of deluxe kind of health service and write it off on your taxes; but if you are a hard-working woman in Delaware or Oregon or around the country and your company does not have a health plan, you get virtually nothing.

So I come to the floor today to say what Democratic economists have said, what Republican economists have said, what the administration officials have said: There ought to be an effort to fix the Tax Code as it relates to health care, and I and Senator BENNETT and others want to; and we want to fix it in this session of the Congress. But to get at that issue you are going to, first, have to meet the needs of children.

I was asked today what the implications of the children's health program are for bipartisanship. I think if this body can pick up on the bipartisan work of the Senate Finance Committee, there are extraordinary opportunities for broader health reform in this session of Congress. I do not think the country wants to wait 3 or 4 or 5 more years to fix American health care.

I have heard the discussion about how there is a Presidential campaign coming up, and let's wait another 2, 3, 4 years to talk about a more comprehensive effort to fix American health care. I do not think any of us got sent here to tell businesses that are trying to compete in tough global markets, to tell those who cannot afford the skyrocketing premiums: Well, we are not going to work on broader health care reform for another 3 or 4 years. I think they want to hear how we are going to deal, in a bipartisan way, with the premier domestic issue of our time. Senators BAUCUS and GRASSLEY and HATCH and ROCKEFELLER have given us an initial dose of bipartisanship, an initial dose of bipartisanship in an area the country cares about, and cares about strongly, and that is meeting the needs of our children. But in the spirit that Senate Finance Committee quartet has worked, I and Senator BENNETT and others would like to pick up on that kind of bipartisan theme and move aggressively to looking at the health care system as a whole and taking steps to transform it.

I will say, I am struck again by how every single day it seems to me opportunities for bipartisanship on health care abound. I was very pleased that the nominee to head CMS, the agency that deals with Medicare and Medicaid, reacted very positively to our ideas on preventive health care. The fact is, in this country, we really don't have health care at all. We have sick care. We wait until somebody is flat on their back in a hospital—and the Medicare Program shows this clearly by paying those bills under Part A of Medicare. Part B of Medicare, on the other hand, the outpatient part of Medicare, pays virtually nothing for prevention, virtually nothing to keep people well.

We have known about the value of prevention for quite some time. The distinguished Senator from Iowa, Mr. HARKIN, has been talking about the value of health care prevention for years and years. What I and Senator BENNETT have proposed for the first time under Federal law is that Medicare would be given the legal authority to go out and lower premiums for seniors who reduce their blood pressure and reduce their cholesterol and take the kind of preventive steps that everyone understands makes sense and helps to prolong an individual's good health and also saves money for the Medicare Program. We were very pleased that the nominee to head the agency that deals with Medicare and Medicaid was supportive of those changes and indicated he wanted to work, if confirmed, in a bipartisan way.

So the fact is, there are great opportunities for bipartisanship on health care in this Congress if we can get past this initial effort at addressing American health care. The Senate has indicated, through the initial authorization of the children's health program and through the budget resolution, that this is the program with which it wants to begin the debate on health care.

In the discussions in the Finance Committee, I followed very closely all of the different alternatives. It was a big bipartisan lift to get a 17-to-4 vote in the Senate Finance Committee. A lot of colleagues wanted to spend more. A lot of colleagues thought the program ought to be available to other groups of citizens. Some felt there wasn't much of a role for Government at all and that even the existing children's health program was too expansive. But the committee came together on a 17-to-4 basis.

I see the distinguished Senator from Iowa has returned. If we can pass this legislation with the kind of bipartisan support that was initially demonstrated in the Senate Finance Committee, I think it is very possible, in spite of all of the popular wisdom to the contrary, this Senate can achieve broader health care reform in this session of Congress. I see one poll after another which indicates that health care is the premier domestic issue of our time; that it is the most important issue to our citizens—in many polls by something like a 2-to-1 margin. So I think in addressing this issue today—health care for children—the Senate can lay a bipartisan foundation for broader reforms.

I think Senator BENNETT and I have provided some direction for the Senate to go from here, but we would be the first to acknowledge there are many Senators with ideas on these issues, and many of them are good. I have already indicated I think the Administration has a valid point with respect to these tax rules on health care. The distinguished chairman of the Finance Committee is back, and he and I have listened to one economist after another testify before the Finance Committee—Democrats and Republicans—talking about how the Tax Code on health care makes no sense and largely comes out of the 1940s.

So we have Senators of both political parties who would like to work on broader health care reform, but first we have to pass this legislation. I hope we will pass it with a resounding bipartisan majority vote so that we could truly lay the foundation for significant and comprehensive health reform to be considered by this body.

I yield the floor.

AMENDMENT NO. 2538 TO AMENDMENT NO. 2530

Mr. GRASSLEY. Madam President, for Senator ENSIGN, I send an amendment to the desk and ask for its consideration.

The PRESIDING OFFICER (Mrs. MCCASKILL). The clerk will report.

The bill clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for Mr. ENSIGN, proposes an amendment numbered 2538 to amendment No. 2530.

Mr. GRASSLEY. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend the Internal Revenue Code of 1986 to create a Disease Prevention and Treatment Research Trust Fund)

At the appropriate place, insert the following:

SEC. __. DISEASE PREVENTION AND TREATMENT RESEARCH TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

''SEC. 9511. DISEASE PREVENTION AND TREATMENT 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 'Disease Prevention and Treatment Research Trust Fund', consisting of such amounts as may be appropriated or credited to the Disease Prevention and Treatment Research Trust Fund.

''(b) TRANSFER TO DISEASE PREVENTION AND TREATMENT RESEARCH TRUST FUND OF AMOUNTS EQUIVALENT TO CERTAIN TAXES.—There are hereby appropriated to the Disease Prevention and Treatment Research Trust Fund amounts equivalent to the taxes received in the Treasury attributable to the amendments made by section 701 of the Children's Health Insurance Program Reauthorization Act of 2007.

''(c) EXPENDITURES FROM TRUST FUND.—

''(1) IN GENERAL.—Amounts in the Disease Prevention and Treatment Research Trust Fund shall be available, as provided by appropriation Acts, for the purposes of funding the disease prevention and treatment research activities of the National Institutes of Health. Amounts appropriated from the Disease Prevention and Treatment Research Trust Fund shall be in addition to any other funds provided by appropriation Acts for the National Institutes of Health.

''(2) DISEASE PREVENTION AND TREATMENT RESEARCH ACTIVITIES.—Disease prevention

and treatment research activities shall include activities relating to:

''(A) CANCER.—Disease prevention and treatment research in this category shall include activities relating to pediatric, lung, breast, ovarian, uterine, prostate, colon, rectal, oral, skin, bone, kidney, liver, stomach, bladder, thyroid, pancreatic, brain and nervous system, and blood-related cancers, including leukemia and lymphoma. Priority in this category shall be given to disease prevention and treatment research into pediatric cancers.

''(B) RESPIRATORY DISEASES.—Disease prevention and treatment research in this category shall include activities relating to chronic obstructive pulmonary disease, tuberculosis, bronchitis, asthma, and emphysema.

''(C) CARDIOVASCULAR DISEASES.—Disease prevention and treatment research in this category shall include activities relating to peripheral arterial disease, heart disease, valve disease, stroke, and hypertension.

''(D) OTHER DISEASES, CONDITIONS, AND DISORDERS.—Disease prevention and treatment research in this category shall include activities relating to autism, diabetes (including type I diabetes, also known as juvenile diabetes, and type II diabetes), muscular dystrophy, Alzheimer's disease, Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis, cerebral palsy, cystic fibrosis, spinal muscular atrophy, osteoporosis, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), depression and other mental health disorders, infertility, arthritis, anaphylaxis, lymphedema, psoriasis, eczema, lupus, cleft lip and palate, fibromyalgia, chronic fatigue and immune dysfunction syndrome, alopecia areata, and sepsis.''.

(b) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9511. Disease Prevention and Treatment Research Trust Fund.''.

Mr. GRASSLEY. Madam President, I yield the floor.

Mr. BAUCUS. Madam President, the Senator from Kentucky, Mr. BUNNING, is going to be offering an amendment. So I ask unanimous consent that the pending amendment be temporarily laid aside so the Senator from Kentucky can offer his amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. I also ask unanimous consent that Senator SALAZAR be allowed to speak following Senator BUNNING.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Kentucky is recognized.

AMENDMENT NO. 2547 TO AMENDMENT NO. 2530

Mr. BUNNING. Madam President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from Kentucky [Mr. BUNNING] proposes an amendment numbered 2547 to amendment No. 2530.

Mr. BUNNING. I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To eliminate the exception for certain States to cover children under SCHIP whose income exceeds 300 percent of the Federal poverty level)

Beginning on page 79, strike line 21 and all that follows through page 81, line 6, and insert the following:

(a) FMAP APPLIED TO EXPENDITURES.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATION ON MATCHING RATE FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE PROVIDED TO CHILDREN WHOSE EFFECTIVE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—For fiscal years beginning with fiscal year 2008, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

(c) APPLICATION OF SAVINGS TO GRANTS FOR OUTREACH AND ENROLLMENT.—

(1) IN GENERAL.—Notwithstanding the dollar amount specified in section 2113(g) of the Social Security Act, as added by section 201(a), the dollar amount specified in such section shall be increased by the amount appropriated under paragraph (2).

(2) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated such amount as the Secretary determines is equal to the amount of additional Federal expenditures for the period of fiscal years 2008 through 2012 that would have been made if the enhanced FMAP (as defined in section 2105(b) of the Social Security Act) applied to expenditures for providing child health assistance to targeted low-income children residing in a State that, on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, has an approved State plan amendment or waiver to provide, or has enacted a State law to submit a State plan amendment to provide, expenditures described in section 2105(c)(8) of such Act (as added by subsection (a)). The preceding sentence constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of such amount to States awarded grants under section 2113 of the Social Security Act.

Mr. BUNNING. Madam President, I offer this amendment to the SCHIP bill. This is the same amendment I offered during the Finance Committee's consideration of this legislation.

I have heard a lot of talk about how the Baucus bill puts the focus for SCHIP back on low-income children—so much talk, in fact, that one would hardly know that the Baucus bill allows certain States to provide families making up to $70,000 or $80,000 a year in income with Government-run health care.

Let's start from the beginning. The way the SCHIP and Medicaid Program work is States get Federal matching dollars to help fund their programs. The SCHIP match from the Federal Government is higher than a State's Medicaid match. This means for my State, the Federal Government's match for Medicaid is about 70 percent, while the State pays the remaining 30 percent. For SCHIP, the Federal match is 80 percent, while the State match makes up the remaining 20 percent.

SCHIP was intended to help States provide health care coverage to children and families whose incomes were below 200 percent of the Federal poverty line. These families were likely working but making too much money to qualify for Medicaid and couldn't afford private health insurance. I would like to note that 200 percent of the Federal poverty level is about $41,000 a year in income for a family of four.

The Baucus bill allows States to expand their SCHIP programs and receive the higher SCHIP matching rate for families with incomes up to 300 percent of the poverty level, or almost $62,000 for a family of four. Personally, I think that in and of itself is too high, especially when the national median income in this country was about $46,000 a year in 2005. In the Baucus bill, States that choose to go above 300 percent of poverty would receive their Medicare matching rate for those families which, remember, is the lower reimbursement rate.

However, the Baucus bill thinks families in New Jersey and New York deserve special treatment under SCHIP. The bill provides an exemption for States that have already gone above or are currently trying to go above 300 percent of poverty for SCHIP coverage. New Jersey already provides coverage for families up to 350 percent of poverty. New York is working to get approval to extend coverage up to 400 percent of poverty. I want to make sure everyone understands, 400 percent of poverty is $82,600 a year for a family of four; 350 percent of poverty is $72,275 per year. Are we really going to be providing Government health care for families making $70,000 to $80,000 a year?

My amendment is fairly simple. It strikes the exemption the Baucus bill has given to just New York and New Jersey so they have to play by the same rules as every other State. If these two States want to provide health care coverage to families above 300 percent of the poverty level, they can do so—they just cannot get a higher SCHIP matching rate. They would get their Medicaid matching rate. That at least leaves the playing field level.

There will be obviously some small savings from this if my amendment passes. My amendment would take these savings and provide additional money to outreach and enrollment grants.

Some people will try to say it is more expensive to live in these two States than it is in other States, and that is probably true in certain areas. However, SCHIP is a Federal program, and all States should play by the same

rules. Also, these two States can still cover these higher income families if they choose. They just have to get the lower Medicaid matching rate to do so.

If New York and New Jersey feel so strongly about letting families making $70,000 or $80,000 a year have Government health care, then the States should be willing to pay a little more from their own tax revenue. The last time I checked, money doesn't grow on trees around here—or at least it very rarely does. The Baucus bill is requiring people in other States such as Kentucky, New Mexico, Florida, and Maine to pay more so New York and New Jersey can cover families at these higher income levels. To me, that is grossly unfair.

Some people may also try to argue that New York is only thinking about going to 400 percent of the poverty level, and they would have to get a waiver or a plan approved by the Department of Health and Human Services for this increase. OK. So then why give them this special protection in the Baucus bill? Why create special rules for New York when they haven't even gotten approval yet? To me, it is outrageous that a program designed for lower income kids is being expanded to include families at 350 percent or 400 percent of the poverty level. That is too high, and it is unfair to ask people in other States to pay for these types of expenses.

So with my amendment, you have two options: more money for outreach and enrollment efforts and requiring all States to play by the same rules or covering kids and families most of us probably don't consider low income—those making up to $72,000 or $82,000 a year for a family of four.

Madam President, I reserve the remainder of my time, and I ask for the yeas and nays on my amendment when it is appropriate.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

Mr. BUNNING. Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Madam President, the Senator from Colorado is to be recognized next. I say to my friend from Kentucky, I think the Senators from the two States that will be directly affected by the amendment will be coming to the floor to speak in opposition. When they do, those Senators will be recognized. In the meantime, I urge the Chair to recognize the Senator from Colorado.

The PRESIDING OFFICER. The Senator from Colorado is recognized.

Mr. SALAZAR. Madam President, I rise to support the effort we have on the floor to address a national health care imperative, which is providing health insurance to 10 million young people in our country today.

For me, when I come to this Senate every day and speak on behalf of the millions of people in my State of Colorado and around the country, I think about the biggest issues we are faced with, the biggest challenges of our time, the imperatives of the 21st century, and there are three in my mind.

First is the questions we face in terms of foreign affairs and how we protect America and homeland security. We will have other occasions where we will deal with the fundamental issue of protecting America and making sure our homeland is secure. We took significant steps last week in that direction when we adopted the 9/11 Commission recommendations.

The second issue is how we move forward and embrace a clean energy economy for the 21st century. With the committees that have reported legislation, including the Energy Committee, which adopted bipartisan legislation here, we took a step forward with that international imperative.

The third issue that I think is an imperative of the 21st century is how we take the health care crisis we have—a system which is not working for the people today—and fix it. Today and this week is an opportunity for us, the Senate, to take a very major step toward making sure we are moving toward addressing the complex issue of health care and providing health care insurance to the 10 million children of America who, without this program, would wake up after September without the health insurance that provides them with an opportunity to live a healthy American life. So this legislation is very important for us to move through this body.

I say also at the outset that we would not be here today had it not been for the bipartisan efforts of Senators BAUCUS and GRASSLEY, in the leadership in the Finance Committee, joined by Senators ROCKEFELLER and HATCH. The four of them moved this legislation forward today in the framework that gives us the great possibility of receiving an overwhelming bipartisan vote as we move this legislation out of the Senate.

By all measures, we know our health care system is in crisis. We have 47 million Americans without health insurance today, and 9 million of them are kids. In Colorado, 20 percent of our population—1 in 5, or 780,000—lacks health coverage; 180,000 of those people in my State of Colorado are children.

These are middle class citizens who are getting squeezed by the ballooning costs of health care. Two-thirds of Americans and 70 percent of Coloradans without health insurance work full time. They play by the rules, but still find coverage out of reach.

For those who are able to afford health insurance, the picture is also grim. Health insurance premiums for family coverage have risen by over 70 percent since 2000. An employer-sponsored family coverage plan now costs nearly $10,000 a year. This is a huge chunk of a working family's income.

Our health care system is in dire need of triage. We must start with those who are most vulnerable, our children, and see to it that they have the health care coverage they deserve.

Covering our kids, providing them preventive care from doctors and nurses, ensuring that they grow up healthy and strong—this has been the focus of our health care work over the last several months in the Senate Finance Committee. This week we bring the bill to the floor with the hope that we will pass it swiftly and with broad, bipartisan support, so that we can give 10 million more kids the opportunity they deserve to live up to their potential.

The reason we focus our first reforms of the health care system on our children is simple: every American child deserves the opportunities that come from a healthy start in life.

The fact that 9 million of our kids—180,000 in Colorado—have no coverage is simply unacceptable. It is a massive liability not just for the health of our kids, but for their education and for our future economic security.

The impacts of a lack of health coverage are clear: uninsured children are 6 times more likely to have unmet medical needs; uninsured children are two and a half times more likely to have unmet dental needs; one-third of all uninsured children go without any medical care for an entire year; uninsured children are less likely to do well in school due to absences from unmet health needs; and uninsured children are more likely to seek care from hospital emergency rooms, which are often the provider of last resort, the most costly venue for care, and the least equipped to provide the type of preventive and comprehensive follow-up care children need.

As sobering as these statistics are, the stories of families and health care providers are even more compelling. Earlier this year, at Senator Baucus' suggestion, I traveled to Greeley, Fort Morgan, Fort Collins, Steamboat, Silverthorne, Grand Junction, Durango, Alamosa, Pueblo, Colorado Springs, and Denver to meet with health care providers, State officials, children's advocacy groups and families interested in the reauthorization of the Children's Health Plan.

I heard harrowing tales about delayed health care that caused children's health to worsen. One school nurse told me of a boy who injured his leg during a school football game. Because his family could not afford to take him to a doctor, they applied ice to his leg and prayed it would get better.

Unfortunately, the boy's leg, which was fractured, grew progressively worse, swelling to two times its normal size. The school nurse told me of the pain and anguish the child endured because his parents could not afford an expensive doctor's visit.

I heard countless other stories of colds that turned into pneumonia, of ear aches that developed into ear infections, and of other illnesses that grew

worse because parents could not afford to seek medical care for their kids. These families eventually had to take their kids to the emergency room for treatment, the most expensive venue for care, and one which typically doesn't provide the type of preventative or comprehensive follow-up care that our kids need.

For millions of children and their families, for our hospitals, clinics and health care providers who can no longer shoulder the burden of uncompensated care, the time has come to provide health insurance to children in need.

I am proud of the work that we have done on this bill in the Finance Committee. It will cover 10 million uninsured children. It is a huge step toward providing coverage for every uninsured child in America, and we have done it with overwhelming bipartisan support in committee.

Unfortunately, the President seems to have a different perspective. He has already issued a veto threat. I believe he is wrong. For the sake of our children we must reauthorize the Children's Health Insurance Program, and we ask the President to help get it done. CHIP has become a critical resource to us in Colorado and nationwide, providing health care coverage to children who would otherwise go uninsured.

I believe that it is our moral and economic obligation in Washington to invest in our children's healthcare, as our investment today, will pay off tomorrow. The President should embrace this proposal for children across the country, and I strongly urge the President to help us get it done.

I want to take a moment to talk about what the bill does, because the veto threat implies a deep misunderstanding about its benefits.

On the broadest scale, the bill before us provides insurance coverage to 3.3 million children who are currently uninsured, while maintaining coverage for all 6.6 million low-income children currently enrolled in the Children's Health Insurance Program.

The bill includes significant incentives for States to enroll more children onto CHIP, particularly children in rural communities where geographic distances and the lack of health infrastructure create barriers to enrollment. Twenty percent of all low-income children live in rural areas, and a significant percentage of them are uninsured. We can do better.

The CHIP reauthorization also allows States to cover pregnant women. Children who are born healthy have a far greater chance of a healthy life. Healthy children save Medicaid and CHIP significant resources in reduced health care costs. It is sensible that they can receive this coverage under our program.

The bill also provides grants to States to improve dental benefits and helps improve coverage for mental health. In order to receive the Federal match, States that offer mental health services will be required to provide coverage on par with medical and surgical benefits under CHIP. Finally, the bill reduces bureaucratic hurdles and improves the program's efficiency by setting quality standards, by allowing States to verify citizenship through the Social Security Administration, and by establishing a pilot program to allow States to implement express lane enrollment.

These are only a few of the key provisions in a bill that dramatically increases coverage for uninsured children across America.

I look forward to a lively week of debate on this bill with the hope that we can further strengthen the package.

Finally, I want to briefly talk about an amendment that I intend to offer, which will help States create and expand home visitation programs. In a home visitation program a nurse, social workers, volunteer, or other professional works with families in their homes to provide prenatal care, parenting education, social support, and links with public and private community services. Home visitation programs have existed in the United States since the 19th century and have a long and solid track record in improving children's health.

My amendment is straightforward. It would create a $100 million grant program to fund cost-effective home visitation programs. It would also require a study of the cost-effectiveness of adding home visitation programs to coverage under CHIP.

From my experience with these programs in Colorado, I think we will find that expanded investment in home visitation programs is a logical step toward improving children's health care.

Nurse Family Partnership, one of our home visitation programs in Colorado, is a great example. It operates in 150 sites in 22 States, providing 20,000 low-income pregnant women with help from trained registered nurses. These nurses work closely with the families to increase access to prenatal care, foster child health and development and promote parental economic self-sufficiency.

The statistics prove the success of the program. Nurse Family Partnership has been shown to reduce child abuse and neglect by 48 percent; reduce child arrests by 59 percent; reduce arrests of the mother by 61 percent; reduce criminal convictions for the mother by 72 percent; increase father presence in household by 42 percent; reduce subsequent pregnancies by 32 percent; reduce language delays in 21-month-old children by 50 percent; and reduce behavioral/intellectual problems of children at age 6 by 67 percent.

A report recently released by the Brookings Institute praised Nurse Family Partnership as one of the most effective returns on investment in the healthy development of the next generation.

Our amendment builds on the great promise that home visitation programs offer and strengthens CHIP's investment in the healthy development of our children. I urge my colleagues to support our amendment when we offer it.

I want to again thank Chairman BAUCUS, Ranking Member GRASSLEY, and Senators ROCKEFELLER and HATCH for their bipartisan leadership on this bill. This is a giant step forward in our Nation's steady march toward providing every child in America the chance to chase their dreams.

Mr. President, I yield the floor.

Mr. BAUCUS. Madam President, the amendments are starting to come before the Senate and that is good. The other news is that all Senators who have lined up to speak at certain specified times are going to have to be very accommodating to other Senators and squeeze down the amount of time they want to speak. Perhaps they can consult with the floor staff to see when they might be able to speak.

I now ask unanimous consent that the Senator from Oregon, Senator SMITH, be recognized to speak next and, immediately following him, that the Senator from Pennsylvania, Mr. CASEY, be recognized to speak. I urge both Senators to limit their remarks as much as possible. Please try to use a little more brevity so we can get to the next speakers. Senator MENENDEZ is also here and he wishes to speak on the amendment offered by the Senator from Kentucky.

I yield the floor.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. CASEY. Madam President, parliamentary inquiry: When the Senator said ''limit the time,'' I am not sure what the Senator meant by that.

Mr. BAUCUS. Well, I have a list of Senators who wish to speak. I have times next to the Senators as to when they are going to speak. I also have time allocated on how much time they think they are going to speak. I am asking all Senators to basically speak for fewer minutes so that all Senators can speak at their allotted times.

Mr. CASEY. My colleague from Montana has been generous with his time and has shown great leadership. I want to make sure I have the time I want on this, so I will wait. I will play it by ear, depending on my colleague from Oregon.

Mr. BAUCUS. Thank you very much.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. SMITH. Madam President, I wish to assure the manager of the bill that I will be as brief as I can on this big issue.

All of us who are parents know that the health of a child is critically important in ensuring they have the opportunity to reach their full potential. Yet today in America there are approximately 6 million children who are eligible for either Medicaid or SCHIP who are going without health care nevertheless. In Oregon alone, there are

approximately 60,000 kids eligible for assistance who are not getting the help they need. Therefore, the debate before us is about whether we as a country will invest in our young people by providing access to health coverage or whether we will leave these children without the essential building blocks of health care upon which they can build successful lives.

I believe in the promise that SCHIP represented in 1997. It was one of the first bills I worked on, with an amendment in the Budget Committee. I urge my colleagues to support the bill the Finance Committee has now produced which sees this whole promise of CHIP one step closer to fulfillment. This bill will allow States to cover an additional 3.3 million children, and in Oregon that would allow an additional 100,000 children to receive health care coverage.

When thinking about our response to the children, I often like to quote one of our Nation's health care leaders, the former Surgeon General, Dr. C. Everett Koop, who said:

> Life affords no greater responsibility, no greater privilege than the raising of the next generation.

The reauthorization of the Children's Health Insurance Program fulfills the Government's responsibility to take care of our Nation's children. It also lives up to the expectations of the American public—we the people—who want Congress to pass this bill and extend health care coverage to America's underprivileged children.

This bill is also a testament to a bipartisan legacy of the Finance Committee. It contains less money and benefits than some desire, while more than others have indicated they will support. Yet when you look at the actual policy, I believe you will find that it deserves the full support of the Senate.

My colleagues and the American public should know that this bill is not, as some have claimed, an expansion, and it is not the federalization of health care. In fact, it simply takes a step, a reasonable step, toward achieving the original objective, the original vision for SCHIP. It will provide adequate funding and make some programmatic enhancements to help an additional 3.3 million children currently eligible to enroll in the program. I wish to emphasize that these children are currently eligible. This just makes the program available to them.

This package which many of us have worked to craft does not create a new Government-run health care system. In fact, 48 States, including my State of Oregon, utilize private health insurers to deliver the SCHIP benefit package. Like Medicare Part D, it is a highly successful melding of Government and private sector care.

I also believe it important to note that SCHIP is an efficient and cost-effective health care program. Its overhead ranges from about 5 percent, compared to the commercial market, which is over 10 percent. Perhaps most importantly, this bill returns the focus of the State Children's Health Insurance Program to children.

Many on both sides of the political aisle were amazed and disappointed to learn that the administration has allowed States to extend coverage under SCHIP to adults. This proposal puts the brakes on that practice and says: Enough is enough. Upon enactment of the bill, the administration no longer will be able to extend waivers to States to cover any adult. Further, by the end of 2009, those States which currently cover childless adults will be required to move those people into Medicaid, and any parent currently covered will be moved into a separate block grant starting in 2010. This represents a bipartisan agreement.

For those of us who have battled over the years to ensure mental health parity, I am pleased to report that the committee accepted an amendment from me and Senator KERRY, and this bill now delivers a victory to those who advocate for mental health parity. It requires States that offer access to mental health care to provide coverage that is on par with coverage for physical illnesses. As a parent whose child battled a mental illness, I know how important it is for our young people to have timely access to mental health care treatments.

Each year in the United States, 30,000 people die by suicide. That is more deaths than by drunk driving and homicides combined. Yet, with proper treatment, these deaths are preventable. Our Nation and our Government simply cannot continue to ignore this problem. That is why this amendment was included, so that we will now begin to reverse this Federal discrimination as it relates to mental health care. I believe that by ensuring equity among mental and physical illnesses, this bill takes the first step toward eliminating the discrimination against persons with mental illnesses that has existed in our Federal and State health care programs for generations. It is an important first step and fulfills the promise of SCHIP for all children, including those children with a mental illness.

For those who believe SCHIP will erode health care coverage through employers, do not believe it. This bill takes a significant step toward offering access to privately delivered options and helps small businesses gain access to affordable health care coverage for all of their employees.

I authored a provision that allows States to create an employer purchasing pool under the premium assistance section of SCHIP. My provision will allow small businesses with less than 250 employees to buy health insurance coverage through a State-sponsored employer purchasing pool. Employers that participate will have access to a choice of privately delivered, quality health insurance products for all of their employees and will receive reimbursement for those employees or their children who are eligible for SCHIP. It is a win-win arrangement that I hope will lead to more extensive coverage among employees and small- and medium-sized businesses.

Finally, this package rightly utilizes the 61-cent increase in the tobacco products excise tax, which I proposed during the Senate's budget debate, to pay for the cost of reauthorizing SCHIP. Increasing the cost of tobacco products not only puts real dollars on the table to pay for SCHIP, but over time it will lower the cost of tobacco-related illnesses for all Federal and State health care programs and will deter young people from smoking.

Why is this important? My State of Oregon was the first in the Nation in 1987 to begin tracking the number of deaths that were related to the use of tobacco. In 2005, the most recent year for which data is available, there were a total of nearly 7,000 deaths in Oregon due to tobacco. This means that tobacco contributed to 22 percent of all deaths in the State of Oregon. In fact, from 1996 to 2005, tobacco use has consistently contributed to more than one-fifth of all Oregon deaths, ranging from 21 percent to 23 percent of the total deaths per year.

Officials in my State explain to me that to determine the death rate in the State, they often look at it in terms of the number of deaths per 100,000 Oregonians. In 2005, the death rate due to tobacco was about 13 times the rate of death from the following causes: alcohol-induced deaths, drug-induced deaths, motor vehicle accidents, and deaths from an infection or parasitic disease. What is more, the State estimates that an additional 800 deaths were attributable to secondhand smoke in 2005. That means in 1 year, 7,721 Oregonians needlessly died because of the use of tobacco.

So for those who question raising the rate of the Federal tobacco excise tax, I say: Look at these numbers. Look at the 7,000 deaths from tobacco in the State of Oregon in 2005 alone and understand that this Federal rate increase could dramatically lower the death rate from tobacco. That is why this bill rightly includes a 61-cent increase in the excise tax.

In closing, Chairman BAUCUS and Ranking Member GRASSLEY have a long working tradition of tackling challenging issues and developing bipartisan solutions. The development of the Children's Health Improvement Program Reauthorization Act of 2007 is no different. Many hurdles were encountered, and many are yet to come, but if the Senate can follow the example set by Chairman BAUCUS and Ranking Member GRASSLEY, I am confident we will see SCHIP reauthorized by the end of September. Therefore, I urge my colleagues to support this bill.

I thank the Chair for the time, and I yield the floor.

Mr. BAUCUS. Madam President, Senator CASEY has been seeking recognition, and I assured him earlier today that he would be able to speak at about this time.

I ask unanimous consent that Senator CASEY be able to speak and that following Senator CASEY, the Senator from Colorado, Mr. ALLARD, be recognized to offer an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Pennsylvania is recognized.

Mr. CASEY. Madam President, I thank the Chair, and I thank Chairman BAUCUS for his leadership and for the way he has conducted the debate on this bill.

I wish to make a couple of points that probably haven't been made yet—some have, in different ways—and the first thing I wish to say is that this bill, overall, provides what a lot of Americans expect us to provide in a bill such as this: It lowers the rates of uninsured children in America, just as the original Children's Health Insurance Program did some 10 years ago now; it strengthens the program by increasing and targeting funding for our children; and it also gives States the tools they need to do the outreach that is required to get our children enrolled and to do that in a way that spends money wisely.

One of the things that has been missed in this debate is that this is really about all of America. This isn't simply about one State or one community. One of the population sectors that I think has been ignored often in this discussion by some people who have talked about this is rural children. You can see on this chart to my right what children's health insurance—this program—means to rural children.

Rural children are far less likely to have access to employer-based health care plans because most of these families that have had to struggle are not getting jobs that offer affordable health insurance. That number has gone far too high in terms of the number of rural families that have lost jobs or are seeking jobs with health insurance.

Secondly, rural children are difficult to enroll in children's health insurance even when they are clearly eligible. Outreach and enrollment efforts are critically important to those communities. That is why the features of this bill that deal with outreach—television advertising and other kinds of advertising—are critically important.

The second point about children who live in rural communities across America—and I have to say in Pennsylvania we have literally millions of Pennsylvanians who live in communities that are defined demographically as rural—is that they are more likely to be poor. Nearly half of rural children live in low-income families at or below 200 percent of the poverty level. So you are talking about a doubling of the number, just a little more than $40,000 of family income.

Additionally, rural children increasingly rely upon children's health insurance, this program. In rural America, more than one-third of all children—one-third of all rural children—rely upon the Children's Health Insurance Program or Medicaid.

Another point on benefits, if we can go to the next chart. There has been a lot of talk about what this program means and how much it costs. It is interesting to debate that, but let us get back to what this program means to families. It means immunizations, routine checkups, prescription drugs, dental care, maternity care, mental health benefits, and down the list. You can see what this means to the life of a family and to the health of a nation. I think it bears repeating just how important those benefits are.

In the next chart, we focus on an example from Pennsylvania. There has been a lot of talk on this floor already, some of it inaccurate talk, so let's get back to the facts. This is what the children's health insurance income levels mean in Pennsylvania. What we are talking about here is $41,300 of income and below, under 200 percent of the FPL, the federal poverty level. Care is free for those families, and the average premium is, of course, zero. But the next category, $41,301 to $61,950, above 200 percent of poverty, up to 300 percent, care is provided at a low cost but a cost nonetheless. They pay a premium—a range of a premium.

Finally, looking at the higher income groups and some people, it is very misleading. For those with incomes of $61,951 and above, at that income level care is provided at cost, and the average premium is $150. We should stop misleading people, talking about wealthier families making $80,500. Others will discuss this later. We have already had a lot of misleading—and I hope it is not deliberate, but there has been misleading rhetoric on the Senate floor already about those families.

Just for the record, not only are there no families at $80,000 in the Children's Health Insurance Program, there are only about 3,000 kids enrolled in the health care program today out of 6.6 million who have a family income of 300 percent of poverty or more. Let's speak the truth and adhere to the facts instead of what we have heard already: misleading statements on this floor about these income levels.

One more point about minority children in America. We have heard a lot about what this means and whether it is working. We have lots of proof already that minority children have already been helped. Since the inception of this program 10 years ago, the percent of uninsured Hispanic children has decreased by nearly one-third; for African-American children by almost one-half. So don't tell us this is not working. Some people on the other side have made that point. This is working for rural kids, and it is working for minority children all across the country, not to mention what I have seen in Pennsylvania.

This will be our last chart. We have heard a lot about what this means for the broad spectrum of America. Here is the fact again: 78 percent of the kids covered by the Children's Health Insurance Program are from working families. I think that is an important point to make when we talk about who is helped by this program.

If we want to go the way the President has taken us and cut off kids from children's health insurance—1.4 million kids will lose their coverage under the President's plan—here is what happens when a child doesn't get dental care. We heard this story a couple of months ago. It bears repeating again—12-year-old Deamonte Driver, from Prince George's County here in Maryland, died because he didn't have coverage for a routine $80 dental procedure for his infected tooth. Without that simple treatment, the infection spread to Deamonte Driver's brain and killed him.

Let's put aside some of the mythology about what we have heard from some people—not everyone but some people in this Chamber—about what this means. If that child had received an $80 dental procedure he might be alive today. But, of course, we hear political rhetoric in here to back up the President. I think it is important to remember why we are here.

I have two more points to make, to keep within my time. John Dilulio, Jr., a distinguished Ph.D., worked for President Bush to lead his faith-based initiatives in the early part of the administration. He wrote an op-ed in the Philadelphia Inquirer a few months ago.

I ask unanimous consent it be printed in the RECORD.

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

[From the Philadelphia Inquirer]

BUSH'S STAND ON INSURANCE PLAN CONTRADICTS WORDS OF COMPASSION

(By John J. Dilulio Jr.)

Eight years ago this week, on July 22, 1999, George W. Bush delivered his first presidential campaign speech, titled ''The Duty of Hope.'' Speaking in Indianapolis, he rejected as ''destructive'' the idea that ''if only government would get out of the way, all our problems would be solved.'' Rather, ''from North Central Philadelphia to South Central Los Angeles,'' government ''must act in the common good, and that good is not common until it is shared by those in need.'' There are ''some things the government should be doing, like Medicaid for poor children.''

I helped draft the speech and served in 2001 as an adviser to Bush. He has made good on some compassion pledges. For instance, he has increased funding for public schools that serve low-income children. His $150 million program for mentoring 100,000 children of prisoners has made progress. In May, he pledged an additional $30 billion in U.S. aid to combat the global HIV/AIDS epidemic and save Africa's affected children.

On the other hand, poverty rates have risen in many cities. In 2005, Washington fiddled while New Orleans flooded, and the White House has vacillated in its support for the region's recovery and rebuilding process. Most urban religious nonprofit organizations that provide social services in low-income communities still get no public support

whatsoever. Several recent administration positions on social policy contradict the compassion vision Bush articulated in 1999.

In May, Bush rejected a bipartisan House bill that increased funding for Head Start, a program that benefits millions of low-income preschoolers. His spokesmen claimed the bill was bad because it did not include a provision giving faith-based preschool programs an absolute right to discriminate on religious grounds in hiring.

That reason reverses a principle Bush proclaimed in his 1999 speech: ''We will keep a commitment to pluralism, not discriminating for or against Methodists or Mormons or Muslims, or good people of no faith at all.'' As many studies show, most urban faith-based nonprofits that serve their own needy neighbors do not discriminate against beneficiaries, volunteers or staff on religious grounds. These inner-city churches and grass roots groups would love to expand Head Start in their communities.

Last week, Bush threatened to veto a bipartisan Senate plan that would add $35 billion over five years to the State Children's Health Insurance Program (SCHIP). The decade-old program insures children in families that are not poor enough to qualify for Medicaid but are too poor to afford private insurance. The extra $7 billion a year offered by the Senate would cover a few million more children. New money for the purpose would come from raising the federal excise tax on cigarettes.

Several former Bush advisers have urged the White House to accept some such SCHIP plan. So have many governors in both parties and Republican leaders in the Senate. In 2003, Bush supported a Medicare bill that increased government spending on prescription drugs for elderly middle-income citizens by hundreds of billions of dollars. But he has pledged only $1 billion a year more for low-income children's health insurance. His spokesmen say doing any more for the ''government-subsidized program'' would encourage families to drop private insurance.

But the health-insurance market has already priced out working-poor families by the millions. With a growing population of low-income children, $1 billion a year more would be insufficient even to maintain current per capita child coverage levels. Some speculate that SCHIP is now hostage to negotiations over the president's broader plan to expand health coverage via tax cuts and credits. But his plan has no chance in this Congress; besides, treating health insurance for needy children as a political bargaining chip would be wrong.

Bush should return to Indianapolis. There, SCHIP covers children in families with incomes as high as three times the federal poverty line The Republican governor who signed that program into law is Mitch Daniels, Bush's first budget office director. For compassion's sake, the president should compromise on SCHIP—say, $5 billion a year more—and work to leave no child uninsured.

Mr. CASEY. I will not read it, but I want to highlight some of what he said. He talked about the President and what has been happening with this debate on children's health insurance. He made this point in the second to the last paragraph:

Treating health insurance for needy children as a political bargaining chip—

And he's referring to the President's other health care ideas——

would be wrong.

He talks about the fact that Mitch Daniels, who worked in a Republican administration—he is the Governor now, Governor of Indiana, also a great supporter of this program. Mr. Dilulio concludes this way. He says:

For compassion's sake, the President should compromise on SCHIP . . .

And allow this to move forward.

I have to say, some of what we heard in the last couple of days has been misleading. In the end it is about this: It is about whether we are going to be fair to families across America, not whether the Senate likes a program or doesn't like it. This is about whether we are going to be fair to families.

Anyone who has had the experience of being a parent knows when their child is born, that parent, whoever they are, falls in love again. My wife and I have four daughters, and we know that feeling. So many others here do as well. As a parent, you always want to love your children and protect them. When a child is injured or gets sick, the first instinct of any parent, but especially a mother, is to hug that child, to dry their tears, and to soothe their pain immediately—not months later, not days later, but immediately. Of course if it is more serious you want to get them to a doctor or a hospital.

But for millions of parents—that is why this bill is so important to get done—for millions of parents that hug that they give their son or daughter, that warm embrace and the comfort that a hug can bring to a child—that will often be all that they have at the end of the road because their son or daughter has no health insurance, like the millions of children we have talked about in the last couple of days. If that child cries in the dark of night from pain or if they endure the slow ache of disease or sickness, the mother cannot bring the full measure of her love to that child. In essence, the mother is rendered powerless because of that. Just think of what that does to a mother and to a family.

When we have debates on this floor about this bill, none of it matters—none of the debate in the last couple of days will have mattered if it does not result in a total commitment to the children of America. Unfortunately, if the President gets his way, we will have failed that basic test about a full commitment to our children.

I will conclude with one line. When my father served as Governor of Pennsylvania, it was one of the first States to have a children's health insurance program. He knew the benefits of it. His test for every public official in every difficult fight was very simple, but it is a very tough test: What did you do when you had the power?

This Senate has the power this week to tell the President that he is wrong about children's health insurance, but more important to tell America that we have made a full commitment to the children of America. If we pass that test we will have done our job. If this body does not, it will have failed that test when we had the power to positively impact millions of children, to have exercised that power on behalf of that child, his or her family, and all of America.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I ask unanimous consent that following the remarks of Senator ALLARD, during which he will offer an amendment, then the Senator from New Jersey, Mr. MENENDEZ, be recognized; following Senator MENENDEZ, Senator LOTT be recognized; and following Senator LOTT, Senator OBAMA.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Colorado is recognized.

AMENDMENT NO. 2536 TO AMENDMENT NO. 2530

Mr. ALLARD. Madam President, I ask the pending amendment be set aside, and we call up Allard amendment No. 2536.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

The Senator from Colorado [Mr. ALLARD] proposes an amendment numbered 2536 to amendment No. 2530.

Mr. ALLARD. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To standardize the determination of income for purposes of eligibility for SCHIP)

At the end of title I, add the following:

SEC. ____. STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.

(a) ELIGIBILITY BASED ON GROSS INCOME.—

(1) IN GENERAL.—Section 2110 (42 U.S.C. 1397jj) is amended by adding at the end the following new subsection:

''(d) STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.—A State shall determine family income for purposes of determining income eligibility for child health assistance or other health benefits coverage under the State child health plan (or under a waiver of such plan under section 1115) solely on the basis of the gross income (as defined by the Secretary) of the family.''.

(2) PROHIBITION ON WAIVER OF REQUIREMENTS.—Section 2107(f) (42 U.S.C. 1397gg(f)), as amended by section 106(a)(2)(A), is amended by adding at the end the following new paragraph:

''(3) The Secretary may not approve a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2110(d) (relating to determining income eligibility on the basis of gross income) and regulations promulgated to carry out such requirements.''.

(b) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary shall promulgate interim final regulations defining gross income for purposes of section 2110(d) of the Social Security Act, as added by subsection (a)(1).

(c) APPLICATION TO CURRENT ENROLLEES.—The interim final regulations promulgated under subsection (b) shall not be used to determine the income eligibility of any individual enrolled in a State child health plan under title XXI of the Social Security Act on

the date of enactment of this Act before the date on which such eligibility of the individual is required to be redetermined under the plan as in effect on such date. In the case of any individual enrolled in such plan on such date who, solely as a result of the application of subsection (d) of section 2110 of the Social Security Act (as added by subsection (a)(1))) and the regulations promulgated under subsection (b), is determined to be ineligible for child health assistance under the State child health plan, a State may elect, subject to substitution of the Federal medical assistance percentage for the enhanced FMAP under section 2105(a)(1) of the Social Security Act, to continue to provide the individual with such assistance for so long as the individual otherwise would be eligible for such assistance and the individual's family income, if determined under the income and resource standards and methodologies applicable under the State child health plan on September 30, 2007, would not exceed the income eligibility level applicable to the individual under the State child health plan.

Mr. ALLARD. Madam President, today I come to the floor to offer an amendment for the purpose of upholding the original intent of the State Children's Health Insurance Program, which is commonly known as SCHIP. In 1997, a Republican-led Congress passed SCHIP to help States provide health coverage to low-income children. Current law defines a targeted low-income child as one who is under the age of 19 years, uninsured, and who would not have been eligible for Medicaid in 1997.

States may set the upper income eligibility level at 200 percent of the Federal poverty level or 50 percentage points above the State's Medicaid income level. But that is not what is happening today.

In my State of Colorado, we had a health care summit meeting early on in the year. It was very popular, well attended by representatives of health providers all over the State of Colorado. They had this to say: We think the SCHIP program is successful, and we think it ought to provide care to needy children, those who are uninsured. They further stated that there needs to be some equity among the various States and the money they get for SCHIP.

Today, anywhere between 12 and 15 States have income thresholds above 200 percent of the Federal poverty level or 50 percent above the State's Medicare income level, which was provided for in the original legislation. So we have 12 or 15 States that have figured out how to get around that provision. States such as California, Maryland, Massachusetts, New York, New Jersey, Pennsylvania, and Vermont use income disregards to expand their income thresholds beyond the intent of the SCHIP program.

As of July 2006, just a year ago, New Jersey topped the list at 350 percent of the Federal poverty level, at $72,275 for a family of four, I am told.

In fiscal year 2005, nearly half of all children in the United States were covered by Medicaid or SCHIP. SCHIP was never intended to cover all 77 million children in the United States. It was never intended to make all children, regardless of income, dependent on Government for access to health insurance.

In April, New York passed its budget which expanded SCHIP to 400 percent of the Federal poverty level or $82,600 for a family of four. By disregarding specific types of incomes, States can ignore earnings between 200 percent of Federal poverty level and their upper limit, as if that income did not even exist. States should not be disregarding large portions of income to avoid SCHIP eligibility levels. Rather than returning SCHIP to its true intent, the pending legislation makes a deliberate choice to drive up eligibility levels.

My amendment brings the language back to the original intent of SCHIP. My amendment would require that a family's gross income be used to determine eligibility for SCHIP, and that the Secretary of Health and Human Services would determine new regulations for eligibility for SCHIP by establishing what is referred to as ''gross income'' and having that defined at a certain level.

States would still have the opportunity to cover any child who was determined to be ineligible for SCHIP based on the changes made by this amendment. They would remain eligible for the program, but the State would be reimbursed according to the Federal medical assistance percentage rate rather than the enhanced Federal medical assistance percentage rate.

So I ask my fellow Senators to support me and fellow Republicans in supporting the SCHIP reauthorization. My amendment tracks current law that upholds SCHIP's original intent, and that is for low-income children. Supporting this alternative is a step toward renewing our commitment to America's most vulnerable population; that is, our children.

I will yield the floor.

Mr. LOTT. Madam President, if the distinguished Senator would withhold so I could just address a couple of questions to him on his amendment? The amendment would say that the States have to take into consideration the gross income of the family, not including certain so-called income disregards.

That is the way we talk in Washington, but to the average man and woman, what are we talking about? Are we saying, even though we think they may have other sources of income—I don't know what that might be, and I was going to ask you, are you talking about rental income? Are you talking about some part-time income? I wonder, what types of things are used by these various States to reduce the gross level of income so they can get under this, whatever it is, 350 percent of poverty or—400 percent of poverty is the newest application, I understand, from New York. Do you have any information on that?

Mr. ALLARD. I thank the Senator from Mississippi for his question. Here is what my amendment does. It directs the Secretary of Health and Human Services to establish rules and regulations to set a uniform gross income among the States. He has 90 days, once the bill becomes law, to do that. This will give the States further opportunity to give their input to the Secretary, and it gives him some flexibility to listen to what their concerns are, but says then these States all have to operate under the same rules.

Some States, for example, when they looked at total gross income, have not included income benefits from other programs. Some States have. So this amounted to a considerable amount of discrepancy, particularly in high-income States where the benefits are running much higher.

So we see some States that are getting a much higher rate of benefit through SCHIP than perhaps the more responsible States, such as your State of Mississippi, my State of Colorado, for example.

So this is an important amendment to bring some integrity to the program.

Mr. LOTT. I thank the Senator for his explanation and for his amendment because it is clear that through these waivers or through moves by various States, without questioning their motives, they have been able to develop a system which is very unequal among the States.

I found, for instance, the reimbursement rate to the States—by the States—as required by the States for Medicaid, for instance, varies greatly from as low as 50 percent to as high as 80 percent. That is not fair, and we need to do something about it. I thank the Senator for yielding.

Mr. ALLARD. I thank the Senator from Mississippi for his question.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. MENENDEZ. Madam President, I rise in strong opposition to, first, the Bunning amendment, which is the one I particularly wish to talk about because it is a direct attack on children in New Jersey. I did not think I would come to the Senate and see such a refined focus on the children of anyone's State. But that is what the Bunning amendment does.

I am sure I could draft amendments that would hone in on the interests of any given State, but I do not think that is where we want to go as a Congress, as a Senate. I do not think that is particularly good public policy. So right now I am fuming.

Let me start off by saying I thought this was one country. One country. There are a lot of things I have voted for in the Senate and in my 15 years in the Congress, in the other body before I came here, that clearly did not specifically benefit my State, from crop disaster, to ethanol, I cannot get an E–85 pump in New Jersey; a whole host of things for farmers and the list goes on and on.

I looked at it, I always looked at it as one country. Sometimes in the allocation of resources there are certain needs that get taken care of in one part of the country, where in another part there are different needs. Those amendments are an attack directly upon that notion that this is one country.

I also think it is very easy to talk about income but never talk about costs, as if living in one part of the country automatically means that those costs are the same in another part of the country. Well, they are not. We recognize that in a variety of laws in which we give differentials to a whole host of different elements, from Federal employees to differentials for the military to a whole host of people based upon where they are stationed, because we recognize that, in fact, there are different costs of living in this country.

So it is interesting to talk about income but not talk about costs. You know what I am for? Let's make sure anyone in the Senate—I am sure everybody here makes in excess of 350 percent of the Federal poverty level. Let's eliminate health care for all of those that you ultimately get by virtue of the taxpayers' dollars.

Do you deserve health care more than children who happen to fall into that category? These are the children of working families. They are not poor, as in not working, because if they were, they would get Medicaid. But they are the children of those individuals who are working, and work at some of the toughest jobs, and yet make an income that does not allow them to purchase health insurance and their job does not seem to offer health insurance.

There is a great universe of Americans whom we are trying to cover under the Children's Health Insurance Program. I agree. What is the goal? The goal is to cover children, children who do not have coverage otherwise. Well, this is exactly what we seek to do.

Now, you know, in New Jersey, we do cover 126,000 children. And, yes, we cover children up to 350 percent of the Federal poverty level. That means there are 3,000 New Jersey children who happen to fall in this category who are in the direct aim of the Bunning amendment, 3,000 children who today get health care who would be knocked out by virtue of the Bunning amendment, and there may be one or two other States that focus on children as well.

My question is: Why are you targeting these children? What did they do to you? What did they do to you? You know, the difference is, maybe if I lived in Kentucky, I could afford to get health care based upon the incomes, but first of all, we have heard a lot of numbers bantered around here, some of which are clearly not true.

Three hundred fifty percent of the Federal poverty level is $60,095 for a family of three. So it is not $82,000, as some suggest, for starters. In fact, there is no child in this country, no child in this country covered up to that dollar amount—in the entire country. That is a scare tactic. It is shameful. We need to cover children up to 350 percent because New Jersey families face higher living costs.

They get less of their return on the Federal dollar, so again we cannot have a policy that doesn't take all of that into account. But let my lay it out for you. At the top of New Jersey's current eligibility level, a family might make somewhere around this $4,428.

Well, when you deduct housing costs in New Jersey, when you deduct food costs, when you deduct transportation to get to work, and I think a byproduct is that we want to, in our values, make sure we value the welfare of these children we are talking about and their health care, we also want to value work. One of the things these parents are doing is they are working. Now, they could not be working and be on welfare and ultimately be eligible for Medicaid. But we want to value work as well. They are working.

So they have to get to work. They have child care costs. Here is what the Department of Insurance in New Jersey says is the cost monthly—monthly—for family care in New Jersey, for family health insurance: $2,065. Now, this does not have utility costs, this does not have clothing, this does not have any emergency expenses for the family. This is no buffer. No buffer. What is the consequence of that to this family if they were trying to have health insurance? They would be in the red each month by $1,200, which means that they simply will not have health insurance, they simply will not have health insurance, and these kids would not have health insurance.

Now, that is the goal of the program, to provide health insurance for children who are not so poor that they would get it under Medicaid, but, in fact, are in a set of circumstances where because their parents work, and not getting insurance at work, they find themselves in that category for which there is no coverage and no money to be covered by virtue of their family income.

So it simply does not do it. It simply does not do it. It is basic math. That is why New Jersey enrolls children up to 350 percent of the Federal poverty level, because if you live in New Jersey with that income, without this coverage, children would not have health insurance. Purchasing a private plan—no matter the tax incentives, I have heard some of the tax incentives that are being offered. There is some suggestion of a $5,000 tax credit. Great. Well, that is 2½ months of health care coverage in New Jersey.

What do we do for the rest of the time? Do we roll the dice? Are we supposed to hope for the other 10 months they do not get sick, they do not get preventative care? That is what our public policy is all about? That is what our values are as a Senate, as a country? I do not think so.

Now, the fact of the matter is, I urge my colleagues to think about this, because in New Jersey, you need to have $43,060 to purchase the same goods in Kentucky for $32,669. That is about $11,000 more to do the same thing as if you are living in Kentucky.

Now, the realty is, that is why one-size-fits-all does not work. I have heard many times on the debates here: States know best, let's have flexibility.

Well, this is a perfect example of how that flexibility has given us the wherewithal to cover children. I must say, I wish to warn my colleagues that supporting the Bunning amendment is about dumping children off the Child Health Insurance Program. It is the beginning of a slippery slope. So now we begin to eradicate those who are at 350 percent, we take them off; so then somebody comes up with another amendment, let's do 300 percent, let's eliminate that; then let's bring someone else who brings in 275 percent, and then the list goes on and on.

Before you know it, instead of having a program that covers more children in our country, we have less children covered. Less children covered in our country. I believe that, in fact, what we want to do is quite different. That is why I respect what the Senate Finance Committee did on a bipartisan basis. They looked at all the issues, all the costs, they looked at the goal of achieving, insuring more children in our country, keeping those who are in the 6.6 million, adding another 3.2 to 3.4 million, trying to reach the goal of insuring all our kids and doing it within a fiscal context that would allow it to happen. That is what this is about. That is what this is supposed to be about.

So I hope my colleagues do not join on the slippery slope that begins to cut back and cut back and cut back, that takes children off health care coverage because it would set a precedent that I think none of us would want to do at the end of the day, not only on children's health but on other issues that may be critical to our States.

I think this is about a set of values in the Senate. What are our values? We hear so much about children are our future. Yet our values speak to, if we pass this amendment, cutting children off health care, even though clearly there is a far greater cost to living in a State such as New Jersey than there is to living in a State such as Kentucky.

Now, there are a lot of things that go on in the Senate on different issues that clearly there is an appeal because of the nature of the unique challenges that States face. Well, we face a unique challenge. We want to make sure our children who are already on—by the way, these are children who already have coverage, who will lose coverage as a result of the Bunning amendment.

I am simply baffled. I thought we were about family values here. I

thought we were about protecting children. I thought we were about increasing opportunity for children to ultimately be covered. I thought we were about enhancing the quality of life and protecting life. Obviously, it is the lives of children whom we are talking about, whom we put at risk by knocking off their coverage.

So I find it embarrassing that some in Washington, some in the very Senate who have about the best health care coverage in the world can come and offer amendments that they cannot live under, that they could not live under if, in fact, they had to.

What Member of the Senate does not make more than 350 percent of the Federal poverty level? Do you not deserve to have the Government subsidizing your health care? You should be out then. Let's have the amendment make that happen too before you take 3,000 kids off the Child Health Insurance Program. It is just incredible in my mind.

So I urge my colleagues, when the time comes, and I hope there will be a timeframe when that amendment is to be pursued because I will be vigorous in pursuing it on the floor, that we do not head down the slope of pitting one part of our Nation against another, pitting the realities of the difficulties of living in one part of our Nation versus the other, pitting children in one part of the Nation versus the other, pitting the very essence of preserving children and their health against some simple formula number that ultimately Members of this body could not live under themselves.

I think if it is good enough for us, it is good enough for these children. I would not want to see a vote that ultimately undermines the ability of thousands of children who presently get health care under this program to be eliminated. That would be a dark day in the Senate's history.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, notwithstanding an earlier agreement, I ask unanimous consent that Senator OBAMA be recognized to speak next and, following Senator OBAMA, Senator LOTT be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Illinois.

Mr. OBAMA. Madam President, let me begin by thanking the Senator from Mississippi for allowing me to speak first. I appreciate his courtesy.

I also congratulate the Senator from New Jersey for his outstanding statement, sentiments which I fully share.

I will be brief.

As I have traveled across the country during these past several months, there are few issues that show a greater disconnect between what the American people want and the way Washington works than health care. Every single year people put it at the very top of the list of their concerns. Every year more people lose their insurance or watch their premiums skyrocket or open up medical bills they can't pay. Yet whenever the issue actually comes up in Washington, they watch health care debates play out that are filled with half truths and scare tactics. They see insurance companies run ads telling folks they will lose their doctor or wait forever if universal health care is passed. They watch the industry spend billions on lobbyists who use undue influence to block much needed reform. At the end of the day, nothing gets done, and we move on to fight about something else.

To most Americans, we seem completely disconnected from the reality they are living every single day, especially when we have a President who has actually said, and I quote:

> I mean, people have access to health care in America. After all, you just go to an emergency room.

That is what passes for universal health care in the greatest, wealthiest country on earth—overcrowded, understaffed emergency rooms that raise everyone's premiums and cost taxpayers more money. It is shameful. What is even more shameful is that 9 million of the Americans who are forced to wait in emergency rooms when they get sick, who have no health insurance at all, are children—children who did not choose where they were born or how much money their parents have, children whose development depends on the care and nourishment they receive in those early years, children whom any parent anywhere should want to protect at any cost.

We can shade the truth and pretend there are only 1 million uninsured, as the President says. We can make excuses for this neglect, we can start getting into an ideological argument, or we can just ignore the problem altogether. But as long as there are 9 million children in the United States with no health insurance, it is a betrayal of the ideals we hold as Americans. It is not who we are, and today is our chance to prove it.

We know CHIP works. Because of CHIP, 6 million children who would otherwise be uninsured have health care today. Because of CHIP, millions of children are protected when their parents lose their health care. Because of CHIP, individual States such as my home State of Illinois are building on its success to expand health coverage even further. And because of CHIP, millions of children with asthma, traumatic injuries, and mental health conditions are able to see a doctor and get the treatment they need.

Even though the uninsured rate among low-income children fell by more than one-third in the years after CHIP was enacted, the trend reversed 2 years ago. Since then, we have seen growing numbers of uninsured children. That is why I am always puzzled when we start getting into these debates that are ideologically driven about whether Government should provide coverage. If market-based solutions provided affordable coverage options for these children, then it wouldn't be necessary for the Government to help provide coverage, because these children wouldn't be uninsured. The reason they are uninsured is because their parents can't afford private coverage.

Uninsured children are twice as likely as insured children to miss out on much needed medical care, including doctor visits and checkups. One-quarter of uninsured children don't get any medical care at all. Those who do get lower quality care. Even with the same illness and conditions, whether it is an ear infection or appendicitis, studies have found that uninsured children get different treatment and often suffer more as a result. One study even found that uninsured children who are admitted to a hospital with injuries are twice as likely to die as children who are admitted with health insurance.

To put this problem in the larger context, we know that when a child gets sick and can't get treated or receives inadequate treatment, he misses more days of school. When he misses more days of school, he begins to do worse relative to his peers. That can have long-term consequences on his chances in life. That is not something I want for either of my two young daughters or for any American child. This body should not want it for any child either.

Let's get serious and solve this problem. Let's reauthorize CHIP. Let's make sure that the 6 million children who are now covered through the program continue to be covered. Let's extend coverage to an additional 3.2 million uninsured children.

We also know the question of children's health care is tied to the larger question of universal care in this country. Because we know that when we cover parents, we also cover children. That is something we have seen in Illinois. When I was a State senator, I was able to help extend health care coverage to an additional 150,000 parents and their children. So if we are serious about covering every child, at some point we are going to have to cover every parent as well.

The American people have been waiting for us to act on health care for far too long. Starting by covering more children should not be a difficult issue to agree on. I urge every Senator to vote for this bill. I know the President has threatened to use his veto, which he has so sparingly used, to deny health insurance to America's children. I urge my colleagues to stand and fight that veto every which way we can. There is not a single person here who, if their child were sick and they couldn't afford health insurance, wouldn't be begging the Government to give them some help. We wouldn't be having these arguments. Let's show some empathy for the families out there, many of whom are working every single day, sometimes working

two jobs and still don't have health insurance. Let's make sure they have what every parent wants, which is some assurance that if their child gets ill, they are going to receive the kind of care they deserve.

Let's cover our children and remind the American people who we are and why they sent us here in the first place.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. LOTT. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LOTT. Madam President, we were alternating back and forth on both sides, but the Senator from Illinois had a need to go forward. I agreed that he would go first and then I would follow.

Let me say on the bill we have here, again, it is very easy to get up and talk about children and the need to help children. That affects us all. I am a parent. I am a grandparent. There is nothing that excites me more in the world than going to see my four little grandchildren. I can't stand the thought of children anywhere, regardless of income level, not getting the kind of health care they need. That is why I voted for SCHIP in 1997. I remember Senator KENNEDY was in the debate. Senator Phil Gramm of Texas had a little different point of view. Senator HATCH was involved. We came to a conclusion. We got a good program to help children who did not have health care. I thought we had done a good thing.

The problem here is, we are exploding the program in terms of costs, tax increases, or cuts in the House. They are not doing the tobacco tax increase. They are cutting Medicare Advantage which affects people at the other end of the age schedule, people who need Medicare Advantage to get health care in rural areas in States such as mine.

There is a balance here. Why can't we agree on a reasonable increase to make sure we continue to cover children who would not be covered otherwise. Also what is happening here is a steady march toward higher and higher and higher income level children. You heard Senator ALLARD talk about the fact, now we are up in the range of $73,000 income for a family of four. The ultimate goal is for all children to be covered by ''Mother Washington,'' Washington bureaucracy health care. Why should any family have to worry, regardless of income, or any State have to worry about children being covered of all ages, forever, for everything, including dental care?

I agree, dental needs can be as damaging healthwise as any other illness. I am connected to a family of dentists, dental hygienists, and dental technicians. But the question is, how much can the Government pay for? Why can't we keep some limits? Why do we want to force people off of private insurance? We are going to have children now covered by private insurance going into SCHIP or Medicaid. Why are we trying to force everybody on to SCHIP?

This chart shows what is happening. When we started this program in 1997, the next year, 1998, the children enrollment in Medicaid and SCHIP, the children's health program, was 27 percent covered by Medicaid, 1 percent was covered by the Children's Health Insurance Program, and 72 percent by other programs including private insurance. By 2005, it had grown to 37 percent covered by Medicaid, 8 percent by the CHIP program, and 55 percent other. With this bill, the underlying bill going into effect the way it is now, it will jump to 71 percent of all children will be covered by Medicaid and SCHIP, and only 29 percent other. You see the steady march toward every child being covered by this particular program.

The problem with this bill can be described with A, B, C. Not only have you had the steady march of higher and higher income level children being covered, adults are being covered. Where is the ''A'' in SCHIP? Again, it is a creeping thing. First, gee whiz, yes, it is supposed to be for children, but pregnant mothers should be covered and what about parents of children. There are some other adults that maybe need some extra consideration, too. So it is not only higher and higher income children, it is adults and more adults and even more adults. So the first appropriate problem is adults, A.

B, we are talking billions here. The underlying program is $25 billion. The Finance Committee adds 35 at a minimum on top of that. And in the outyears it expands tremendously, up to, I think in the year 2012, the number is maybe 37 billion in that single year. Remember, if we pass the Finance Committee bill, that 60 billion—25 plus 35, it will be 60 billion—the House is going to pass a bill at what, 80, 90, 100 billion, paid for by taking money away from Medicare beneficiaries and we go to conference, if we go to conference. What will happen? What always happens, you split the difference. We are at 60; they are at 90. How about 75, $75 billion? How is that going to be paid for? It is going to be paid for by cutting benefits for the elderly and/or raising taxes for all kinds of people.

We can fix this, though. It gets back to the A, B, C. Keep to the core mission, children who are low-income families. We need to get back to that. We have some good amendments pending. We should pass the Bunning amendment which would eliminate the high income eligibility above 300 percent, the Allard amendment which would stop the income disregards which drives the income level up steadily, and I understand that Senator GREGG will have one that will strike the adult coverage.

We can fix this. We could get together on a bill that would be bipartisan and would help the children who do need it, the ones we started out to help before we got the bright idea we will cover everybody by the Children's Health Insurance Program.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I was wondering if the Senator would yield for a question.

Mr. LOTT. Madam President, I am glad to yield.

Mr. KENNEDY. Madam President, I see the Senator from Wyoming. I want to address the Senate for a minute, but I want to inquire of the good Senator from Mississippi if I could engage him in a question or two.

I listened with great interest to the Senator from Mississippi talking about the cost of this program and the paying of this program. Does the Senator agree with me that every Member of the Senate has a health insurance program that is funded and financed 72 percent by the Federal taxpayer? Does the Senator agree with me on that?

Mr. LOTT. Madam President, we do have a program that has input from the Treasury, yes.

Mr. KENNEDY. Well, the input is 72 percent for every Member in our health insurance program. Every Member's program, Republican and Democrat, is paid for by the American taxpayer, No. 1. Secondly——

Mr. LOTT. Well, if I can respond, I have a solution. Let's cut that. Maybe we are not entitled to that.

Mr. KENNEDY. If the Senator wants to offer that amendment, fine. I hear him talk about children, but I do not hear him talk about that.

Secondly, would the Senator not agree with me that Members of the Senate have access to Bethesda Naval Hospital and Walter Reed Hospital and virtually free care at those places, which the children of America do not have? Would the Senator not agree with me that we are treating Members of Congress one way and the children another way?

Mr. LOTT. Well, now, Madam President, I might say, the Senator has been here much longer than I have, and I presume he would know the origin of how these programs were created and voted for or against them. But I want to correct something he said right at the beginning. I have not advocated cutting children. I advocate covering the children who are now covered and making sure we cover the children we have committed to. What I am opposed to is the ever increasing income level and number of children and adults.

What about adults who are being covered by this program? If it is going to be ''ACHIP,'' adults-children health insurance program, that is one thing. But I would like to keep the focus on covering the children who really need it and would not be able to get it perhaps through a private insurance program or in Medicaid.

But if the Senator wants to propose we cut the Senator's benefits, I will be glad to join him in that.

Mr. KENNEDY. I am for having a universal——

Mr. LOTT. Everything we are doing to ourselves, we might as well do that too. That would be fine with me. If we could control the growth of this program, I would be more than glad to help pay for it.

Mr. KENNEDY. If the Senator will yield for one more question. He was talking about coverage. We have 9 million children who are not covered. All of our children are covered. We have $160,000 in income, and every one of our children is covered. Why is the Senator so concerned about trying to cover the remaining children who are not covered in this country? Under this program, we cover 4 million more. All of our children are covered. We have $160,000 in income.

Mr. LOTT. I am perfectly delighted to do that. Of course, my children are grown, and they are not covered at all by this, but I would be glad, to control that, to do anything the Senator wants to do to the Senate. I suspect it richly deserves it.

And another thing, what I am saying is, one State is only covering children up to 200 percent, other States now have 350 percent, or even one of them is now wanting 400 percent of poverty for children and adults.

All I am saying is, stick with the program we intended. Let's not turn this into just a Washington bureaucratic health-run program. That is what this is all about. This is about moving us toward a system we could not get any other way, where the Government will pay for and control everything in terms of health coverage in America. I do not believe the American people want it.

I worry about my children and grandchildren in this respect. What kind of burden are we putting on their backs in terms of what they will have to pay for in the future? Does nobody ever think about that anymore? Every program is growing exponentially; every one of them. So I worry about my grandchildren having to pay for all the things we are coming up with here.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, the Senate has been very gracious in working out times. Two Democratic Senators spoke, and Senator LOTT had the floor. So I ask consent now that the Senator from Wyoming, Mr. BARRASSO, be able to speak—that would be two Republicans in a row—and following him, if he wishes, that Senator KENNEDY be recognized to give a statement on the bill for about 15 minutes. I thank the Senator.

So I ask consent that Senator BARRASSO be recognized, and following Senator BARRASSO that Senator KENNEDY be recognized.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. BARRASSO. Thank you, Madam President.

Today, I rise to speak about health care for children. We are talking about the SCHIP program, and I come to the floor with great interest because the ''S'' in SCHIP stands for State, and the ''C'' stands for children.

For the last 5 years, I spent time in the Wyoming Legislature on the Labor, Health, and Social Services Committee, where we worked closely on the issue of children's health, and specifically worked closely with SCHIP.

I have been a fan and a supporter of children's health, and specifically of SCHIP. In Wyoming, SCHIP has been a very successful program. In Wyoming, right now, there are over 5,000 young people who are in this program. Madam President, 5,642 was our count in July. We call the program Kid Care. That is because kids can be born with club feet. Kids can fall at the playground. Kids can have problems with measles or mumps.

Nationwide, this very successful program has covered over 6 million children. It is a good program. Some folks confuse SCHIP with Medicaid. They are very different. Medicaid is designed for people below the poverty level. SCHIP is for people above the poverty level, but in that income range of up to 200 percent of the Federal poverty level. For us, that is an income of about $40,000 a year for a family of four.

In Wyoming, if you talk to anyone in the legislature, from both parties, they will tell you this program has been cost effective. It is not an entitlement. It is done through a combined partnership with Blue Cross-Blue Shield, a public-private partnership. It covers the people in Wyoming who are intended to be covered.

Many Government programs do not work well or produce results. Yet SCHIP very successfully achieved what it set out to do about 10 years ago when the program began. We have significantly reduced the number of uninsured children in America. It has worked. That is why I want to be clear from the outset, as we go into this debate, I am 100 percent committed to reauthorizing this very important safety net program for kids. I strongly supported the program as a State senator. I will continue to do so in my capacity as a U.S. Senator.

Madam President, 5,642 Wyoming children depend on SCHIP right now to stay healthy. There are additional young people in our State who are eligible for SCHIP but who are not yet enrolled. So I want to do more in terms of outreach, working on outreach and enrollment efforts to find these people, to target these low-income children, and get them enrolled in the program.

I want to support and enhance public-private collaborations to make sure we are doing the most cost-effective, efficient, and quality health care possible for these young people, but mostly I want to make sure this Senate and this Congress produces a reasonable, commonsense piece of legislation that we can send to the President and that he will sign.

I have concerns with the bill that is in front of us. This bill, this piece of legislation, reported out of the Finance Committee, takes a successful spending program and uses it as a vehicle to create a new entitlement. The bill that I look at today covers high-income people, covers people who already have insurance, and covers adults. To me, this bill should be all about children.

Well, let's look at those three concerns.

High-income people: This bill allows families at 400 percent of the poverty level to be covered. In New York State, that is an income of $82,600 a year. In New Jersey, 350 percent of the poverty level is an income of over $72,000 a year. At home in Wyoming, we play by the rules. It is 200 percent of the poverty level. That is what we need. That is what works.

Are there kids in New York and New Jersey who need to be covered? Of course. There are kids everywhere who need to be covered. But why the different rules for different States? And why so many high-income people as part of the program?

So that is No. 1.

No. 2, people who already have health insurance: When you start to cover children in families above that 200 percent of the poverty level, many of those children are in families where they already have insurance. Madam President, 77 percent of the children in families between 200 and 300 percent of the poverty level have private health insurance. When you go above that, above the 300 percent level, between 300 and 400 percent of the Federal poverty level, 89 percent of those children are in families where they have private health insurance.

When you do the math and look at the numbers, people in those categories will be financially compelled to take their children off of the private, usually employer-sponsored health care plans, and put them on the taxpayer-supported plans.

The Congressional Budget Office looked at this, and they think, with this plan, 2.1 million people will move from private coverage to Government dependency, if this legislation is enacted.

This is supposed to be a program to help children, children who do not have health insurance. It seems as if some in this body may be trying to use this plan to nationalize health insurance.

The third thing I see that is a concern with this plan is in some places it covers adults, not just children. It covers the parents of children. Nowhere—nowhere—in the word ''SCHIP'' is there the letter ''A'' for adults. The ''C'' stands for children.

This country does need to have a serious debate on health care, and it should not be on the backs of these children covered under SCHIP. In the future, we need to debate health care

in America, how we pay for health care, how we encourage people to better care for themselves, to take more responsibility for their own health, what incentives we can have for people to stay well, how insurance is used in this Nation. Should it be deductible for all, instead of just in businesses and not by individuals? Should there be tax credits? Is there a way we can set up small business health plans to help people who need insurance?

I find that people are very thoughtful when it comes to how they spend their own money. So often, in the medical world, very few people spend the same kind of time making those financial decisions as they do when they are spending money out of their own pocket, when it is a third-party payer who is doing the spending.

In the future, we need to have a debate and discussion about how we handle medical errors in this country: No. 1, how to prevent them from ever happening; and, No. 2, how to deal with the fact that when they occur, we want to make sure people are taken care of quickly, and that anything that goes to them goes more to the injured party than it does to the system.

We need to find ways to lower the significant cost in America of defensive medicine.

These are all very serious issues. They all deserve a serious national debate, and that day will come. But the bill today wrongly attempts to massively expand a successful program under excessive spending for many people who do not need it, and it avoids a debate we need to have on health care in America.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I believe I have 15 minutes. Am I correct?

The PRESIDING OFFICER. The Senator is not limited.

Mr. KENNEDY. Well, Madam President, I think the floor manager intended to yield me 15 minutes, for which I am very grateful.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I ask my friend, how long does he wish to speak, 15, 20 minutes?

Mr. KENNEDY. Fifteen minutes.

I see the Senator from Connecticut on the floor. I know we had accommodated the Senator from Illinois a short while ago. I do not mind accommodating him. I see, then, the Senator from Kentucky on the floor.

Could I ask my friend from Kentucky, if we do not exceed 15 minutes, would he mind if I yielded a few minutes to the Senator from Connecticut? We basically are going from one side to the other.

Mr. BUNNING. To the Senator from Connecticut? That would be perfectly all right, just so long as I get the time that was allotted to me.

Mr. KENNEDY. Madam President, if it is agreeable with the floor manager, I would take 11 minutes and yield the Senator 4 minutes, if that is OK. Would the Chair remind me when I have used 10 minutes and I have 1 minute left?

The PRESIDING OFFICER. The Senator will be notified.

Mr. KENNEDY. Madam President, many of the best ideas in public policy are the simplest.

The Children's Health Insurance Program is based on one simple and powerful idea—that all children deserve a healthy start in life, and that no parents should have to worry about whether they can afford to take their child to the doctor when the child is sick. CHIP can make the difference between a child starting life burdened with disease, or a child who is healthy and ready to learn and grow.

This need not be a partisan issue. My good friend Senator HATCH and I worked together in 1997 to create this program that was our shared vision for a healthier future for American children. This year we have once again worked together to find common ground on covering the children who deserve decent, quality health care.

In Massachusetts in the 1990s we agreed that health care coverage for children is a necessity and that action needed to be taken. In 1993, the Massachusetts Legislature passed the Children's Medical Security Plan, which guaranteed quality health care to children in families ineligible for Medicaid and unable to afford health insurance.

A year later, Massachusetts expanded eligibility for Medicaid and financed the expansion through a tobacco tax—the same approach we used successfully a few years later for CHIP and he same approach that is proposed in the bill before us now.

Rhode Island followed and other States took similar action and helped create a nationwide demand for action by Congress to address the unmet needs of vast numbers of children for good health care.

In 1997, Congress acted on that call, and the result was CHIP. Senator HATCH and I worked together then—as we have this year—to focus on guaranteeing health care to children who need it. Now, in every State in America and in Puerto Rico, CHIP covers the services that give children a healthier start in life—well child care, vaccinations, doctor visits, emergency services, and many others.

We know that CHIP works. Children across America depend on it for their health care, but there are still too many children that are left uninsured.

In its first year 1997, CHIP enrolled nearly a million children, and enrollment has grown ever since. An average of 4 million are now covered each month, and 6 million are enrolled each year. In every State in America and in Puerto Rico, CHIP covers the services that give children a healthier start in life—well child care, vaccinations, doctor visits, emergency services, and many others.

As a result, in the past decade, the percentage of uninsured children has dropped from almost 23 percent in 1997 to 14 percent today. That reduction is significant, but it is obviously far from enough.

Children on CHIP are more likely to have a regular source of care than uninsured children. Ninety-seven percent of CHIP children can see a doctor regularly compared to only 62 percent of uninsured children.

What does this mean for these children? It means that their overall quality of life is improved because they can get the care they need when they need it. Their parents are more confident that they can get the health care they need, they are more likely to have a real doctor and a real place to obtain care, and their parents don't delay seeking care when their child needs it. Children on CHIP also have significantly more access to preventive care.

Studies also show that CHIP helps to improve children's school performance. After just 1 year on CHIP, children pay better attention in class and are more likely to keep up with all school activities. When children are receiving the health care they need, they do better academically, emotionally, physically and socially. CHIP helps create children who will be better prepared to contribute to America.

CHIP has perhaps had the greatest impact on minority communities. Sadly, we still have persistent racial and ethnic health disparities in America. African Americans have a lower life expectancy than Whites. Many Americans want to believe such disparities don't exist, but ignoring them only contributes more to the widening gap between the haves and have-nots. Minority children are much more likely to suffer from asthma, diabetes, HIV/AIDS and other diseases than their White counterparts.

Minorities are more likely to be uninsured than Whites. More than half of all children who receive public health insurance belong to a racial and ethnic minority group. The good news is that since the beginning of CHIP, the number of uninsured Latino children has decreased by nearly one-third and the number of uninsured African-American children has decreased by almost half.

Having CHIP works for minority children. CHIP all but eliminates the distressing racial and ethnic health disparities for the minority children who disproportionately depend on it for their coverage. Minority children are more likely to have their health care needs met. In other word, they can see the doctor when they need to, go to the hospital and get the medicines they need, just like other children, when they are on CHIP.

They are also more likely to have a real doctor—not just sporadic visits to the emergency room—when they are covered by CHIP.

For specific diseases like asthma, children on CHIP have much better outcomes than when they were uninsured.

CHIP's success is even more impressive and important when we realize

that more and more adults are losing their own insurance coverage, because employers reduce it or drop it entirely.

That is why organizations representing children, or the health care professionals who serve them, agree that preserving and strengthening CHIP is essential to children's health. The American Academy of Pediatrics, First Focus, the American Medical Association, the National Association of Children's Hospitals and countless other organizations dedicated to children all strongly support CHIP.

A statement by the American Academy of Pediatrics puts it this way:

> Ennrollment in SCHIP is associated with improved access, continuity, and quality of care, and a reduction in racial/ethnic disparities. As pediatricians, we see what happens when children don't receive necessary health care services such as immunizations and well-child visits. Their overall health suffers and expensive emergency room visits increase.

Today, we are here to dedicate ourselves to carrying on the job begun by Congress 10 years ago, and to make sure that the lifeline of CHIP is strengthened and extended to many more children.

Millions of children now eligible for CHIP or Medicaid are not enrolled in these programs. Of the 9 million uninsured children, over two-thirds—more than 6 million—are already eligible for Medicaid or CHIP. These programs are there to help them, but these children are not receiving that help either because their parents don't know about the programs, or because of needless barriers to enrollment.

Think about that number—9 million children in the wealthiest and most powerful nation on Earth. Nine million children whose only family doctor is the hospital emergency room. Nine million children at risk of blighted lives and early death because of illnesses that could easily be treated if they have a regular source of medical care.

Nine million uninsured children in America isn't just wrong—it is outrageous, and we need to change it as soon as possible.

We know where the Bush administration stands. The President's proposal for CHIP doesn't provide what is needed to cover children who are eligible but unenrolled. In fact, the President's proposal is $8 billion less than what is needed simply to keep children now enrolled in CHIP from losing their current coverage—$8 billion short. To make matters worse, the President has threatened to veto the Senate bill which does the job that needs to be done if we are serious about guaranteeing decent health care to children of working families across America.

We cannot rely on the administration to do what is needed. We in Congress have to step up to the plate and renew our commitment to CHIP.

The Senate bill is a genuine bipartisan compromise.

It provides coverage to 4 million children who would otherwise be uninsured.

It adjusts the financing structure of CHIP so that States that are covering their children aren't forced to scramble for additional funds from year to year and so that Congress doesn't have to pass a new band-aid every year to stop the persistent bleeding under the current program.

Importantly, this bill will not allow States to keep their CHIP funds if they aren't doing something to actually cover children.

Equally important, this bill allows each State to cover children at income levels that make sense for their State.

The bill also supports quality improvement and better outreach and enrollment efforts for the program. It is a scandal that 6 million children today who are eligible for the program are not enrolled in it.

In sum, this bill moves us forward together, Republicans and Democrats alike, to guarantee the children of America the health care they need and deserve.

Our priority should be not merely to hold on to the gains of the past, but to see that all children have an access to decent coverage. Families with greater means should pay a fair share of the coverage. But every parent in America should have the opportunity to meet the health care needs of their children.

In Massachusetts, I met a woman named Dedre Lewis. Her daughter Alexsiana developed an eye disease that if left untreated would make her go blind. Because of our State CHIP program, Masshealth, Dedre is able to get the medicine and doctors visits need to prevent Alexsiana's blindness. Dedre said this:

> If I miss a single appointment, I know she could lose her eyesight. If I can't buy her medication, I know she could lose her eyesight. If I didn't have Masshealth, my daughter would be blind.

This is the impact CHIP has on families across America.

Let me say that quality health for children isn't just an interesting option or a nice idea. It is not just something we wish we could do. It is an obligation. It is something we have to do. And it is something we can do today. I look forward to working with my colleagues to make sure this very important legislation is enacted.

I want to pick up on a theme I mentioned just a few minutes ago, and I stand to be corrected. I would say there is not a single Member of the Senate who doesn't take, effectively, the Federal employees insurance program, and in our situation, the Federal Government pays for 72 percent of it. We have one Member, and I admire him—I have just learned of his name, and I will not mention it here; I will ask whether I can include it as part of the RECORD rather than embarrass him—but it is a noble act on his part when he said that until we get universal coverage, he wasn't going to take this.

But the idea that all Americans ought to understand now is what we are standing for—and I again commend the Senator from Montana and the Senator from Iowa and my friend, Senator HATCH, when we worked together years ago, and Senator ROCKEFELLER on this program—is a rather simple and fundamental concept, and that is this: Every child in America ought to have a healthy start.

Here in the Senate, we are about expressing priorities. Those of us on this side of the aisle and a group on the other side—a small group on the other side, a courageous group on the other side—have stated that same concept, that every child in America should have a healthy start, No. 1; and No. 2, that every parent in America should be relieved of the anxiety of worrying about whether they have sufficient resources to be able to make sure their child is going to receive decent quality health care. Those are revolutionary thoughts, are they not? Those are surprising concepts; isn't that right?

Evidently, our friends on the other side of the aisle get all worked up about those two concepts—that all children in this country should have a healthy start and that mothers and fathers should be relieved of the anxiety that when their child has an earache or their child has a soar throat or their child has a headache, they have to wonder whether their child is 150 dollars or 175 dollars sick because that is what it costs to take them to the emergency room. So they wait overnight. They let the child get a little sicker. They have a sleepless night. They worry. They hope and they pray that their child gets better. Well, we in this body say that America can do better.

I listened to my friend—and he is my friend—from Mississippi talking about the cost of this program: $60 billion over 5 years. That is what we are spending in 5 months in Iraq—5 months in Iraq. What would the American people rather have—coverage for their children or a continued conflict in Iraq where we are losing the blood of our young men and women? This is the issue. Let's not complicate it. Let's not make it difficult. Let's not make it unreasonable. That is what this is about.

Sure, we have listened to the arguments: Oh, someone is going to have to pay for it. Yes, it is going to be those who are smoking. What is the result of increasing the tobacco tax? What is the direct result? Tobacco—cigarettes—when used as advertised increases deaths in America. Among whom? Among children. Every day, 2,800 children become addicted. Every year, 500,000 people die because of the use of tobacco. So what happens if we raise the tax 61 cents on cigarettes? You know what happens. Children stop smoking. Oh, they do? Yes, they do. Who says so? Who says so? Just look at the history of what has happened when we have increased the tax on cigarettes.

So I commend those on the Finance Committee for finding a revenue measure that will ensure—not that all children will stop smoking and end it but

that this will be a major disincentive for young people to smoke. On the other hand, it gives children a healthy start and relieves the anxiety for parents.

So this is a measure which speaks for action. It speaks for justice. It speaks for fairness. It speaks for our values. I, for one, strongly believe in the concept of comprehensive health care, and we will have that debate at another place and at another time.

I know my children were covered. They are grown now, as others have been here, but I know when they needed health care, they were able to receive it. I remember very clearly that when my child lost his leg to cancer, we saw families in that chamber who were absolutely driven into poverty because they couldn't afford the same kind of health care we had.

This is a statement that we in the Senate find children to be a priority and find their parents to be a priority and find it to be in the interest of children to increase the tobacco tax.

This legislation makes a great deal of sense, and I again commend the sponsors for it.

Whatever time remains I yield to my friend and colleague from Connecticut.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Connecticut is recognized.

Mr. DODD. Madam President, I wish to begin my comments by thanking our colleague from Massachusetts once again for giving heart to an argument that sometimes gets lost in statistics and numbers.

As all of us know, every one of us has watched either fellow Members or others—our staffs or constituents—who have gone through the dreaded situation of watching a child in need of health care. We know how fortunate we are to be Members of Congress, as we receive a tremendous amount of support for health care services. The fact that we are living in a day and age in the 21st century when so many of our children, growing numbers in our society, are without any kind of health care coverage at all. It is shameful, to put it mildly. I commend the distinguished Senator from Montana, the chair of the Finance Committee, and once again the Senator from Massachusetts for his tremendous support of this effort.

I wish to offer an amendment at the appropriate time. As many of my colleagues know, over a period of 7 years, three Presidents, and two Presidential vetoes, I worked toward passage of the Family Medical Leave Act. It finally became law in 1993. Today, more than 50 million Americans have been able to take advantage of the protections of that law. It is related to the subject matter of the bill at hand, a little bit off center, but it's about caring for our families.

Last week, Senator Dole along with Donna Shalala and others, offered recommendations from the President's Commission on Care for America's Returning Wounded Warriors. They urged Congress to draft legislation to allow up to 6 months of family and medical leave for family members of troops who have sustained combat-related injuries and meet the other eligibility requirements of the law. We believe this is a worthwhile proposal, so I introduced the Support for Injured Servicemembers Act last week with several of my colleagues.

I am very grateful to Senator DOLE, a former colleague of ours, and the entire Commission for their thoughtful work on this crucial issue.

For 20 years, we have worked on legislation to extend family and medical leave to families in this country. So I hope that at the appropriate time, my amendment on this matter will be considered and unanimously adopted. There may be an argument on germaneness, but we can't wait to help the men and women who are injured in service to our country. I can't think of a more appropriate step for us to take than to allow these veterans who are recovering from their wounds to have a loved one with them during that period of recovery.

I wanted to lay out for my colleagues the value of this amendment, how valuable the protections of family and medical leave have been for families. In fact, we have introduced legislation to provide paid family and medical leave. I won't be offering that at this juncture, but now offer an extended unpaid leave program. My amendment would simply extend the period of job protection for up to six months for those who care for our returning heroes as they recover from their injuries. The reasons are obvious.

In the Wounded Warriors Commission survey, 33 percent of Active-Duty and 22 percent of Reserve components and 37 percent of retired/separated servicemembers report that family members or close friends relocated for extended periods of time to be with them while they were in the hospital. Twenty-one percent of Active-Duty, 15 percent of Reserve components, and 24 percent of retired/separated servicemembers say friends or family gave up a job to be with them or act as their caregiver.

It seems to me they shouldn't have to give up a job in order to be with a recuperating servicemember coming back from Iraq or Afghanistan. The Commission's findings indicate the critical role that family and friends play in the recovery of our wounded servicemembers. Currently FMLA provides for 3 months of job-protected unpaid leave to a spouse, parent or child acting as a caregiver for a person with a serious illness. The report indicates that many servicemembers rely on other family members or friends to care for them. My amendment allows these other caregivers—siblings, cousins, friends or significant others to take leave for up to six months, when our returning heroes need them the most, without fear of losing their jobs. My amendment goes beyond some other proposals in other ways as well. It covers caregivers staying with the recovering servicemember in a military hospital as well as those providing care at home. This proposal would apply to all individuals currently covered by FMLA, including federal civil servants, who might find themselves caring for a wounded warrior.

My amendment only addresses servicemembers with combat-related injuries. This is a narrow universe of individuals who experience extraordinary circumstances. Taking care of our soldiers, sailors, airman and Marines returning from Iraq and Afghanistan was the point of the Commission and the Wounded Warriors Act that we recently passed. I can't think of anything more important that we could do this week before August break than to pass a proposal that would provide these service men and women the opportunity to have a loved one with them as they recover.

I send my amendment to the desk. I thank my colleague from Massachusetts for his tireless work, the Senator from Montana, of course, and the Senator from Iowa, who have worked hard on children's issues, and ask them to consider this amendment at the appropriate time.

I yield the floor.

The PRESIDING OFFICER. The Senator from Kentucky is recognized.

Mr. BUNNING. Madam President, I would like to talk about the State Children's Health Insurance Program, also known as SCHIP.

A few weeks ago, the Finance Committee passed the Baucus bill to reauthorize this program. I did not support this bill in committee and I will not be supporting it on the floor. Today, I would like to take a few minutes to explain my concerns with the Baucus bill. I would also like to talk about the SCHIP reauthorization bill I will be supporting this week and have helped to craft over the past couple of months—the Kids First Act.

This bill is a good piece of legislation that reauthorizes this important program in a fiscally sound way and keeps the focus of the program on what it was originally for, which is low-income children.

I have significant concerns with the budget gimmicks used, the SCHIP provisions, and the tax increases in the Baucus bill. The budget gimmick used to fund the Baucus bill is irresponsible, jeopardizes coverage under the program, and basically guarantees another tax increase 5 years from now. Under the bill, SCHIP spending in 2012 reaches $16 billion; however, the very next year, spending drops to $3.5 billion. While this strategy helps the drafters hide an additional $40 billion in spending, does any Member of the Senate really think that SCHIP spending in 2013 will be $3.5 billion? That is below the current spending level of $5 billion a year. Does any Member really think we will kick millions of kids off

this program in 2013 to accommodate this lowered spending? Of course, the answer is no. That means Congress will have to come up with a significant amount of money to pay for the increased spending, which will likely mean reaching into the wallets of hard-working Americans again.

I also believe SCHIP should be a program for low-income children. When Congress created the program in 1997, it was intended for children without health insurance who lived in families making less than 200 percent of the Federal poverty limit. For 2007, 200 percent of poverty is about $41,000 in income for a family of four.

Not many people realize adults are now covered under SCHIP. Most people rightly think this is a program only for children since it is the State Children's Health Insurance Program. That is its name. Over the years, the Department of Health and Human Services has approved expansions to the program to allow States to cover these adults. These expansions should not have been approved in the first place, and it is Congress's responsibility in the reauthorization to rein in these abuses.

While the Baucus bill at least ends coverage for childless adults currently on SCHIP, it still allows other adults—specifically, parents—to stay on the program in certain States, and any State that currently covers parents can keep adding new parents to their programs.

The Kids First Act, which I am supporting, responsibly reauthorizes the SCHIP program and keeps the focus on low-income children. This bill reauthorizes the program for 5 years at a cost of about $39 billion. This would still be a significant but responsible increase over spending in the first 10 years of the program.

The bill would require States that want to cover children and pregnant women above 200 percent of the poverty level, or $41,000 for a family of four, to pay more from their State coffers than they do now to do so.

The bill also takes steps to limit the number of adults on the SCHIP program. While we would not require States to remove any adults currently on the program from their rolls, we would reimburse States at a lower amount for the childless adults and parents they currently have on their programs.

Also, States could not add any new childless adults or parents to their SCHIP rolls. If they want to cover these individuals, then they need to do it under their State Medicaid programs.

The Kids First Act also stops the Department of Health and Human Services from approving any more waivers or demonstration projects for States that want to cover parents or childless adults.

The Kids First Act is a good proposal that I hope will get full consideration on the Senate floor. It keeps SCHIP focused on low-income children, curtails States' ability to add new parents or childless adults to the program, and makes sense from a fiscal standpoint. Unfortunately, the Baucus bill falls short on these key points.

Also, the tobacco tax in the Baucus bill is fundamentally unfair to my State and the surrounding States. I want to show you a chart I have here, which shows the 50 States. This illustrates the real problem. It is compiled from data drawn from a CDC database on tobacco consumption and projections by Families USA concerning SCHIP spending. You will see here that there are big winners in this program, and they are in dark green on the chart. You can see Texas, California, Arizona, New Mexico, New York, and California, which is $2.564 billion. New York is $1.684 billion. It shows Kentucky, Tennessee, South Carolina, North Carolina, Virginia, Ohio, Indiana, Missouri, Iowa, Wisconsin, and particularly Florida; it shows those States as dead net losers—$703 million in Florida; $602 million in Kentucky; $517 million in Indiana; $536 million in North Carolina, and so on. It also shows States that are neutral, such as Oregon, Idaho, Nebraska, and some other States that are kind of in the middle, such as West Virginia, Georgia, Alabama, Mississippi, and so on. You can see from the chart that we pick big winners and big losers, some neutral and some lower losers, not big such as the ones in dark brown. It is very important that you realize that is a completely unfair reason and method of funding SCHIP.

The problem with the tax is that the money comes from low-income smokers in my State and all of the dark brown States on this chart, and it is going to pay for an extravagant expansion of SCHIP in California, New York, Texas, and the States depicted in green.

This bill will also, without any doubt, add an enormous boost to black-market tobacco smuggling and counterfeiting. The plan would be a tremendous gift to organized crime and the black-market kingpins, who will profit handsomely from it in future years. There is plenty of past evidence of this. In 2002, for example, New York City increased its tobacco tax from 8 cents per pack to $1.50 per pack. The city's revenue estimators predicted an additional $107 million in revenue. Do you know what they got? It brought in $43 million. What is more, the tax increase on cigarettes cost the State over $600 million in tax revenue due to lower sales at convenience stores throughout New York State. An economist found that most of the reduction was due to smuggling, cross border sales, Internet sales, and sales on Indian reservations.

Even supporters of this bill acknowledge that the higher tax will have an impact on demand. It will reduce legal consumption of cigarettes. It is not likely to reduce total consumption, as the supporters of the bill say it will, because it will also increase smuggling. But legal consumption is what matters to the United States because that is the only part that is taxed.

The revenue estimate provided by the Joint Committee on Taxation shows this. Revenue is projected to decline by $700 million per year by the last year of the estimating window. That is right. Understand this now. Revenue is expected to go down over time as the number of legal sales of tobacco products declines.

Whatever its other problems, the tobacco tax is a poor foundation for SCHIP. We are matching a declining source of revenue with a growing Federal problem. This does not make any fiscal sense.

If we were honest and we truly wanted to fully fund SCHIP spending with a tobacco tax, the Federal Government would have to encourage people to smoke.

That is what this next chart shows: additional smokers. The Federal Government would need an additional 22.4 million smokers by the year 2017. Of course, I don't support such an effort, but this highlights the budget gap, as you can see, from 2010 up to 2017. The revenue for this program is going to have to come from more tax increases down the road.

We all say we oppose regressive taxes, but what we are considering today is a highly regressive tax. In fact, this tax is among the most regressive type of tax we could consider.

In my State of Kentucky, the impact on low-income taxpayers will be compounded. It will hit low-income Kentuckians, Kentucky tobacco farmers, and every citizen in the Commonwealth of Kentucky. Although there has been a dramatic decrease in the amount of tobacco farmers in my State due to the tobacco buyout, tobacco continues to play an important role in Kentucky's agricultural landscape. Tobacco barns and small plots of tobacco still dot the Kentucky landscape. Cash receipts for tobacco are projected to contribute between $300 million and $350 million to Kentucky's economy this year.

An increase in the excise tax on tobacco will drive down demand for consumption, which will result in less tobacco being purchased from Kentucky tobacco farmers by manufacturers—both cigarette and non-cigarette. It will likely force the specialty growers in my State—Kentucky burley leaf and Kentucky-Wisconsin leaf—completely out of business. These are small family farms in rural Kentucky that rely on these revenues for their crops. The money they get from the tobacco pays for their mortgages, puts their kids through school, and allows them to keep farming.

The CBO has estimated that the SCHIP proposal will result in a 5 to 6 percent reduction in demand for tobacco during its first year in existence. This will likely cause a $5.4 million reduction in payments to rural farmers

in my State under the master settlement agreement we signed a few years ago.

Some people will say there is nothing wrong with all of this because it will force some people to quit smoking and we are using the money to help poor children. But who gets credit for this supposed act of charity? This plan would take money from one group of poor people and give it to another.

I urge my colleagues to oppose the Baucus SCHIP bill and support the Kids First Act.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Madam President, I have two requests. First, I ask unanimous consent that at 5:20 today, the Senate vote in relation to the Allard amendment No. 2536, with the time from 5:15 to 5:20 p.m. equally divided between Senator ALLARD and myself or our designees; that no second degree amendments be in order to the amendment prior to the vote.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BAUCUS. Madam President, I also ask unanimous consent that following the vote on the Allard amendment, Senator DORGAN then be recognized.

Mr. BURR. Madam President, can I ask the Senator to change the unanimous consent request to add myself after Senator DORGAN.

Mr. BAUCUS. Madam President, I so change my request.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Colorado is recognized.

Mr. ALLARD. Madam President, what is the pending amendment?

The PRESIDING OFFICER. The Allard amendment.

Mr. ALLARD. Thank you.

Madam President, I plan on going ahead and, if I understand what we have agreed to, I have 2½ minutes to speak. I plan on spending a minute or minute and a half to talk about my amendment, and then I will yield and wrap it up later. I would appreciate it if the Chair will alert me when I have spoken for about 1½ minutes.

Mr. BAUCUS. Madam President, the normal order is that the sponsor of the amendment speaks first and those opposed second. If we can maintain that, it would be 2½ and 2½.

Mr. ALLARD. That is fine.

Madam President, I rise to encourage my colleagues in the Senate to vote with me on this important amendment. What we see happening now is that there is a discrepancy between the calculation of gross income between the various States. Because of the way the various States are calculating their gross income, some States are getting more benefit under SCHIP than others. The State of Colorado, for example, is not one of those States. There are 12 to 15 States that have made some adjustments in the way they figure gross income, and that entitles them to more Federal dollars as far as SCHIP is concerned.

So what my amendment does, if it is adopted, it will direct the Secretary of Health and Human Services to put in regulations the definition of gross income. This is going to have a 90-day period in order to establish this value, and this will then allow the States an opportunity to come and give their input as to what they think the calculation of gross income should be. Then, when that rule and regulation is enacted, all the States are going to be acting under the same rules so they will all be figuring their gross income in the same way.

I think this is an important amendment. I think when we are talking about equity of benefits to the various States, it is extremely important we make sure they are operating under the same rules. Right now we have some of the States that disregarded the original intent of SCHIP and, as a result of that, they are receiving considerably more benefit as far as SCHIP is concerned than some of the other States.

My hope is my language will be adopted, and then we can move forward with this program. It has been working. We have to create some equity among the States.

I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER (Mr. SALAZAR). The Senator from Montana.

Mr. BAUCUS. Mr. President, how much time is remaining on both sides?

The PRESIDING OFFICER. The Senator from Colorado has 12 seconds; the Senator from Montana has 2 minutes 30 seconds.

Mr. BAUCUS. I don't want to belabor the issue, so I will use all my time.

Mr. President, the hallmark of the CHIP program, the Children's Health Insurance Program, is block grants, not entitlements. That is first. Second, it gives the States flexibility. States design their own program. This is a State Children's Health Insurance Program. Different States are different. Different States have different needs. Different States have different costs of living. Different States are different.

Many States find themselves in a situation where a law might restrict them. If the States did not have flexibility, many people who earn a little too much might find they cannot get health insurance, and so they quit their jobs. The goal is to get people to work. People want to work. The goal is to make sure people have health insurance. People need health insurance. But in many States, people are just above the level here, and if they can't find health insurance, they quit their jobs so they can be in the Children's Health Insurance Program.

I think States should have the right to make some adjustment to keep people working so they get health insurance. Now, if this amendment passes, 30 States will be adversely affected. Children in 30 States will be adversely affected. I don't think we want to do that. States need flexibility. Many Senators in this body have said many times, we shouldn't have one size fits all. We need flexibility.

There are very definite Federal limits on how much States can make an adjustment—that is, not include a certain amount of income—so those people don't have to quit their jobs and can keep their private health insurance.

So I would say I understand the basic theory, but we can't let perfection be the enemy of the good. We cannot. We cannot take away health insurance coverage from kids in 30 States. I do think the goal is for people to work. We want people to work. We should not adopt policies, which this amendment in effect would do, and say: OK, people, sorry, you can't work. You can't work so you can qualify for children's health insurance. I think we want people to work in States so they can get health insurance.

I strongly urge Members to not agree to this amendment. It has surface appeal but only surface appeal. If you dig down and find out what is happening in many States, I think Senators will realize this is not the right thing to do and will oppose the amendment.

Mr. ALLARD. Mr. President, this is a matter of fairness among the States. Any child determined to be ineligible for SCHIP would remain in the State program, but the State would be reimbursed according to the FMAP rate rather than the enhanced EFMAP reimbursement rate.

I think this is an important issue as far as equity among the various States. I ask Members to join me in voting for this particular amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There appears to be a sufficient second.

The question is on agreeing to the amendment.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from Delaware (Mr. BIDEN) and the Senator from South Dakota (Mr. JOHNSON) are necessarily absent.

Mr. LOTT. The following Senators are necessarily absent: the Senator from Kansas (Mr. BROWNBACK) and the Senator from Arizona (Mr. MCCAIN).

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 37, nays 59, as follows:

[Rollcall Vote No. 286 Leg.]

YEAS—37

Alexander	Coburn	Dole
Allard	Cochran	Ensign
Barrasso	Corker	Enzi
Bennett	Cornyn	Graham
Bunning	Craig	Gregg
Burr	Crapo	Hagel
Chambliss	DeMint	Hutchison

Inhofe	McConnell	Thune
Isakson	Murkowski	Vitter
Kyl	Roberts	Voinovich
Lott	Sessions	Warner
Lugar	Shelby	
Martinez	Sununu	

NAYS—59

Akaka	Feingold	Nelson (FL)
Baucus	Feinstein	Nelson (NE)
Bayh	Grassley	Obama
Bingaman	Harkin	Pryor
Bond	Hatch	Reed
Boxer	Inouye	Reid
Brown	Kennedy	Rockefeller
Byrd	Kerry	Salazar
Cantwell	Klobuchar	Sanders
Cardin	Kohl	Schumer
Carper	Landrieu	Smith
Casey	Lautenberg	Snowe
Clinton	Leahy	Specter
Coleman	Levin	Stabenow
Collins	Lieberman	Stevens
Conrad	Lincoln	Tester
Dodd	McCaskill	Webb
Domenici	Menendez	Whitehouse
Dorgan	Mikulski	Wyden
Durbin	Murray	

NOT VOTING—4

Biden	Johnson
Brownback	McCain

The amendment (No. 2536) was rejected.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, what is the regular order?

The PRESIDING OFFICER. Under the previous order, the Senator from North Dakota is to be recognized, followed by the Senator from North Carolina.

The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that following those two Senators receiving recognition, Senator MCCASKILL then be recognized; that following Senator MCCASKILL, Senator GREGG be recognized for an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I yield to the Senator from Ohio for a unanimous consent request.

Mr. BROWN. Mr. President, I ask unanimous consent that amendment 2551 be modified with the changes at the desk, notwithstanding the fact that the amendment is not pending.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Montana.

Mr. BAUCUS. Mr. President, I think the regular order is to recognize the Senator from North Dakota.

The PRESIDING OFFICER. The Senator is correct. The Senator from North Dakota is recognized.

Mr. DORGAN. Mr. President, first of all, let me thank my colleagues, Senator BAUCUS and Senator GRASSLEY, the chairman and ranking member of the Finance Committee, for bringing to the floor the piece of legislation called the Children's Health Insurance Program. It is a very important bill. It will add several million more children to the health insurance rolls and provide important health insurance for kids who otherwise would not have it. I believe all of us in this Chamber would believe that children's health care should not be a function of how much money their parents may have in their pocketbook or their checkbook. A sick child needs health care. This legislation moves in that direction. I am pleased to support it. I thank my colleagues for the work they have done on it.

I do wish to offer an amendment at this point, and I wish to talk a bit about a very important issue that also relates to health care.

My amendment deals with the Indian Health Care Improvement Act. It is true that we will now improve the lives of 3 million children with the underlying bill. I fully support that and compliment my colleagues for doing that. It is also true that there are at least 2 million American Indians in this country living on Indian reservations who are seeing health rationing virtually every day of their lives. It is unbelievable that that condition continues to exist.

We have a trust responsibility for those people. The American Indians are a group of people in our midst with whom we made treaties, we made agreements, and we have the trust responsibility for Indian health care. We have not nearly met those responsibilities.

I would observe that we have a responsibility for the health care of those who are incarcerated in Federal prisons. Guess what. We spend twice as much per person on health care for Federal prisoners as we do in meeting our health care responsibility for American Indians on a per capita basis.

AMENDMENT NO. 2534

(Purpose: To revise and extend the Indian Health Care Improvement Act)

Let me say that I have filed amendment No. 2534. Let me call up that amendment, which is at the desk. I offer this on behalf of myself, Senator JOHNSON, Senator MURKOWSKI, Senator BINGAMAN, and Senator STEVENS.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendment be set aside.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Mr. President, reserving the right to object, I was wondering if I could ask the Senator from North Dakota how long he expects to debate this amendment.

Mr. DORGAN. I intend to speak about 25 minutes.

Mr. GREGG. I thank the Senator.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from North Dakota [Mr. DORGAN], for himself, Mr. JOHNSON, Ms. MURKOWSKI, Mr. BINGAMAN, and Mr. STEVENS, proposes an amendment numbered 2534.

Mr. DORGAN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. DORGAN. Mr. President, let me describe now, if I might, the issue of health care for American Indians, which I believe is an urgent national need. We have a trust responsibility for their health care. We have a piece of legislation that exists in law called the Indian Health Care Improvement Act, but it needs to be reauthorized. It has not been reauthorized for 15 years. It expired 7 years ago. We need to do this. Year after year after year, this Congress postpones it. We have passed legislation out of the committee; it does not get to the floor; it does not get done.

Let me show my colleagues a picture of a young 14-year-old girl. This precious child—her name is Avis Littlewind. Her relatives gave me permission to use her picture. Avis is dead. Avis committed suicide. I want to tell you the story about Avis because I went to talk to the school officials, the tribal officials, the mental health officials, and those who were in the extended family.

This 14-year-old girl took her own life. It probably should not have been a surprise to anyone because for 90 days this little girl lay in bed in a fetal position, missed school. Something was very wrong. This little girl had a sister who, 2 years previous, had committed suicide. This little girl had a father who took his own life. This little girl had another parent who was a very serious drug abuser. She laid in bed 90 days before she took her life.

Now, one might ask the question: Why does this 14-year-old girl just fall through the cracks? She thinks she is in a situation that is hopeless. She feels helpless and she takes her own life. But this little girl had a full life in front of her.

You know something? On that Indian reservation where Avis Littlewind lived, there were no mental health treatment facilities for someone to take this young lady, this young girl. One might ask and certainly should ask: Why is it in this country that mental health treatment is not available to a young child like this? Why is it that the person responsible for trying to give this young lady some help did not even have a car or any transportation? Even if you could find a mental health professional to treat this person, there is no transportation to get the person to treatment. Why is it that for 90 days this young lady lay in bed, and nobody from the school, nobody from the area, said: All right, there must be a big problem here; let's find out what is going on.

The fact is, this is one precious child who took her life. We have had clusters of teen suicides on Indian reservations. This is but one aspect of the Indian Health Care Improvement Act, but it is not just mental health. The bill covers virtually every aspect of Indian health.

We are told that about 60 percent of Indian health care needs are met. That means 40 percent of the health care needs are unmet. There is full-scale health care rationing on Indian reservations. If we were to debate that on

the floor of the Senate, people would be appalled. You can't ration health care. Yet, that is what is happening.

We have a trust responsibility, and yet health care is being rationed with respect to Native Americans. American Indians die at higher rates with respect to tuberculosis, 6 times the national average; alcoholism, 5 times the national average; diabetes, 180 percent higher than the national average. In Alaska, Native communities in Alaska have fewer than 90 doctors for every 100,000 Alaska Natives. That compares to 229 doctors for every 100,000 Americans. Heart disease, diabetes, blood pressure, stroke—you name it. The incidence of most diseases affecting our Native Americans are at much higher rates than for non-Indians. Cervical cancer for American Indians and Alaska Natives is nearly four times higher than cervical cancer for other women in this country.

I mentioned before that Federal prisoners, for whom we have a responsibility for health care, receive twice as much funding per person on their health care needs than do American Indians for whom we have a trust responsibility. Stated another way, we spend twice as much per person on Federal prisoners than we do with respect to American Indians, and we have a trust responsibility in law to deal with American Indian health issues.

I want to show a photograph to describe health care rationing. This is a photograph of Ardel Hill Baker. She has also allowed me to use her photograph. Ardel Hill Baker was having a heart attack. As she was having a heart attack, she was taken from the Indian reservation by ambulance to a hospital. When they offloaded her from the ambulance onto a gurney to take her in the hospital, this woman, at the emergency room entrance, having a heart attack, had a piece of paper taped to her thigh. The hospital dutifully looked at that piece of paper. The piece of paper that was taped to her thigh said that the Indian Health Service contract health care is not an entitlement program, meaning there are no funds to pay for this service because it is not a life-or-limb medical condition.

Let me say that again. Someone is having a heart attack. When they are brought to the hospital, they have a big piece of paper taped to their leg. It says to the hospital: By the way, if you admit this person, you are on your own because our contract health care money is gone. In fact, this is the piece of paper which was taped to the leg of an Indian patient coming into a hospital, having a heart attack. What would anybody in this Chamber think if this were taped to the leg of their spouse or their son or their daughter? They are having a heart attack, but the hospital is told: You know what, we do not have any money for this person; if you admit this person, you are on your own. Contract health care. It is called health care rationing.

Tribal chairmen tell me that the refrain on their reservation is: Don't get sick after June because if you get sick after June, there is no money in contract health care. By the way, you can get a little help still, but it has to be life or limb. You must be threatened with the loss of a limb or the loss of your life; if not, tough luck.

We would be outraged, outraged, every single one of us, if this were our relative. But it was not. It was Ardel Hill Baker. She survived, but there are plenty who do not.

This is Lida Bearstail. Lida Bearstail had a serious problem with her leg. The bones in her knee were rubbing against each other; cartilage was worn away. She was in great pain, in great discomfort.

The normal treatment for perhaps someone in this Chamber or perhaps for a relative of someone in this Chamber would be to get a knee replacement, but in Lida Bearstail's case, Lida Bearstail was not given the option of getting a knee replacement.

Despite the great pain, it was not determined to be priority one, life or limb. She wasn't going to lose her limb or her life. She could just live with the pain. So because it wasn't priority one, life or limb, this woman whose bones were rubbing together in the knee in unbelievable pain was told: There is no health care available for you.

We have hearings to talk about all these issues. A doctor comes to our hearing and says: I had a patient come to me with a very serious problem with a knee. It was a ligament problem, very serious, very painful. That patient went to the Indian Health Service and they said: Wrap that knee in cabbage leaves for 4 days and you will be OK.

It is pretty unbelievable. Yet we can't get a bill on the floor of the Senate to deal with Indian health care. That is unbelievable. We have a responsibility to pass this legislation. I passed it out of the Indian Affairs Committee. Now we need to move it through the Senate and then the House so we can say to these people who need health care—the first Americans, Native Americans that this country understands its obligation, understands its trust responsibility, and we are going to do what we need to do to pass the legislation.

It is almost unbelievable that with all the priorities we discuss, we can't somehow make this a priority. In my State, we have some wonderful Indian tribes. The Three Affiliated Tribes is a wonderful tribe. It includes the Mandan, the Hidatsa, and the Arikara Nations. If you get sick on that reservation in Twin Buttes, ND, your nearest health facility is a little old building with a couple of tiny examination rooms. If you are lucky enough to get sick on one of the right days when a nurse is there and one of the few days when a doctor might be there, you might do OK. But this is a 1-million acre reservation. It is a big place. We had testimony from law enforcement the other day on that reservation. The first you would expect to be able to get someone to come to deal with a law enforcement call, no matter how serious, would be about an hour and a quarter to an hour and a half. So call while a crime is being committed and, perhaps an hour and a quarter later, if you are lucky, someone from law enforcement will show up. You might understand then that if you need a prescription or if you have a health care emergency, the dilemma Indians face on reservations.

A mother who has a feverish child who needs an antibiotic, or a diabetic who needs insulin—who don't have ready access to health care facilities, in circumstances such as that, we must find ways to meet these health care needs.

There are some who say—and I agree—we need substantial change. My colleague from Oklahoma is here. He talked about the prospect of saying: All right, let's have dramatic change. I am perfectly willing to work on dramatic change, to say that if we have a trust responsibility for someone for health care, let's let them show up at a hospital someplace and let's pay the bill so they can go to the providers who have the capability. We have the responsibility to do that. The problem is, we can't get a bill such as that through this Senate. I have offered time and again on the floor to add funding. The last time I tried to add $1 billion. It went down on a partisan vote. You can't get money added in this Senate to meet the responsibility we ought to meet with respect to Indian health care.

We have worked in a bipartisan way on this legislation in the Indian Affairs Committee. The vice chairman of the committee, Senator MURKOWSKI of Alaska, is a cosponsor as well. The Indian Health Care Improvement Act is legislation that begins to answer and advance the interests of providing health care to American Indians and meeting our trust responsibility to do so. We would authorize additional tools to deal with the issue of teen suicide on Indian reservations.

I began by talking about Avis Littlewind, but I could have talked about many others. I have had several hearings on this subject. The bill also includes new provisions to address lack of health care services. We have begun trying to find a different construct of convenient care for American Indians on reservations. It includes several Medicaid provisions that are in the jurisdiction of the Finance Committee. The Finance Committee is going to be holding a markup. We will talk with the chairman and ranking member about including this bill in that markup.

My point today is very simple. I understand the need to provide additional health care opportunities for 3 million American children is very important. It is no more important than providing the health care we promised we would provide to 2 million American Indians who live on reservations for whom we

have trust responsibilities. We have broken far too many promises to American Indians. We have done it for far too many decades. It is time for this Congress and the country to keep its word and meet its promise. We don't have a choice, and it is not going to break the bank to do that.

I encourage all my colleagues, go to the Indian reservations. See for yourself. See a dentist practicing in an old trailer house for 5,000 patients, operating out of an old trailer. Go see that. Then ask yourself: Is this the kind of health care we promised? Are we delivering what we promised? The answer is a resounding no.

I understand in this Chamber there are priorities. With respect to the priorities all of us have, we all have different things we are passionate about. We have now on the floor a health care bill. This legislation is important. The reason I offer this amendment is, when we talk about health care, I think we have a responsibility to address Indian health as well. If we can, we need to, either tonight or tomorrow, get a commitment on dates to mark up and bring to the floor of the Senate the Indian Health Care Improvement Act, which is 7 years overdue and 15 years since it was last reauthorized. If we can get that commitment, I will know we are going to get this through the Senate. That is the goal.

I am going to visit with Senator BAUCUS. Let me also make the point, Senator BAUCUS has been a very strong supporter of Indian issues. I have been happy to work with him. The Indian Health Care Improvement Act was sent to the Indian Affairs Committee. We have moved this out of committee. I think we have written it in a way that substantially improves Indian health care. Now it waits, as it waited last year, the year before and the year before that and the year before that. Every single year it is the same thing. I am flat out tired of it. I will not let it happen this time. One way or another, this needs to get done by this Senate because this Senate has a responsibility to do it. We have not met this responsibility for too many years. This year I insist we do so. The fact is, kids are dying. Elders are dying because the health care doesn't exist that we had previously promised. We have a responsibility to do something about it.

I say to the chairman of the committee, I will visit with Senator REID, and I know Senator BAUCUS is a strong supporter of Indian issues. I hope if I can get a commitment that we can get from the Finance Committee a markup—and I know the Senator wants to do that—if I can then get a commitment from Senator REID to bring this to the floor, I don't intend to interrupt the children's health insurance bill, but if I can't get that commitment, I fully intend to interrupt this bill as long as I can interrupt it because it is that important.

To my colleague from Montana, let me say thank you for allowing me to at least at this moment offer this amendment, and let me ask my colleague if I can get some hope that the two of us, working with others, can move together to get this through the Senate in a reasonable time. I am going to ask the same of the majority leader, who I know also is very supportive of Indian issues and very much wants to get this done.

The PRESIDING OFFICER (Mr. MENENDEZ). The Senator from Montana.

Mr. BAUCUS. Mr. President, I commend the Senator from North Dakota. If our colleagues could see the conditions of health care on the reservations of this country, they would be appalled, absolutely appalled. It is as bad as a Third World country. It is disgusting the low quality of health care on the reservations. The Senator from North Dakota earlier mentioned the life-and-limb provision. Basically, the Indian Health Service does not take people unless it is for life and limb, unless you have lost a limb or your life is in jeopardy, nothing less. That is not entirely true because it depends upon the allocation of the various Indian Health Service hospitals around the country. But very quickly, those hospitals get to the point where they are at the life-and-limb threshold. They have used up what few paltry dollars they have. So on the Blackfeet Reservation of Montana, someone is ill, a child is ill. If they have reached that reservation and reached the life-and-limb limit—which happens, I am told, midway through the year—that is it. They don't get any health care. It is an absolute outrage.

We all know the health conditions on Indian reservations are much worse. Statistics show it is much worse than the national average. About 27 percent of Indian kids don't have any health insurance whatsoever. I might also say the tuberculosis rate on the Indian reservations is about 7½ times that of the general population. The same is true of the suicide rate and so on. I say to my good friend from North Dakota, absolutely, I am committed. We passed this bill out of committee. It passed last year. It passed by unanimous vote in committee. I am very committed to having a markup. Indeed, I think we scheduled September 12 to get this out of committee so we can find a way to get this bill enacted this year. I share the conviction. We have to find a way to get this done this year. It is an outrage, a total outrage in the United States of America to let these conditions continue. Frankly, this legislation is only the beginning to bring the level totally all the way up to what it should be.

I thank the Senator for offering this amendment tonight. I am committed to find a way to get this enacted into law this year.

Mr. DORGAN. Mr. President, let me say thank you. If we can get a markup in the Senate Finance Committee on September 12, that allows the bill to move to the floor of the Senate. I am going to talk to Senator REID, who I know is a strong supporter of Indian issues and feels very strongly about this. If I can get a commitment, I know he wants to provide that commitment to get to the floor of the Senate, then I will seek to withdraw the amendment from this bill. But I do want to visit, and perhaps in the morning on the floor, with Senator REID on that subject.

I wished to make two more points, and then I know my colleague from North Carolina seeks recognition.

This chart shows the expenditures per capita relative to other Federal health expenditure benchmarks. This deals with Indians versus all others—Indians get far less. Here is the expenditure per capita for Medicare, the Veterans' Administration, Medicaid, Federal prisoners, the Federal Employees Health benefits. Here is Indian Health Service. It is unbelievable to me how much less it is. In many ways, all of this is intertwined—social services, health care, law enforcement, housing, education, it is all intertwined. What got me interested and involved in Indian issues—and I am privileged to serve as chairman of the Indian Affairs Committee and feel a deep responsibility to force us to do the right thing—what got me involved one day was a young girl named Tamara.

Tamara was a young 3-year-old American Indian girl who was put in a foster home. But the person who was handling the social services cases was handling 150 cases, so they did not bother to check the home this little girl was going to be put into. It was not long before, at a drunken party, that little girl had her nose broken, her arm broken, and her hair pulled out at the roots. It will scar that little girl for life. I met her. I met her granddad. I talked to the social worker. I fixed that social worker problem by getting additional workers in, so that it does not happen again.

The fact is that should never happen. These incidences should not happen. We do not have the resources to do what is necessary, to do what needs to be done. Nowhere is that more true than in health care. Health care is not a luxury. When there is a sick kid someplace, or a sick elder, when somebody has a health problem, we have a responsibility to find a way to help.

For those who might listen to this and say that Indian health care is not our responsibility, oh, yes, it is. We signed treaties. We made promises, and we broke them every chance we got. Maybe in the year 2007 we can begin keeping a promise or two. These are promises we have a responsibility to keep. It is our trust responsibility.

There is a lot to do in health care, but there is nothing more important than meeting our obligation to provide health care for Native Americans because we made that agreement with them, and we need to keep that agreement.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I rise to speak on the SCHIP bill. I have an amendment to the SCHIP bill, but I do not intend to call it up at this time. I wish to speak on SCHIP, as well as on my amendment.

I also take this opportunity to ask unanimous consent to add Senator DOLE as a cosponsor to the amendment.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BURR. Mr. President, I think it is safe to say that health care is probably one of the most important things this body can debate. I think you have to look at our overall health care system today to understand why it is so important. It is because we have the best health care delivery system in the world, bar none.

We have seen other countries try to develop a system that fit within a budget framework that, over time, as the dollars got tight, constricted the level of care delivered, creating waiting lines for individuals who had certain health conditions. But the United States has always been considered the innovative health care delivery system of the world. It was accessible for most, regardless of region. I think it is safe to say for a long period of time it was very affordable. But that has all changed.

The U.S. system still provides a level of security if, in fact, you are insured. If you are not insured, I am not sure the sense of security—just knowing there is a hospital or doctors—necessarily provides you with a tremendous amount of security.

With every day that continues on, the level of choice that exists within the United States health care system begins to get less and less. Most of us have been here for the debates of the creation of HMOs and PPOs, and all the products that employers, insurers, and individuals desperately try to create to address this rising cost of health care, while maintaining some degree of benefit for the individual and for their family. But over time, we have continued to see changes to those products, to where there is very little difference between the products now except for what we call them. Clearly, that has eliminated many of the choices.

What has happened to the U.S. system, over a very slow period of time, maybe the last two decades? Over 50 percent of the American people are now on a Government health care plan. It is no longer private-sector driven. We are here with this big question mark about why market conditions do not affect the cost of health care or the cost of premiums or that they do not create choice. In fact, over half of the American people are now in a Government-run system, one that mirrors more what others in the country have tried, only to find out that unless you have an unlimited pool of money, they do not work.

Well, what do Government systems eventually create? They create a system that has less doctors, less nurses, less hospitals, which means less care for those in the country.

I know the ranking member represents a State that is considered to be rural. North Carolina is a State considered to be rural. If you have a contraction of doctors, if you have a contraction of specialists, if you have less nurses in the pool, it means there is not enough to go around all the facilities. There are many regional areas of my State today where we cannot find OB/GYNs to deliver babies.

Now, sure, I can look at a pregnant woman and say: Within a 30 or 45-mile radius, you will be able to get delivery care. But try to explain to a mother, when her water breaks and she goes into labor, that the person who is going to deliver that baby is 45 miles away. In fact, the prenatal care, for that individual who needs it, is now 45 miles away because that is where her OB/GYN is, and we are not going to be able to get the level of prenatal care in rural America that we want.

What has the Government controlling more of health care produced? Less choices, fewer providers, and less services, and especially for those limited amounts of services that are preventive.

Let me state from the beginning of this debate, I am for reauthorizing the SCHIP bill. I will support the substitute that Senator MCCONNELL will offer which provides $38.9 billion over 5 years, which is an increase of $13.9 billion.

I also was in the House, on the Energy and Commerce Committee, in 1997, when we enacted the first SCHIP bill, which was a $40 billion Federal commitment over 10 years to those children at 200 percent of poverty or less. Many States expanded that SCHIP program to cover parents of SCHIP kids and childless adults.

The McConnell reauthorization protects the original SCHIP program by making sure that low-income children are the focus of our effort.

Now, I will say, North Carolina has one of the best SCHIP programs in the United States. I am pleased that Senator MCCONNELL's reauthorization will give North Carolina the additional funds it needs to continue serving low-income children. But I am, sadly, here today to tell you I am not for expanding the rolls of SCHIP. The Finance Committee bill adds more than $30 billion to the current SCHIP base budget—$25 billion—to, roughly, cover 3.3 million additional children.

Now, CBO scored what the State and Federal Government spending will be per child. Let me put that up for everybody: $3,930 per child. Yet, today, the average private health care plan in the private sector is $1,130. My question is, if we are going to spend $3,900 per child in a Government plan, but we can insure them fully in the private sector today for $1,130, where is the choice? As a colleague of ours in the House used to say: Beam me up, Scotty. Something is wrong here. This seems like a no-brainer. This is not an investment that one can make on the part of American taxpayers and feel good about.

In 1997, we spent $40 billion. It was an honorable goal. Quite frankly, the program has been very popular. The Baucus reauthorization plan, though, would spend $60 billion over the next 5 years.

Now, people will talk about budget gimmicks. I am not here to talk about that. I think they are here. I think it hides millions of dollars that I think are extra spending—and maybe they are going to insure this 3.3 million, and $3,900 per child is incorrect, or maybe there are more people who are going to be covered, and many of them outside of the ranks of low-income children—but there is no question the Baucus-Grassley bill expands SCHIP so much that I feel children who need it the most will get lost in a new, larger Government-run program.

As a matter of fact, if SCHIP works as well as I think it does, why would we change it? I think some would tell us we are not here changing the SCHIP program. But I would only point to section 606 of the Grassley-Baucus bill, where they remove the word ''State'' from the name of SCHIP. See, SCHIP is the State Children's Health Insurance Program. It was always designed as us being an enhanced share for the States, and the States running the program. Now, SCHIP is going to be called the Children's Health Insurance Program. It sounds like a big, one-size-fits-all Government program to me.

The solution to our health care crisis is not to put every child in America in a Government program. Today, one out of every two children in America is in a Government program. They are either enrolled in Medicaid or SCHIP.

The Baucus plan puts more children into Government health care. A recent CBO analysis concluded that for every 1 million additional children covered under SCHIP, an estimated 250,000 to 500,000 will be switched from private insurance to the new public SCHIP coverage.

Now, let me say that again. CBO estimates—this is not me—CBO estimates that for every 1 million new kids we put into SCHIP, somewhere between 250,000 to 500,000 will switch from their parents' insurance to the new Government plan.

Now, that is 3.3 million kids, which means 1.65 million could be switched from private insurance to Government insurance, at 3,900 and some dollars, estimated by CBO. Again, where is the sanity and the obligation and fiduciary responsibility we have to the taxpayers? Why in the world would we create an avenue for people to go off their family's plan and come on a Government plan, where we are committed, as CBO said, to spend $3,900, roughly, per child?

Now, before people think we are all insane—they know I am now—what

should we be discussing? I believe we should be discussing how do we reform the health care system? I do not think I would find much opposition except on how we do that because there are 45 million uninsured Americans today. If they are sitting at home listening to this debate about covering 3 million low-income children, or wherever they are on the income scale, for a person sitting at home, who is an adult today, they are saying: What about me? What about the fact that I do not have insurance?

If they have no job, and they have no income, we know they are on Medicaid. If they have a job, and they do not qualify financially for Medicaid, then where do they go? Well, there are 45 million of them out there somewhere who are in this classification. Some of them are kids and some of them are adults. Every time they access health care, and they cannot pay for it, an incredibly predictable thing happens: The cost that is unrecovered is shifted to everybody else in the system.

In North Carolina, there are 1.3 million who are uninsured. Seventeen percent of the North Carolina population is uninsured, and 16 percent of the American population is uninsured. Yet our debate is limited to 3.3 million children.

It is not about how we insure America. It is not about the rising cost of health care. It is not about the fact that health care premiums have, in fact, doubled in the country since the year 2000. If compared with the growth of inflation since 2000—at 18 percent—and the growth of wages—at 20 percent—health insurance premiums for family coverage have increased 73 percent over the last 5 years. Health care costs are rising three times the rate of inflation, and with no corresponding rise in quality.

Now, there is the red flag. We have seen a 73-percent increase in the premium. If you could turn to something tangible in the system to say that quality has gotten that much better, then one could maybe rationalize this increase. But the fact is, there has been no corresponding rise in quality. As a matter of fact, today there are no health care plans that are focused primarily on wellness and prevention.

I remember when we tried to get mammographies and PSAs covered in Medicare, and we tried to get an array of preventive health care, it was the hardest thing I have ever worked on in health care to try to get added to a system. I guess it is because Medicare beneficiaries are old to start with, and why would we do anything preventive. Yet if we look at the research that goes on every day, and that we pay for, we find the earlier we can detect cancer, the earlier we can detect diabetes, the more we can monitor disease management, the better the outcome is but, more importantly, from a taxpayer's standpoint, the less it costs the system.

We know that happens in the Government system. We don't implement wellness and prevention like we should. If we did, we would require it in Medicaid. But we have an opportunity—as we talk about redesigning the American health care system, we have an opportunity to build wellness and prevention as the main piece of this broken system.

Today we have a system that only triggers when you get sick. It doesn't trigger when you want to stay well. It triggers when you get sick. But if you look at companies that have said: There is no way I will ever be competitive if, in fact, the health care system doesn't change in America—they made a decision that they are going to go outside of the insurance products that are available today, and they are going to do things that are creative out of the box. And they are self-insured and they have gone out and partnered with somebody to administer their plan. What do you find? It is Dell Computers, which now has about 4 years of experience with disease management and how to bring down the overall costs of health care for their employees—not just corporately but for their individual costs to their employees—all the way to Safeway, that has a model that I know every Member on the Hill has probably been briefed on—what Safeway is doing, which is giving people control of their care but, more importantly, stressing to them that prevention and wellness is something for which they will actually receive an incentive.

People without access to employer-sponsored coverage are severely disadvantaged under the current system. I know both of the Senators who are in charge of the tax committee probably would agree that we have inequities. Ninety-one percent of workers in large firms have health insurance. Sixty-six percent of workers in small firms—10 employees or less—have health insurance. Twenty-nine percent of the uninsured work in small business. The percentage of employers offering coverage has dropped 8 percent since the year 2000.

Whoa. Global economy. That is what has happened since 2000. There is a global economy where it doesn't matter where you manufacture. All that matters is where are your customers. Most U.S. businesses have changed from a model that was predominantly for domestic consumption to a model today where 60 or 70 percent of their business is international, and 30 or 40 percent of it is domestic—in the United States. We ought to look at some of the decisions they have made and wonder: why didn't we have this challenge before this point with those employers, looking at their business model and saying: How can I continue to pay a health care cost that rises in double-digit ways each year with inflation and remain competitive with my global competition which doesn't have that cost?

Well, I am going to put the Senate on notice: This is happening at an alarming rate. If U.S. businesses determine that they are not competitive in the marketplace they are selling to, which is global, and health care cost is the No. 1 issue that makes them non-competitive, in the absence of us reforming the system and creating a way for them to provide health care—not that seeks double-digit inflation every year but begins a downward pressure on the cost of health care—I will assure you they have two choices: they eliminate the benefit or they leave the country, and both of them are devastating to the United States.

If we don't reform health care, what happens? Health care becomes unaffordable for people. U.S. businesses become uncompetitive. Government will have its normal reaction. It will ratchet down the reimbursements that we pay through Medicare and Medicaid and the effect of that is that private insurance sees that as an opportunity to ratchet down the provider reimbursements. Doctors and nurses get paid less. More people go on Government health care. Doctors and nurses will become Government employees. Hospitals will become Government property. Insurance companies will become paper pushers. We must all agree that the outcome has to be better for us.

By the way, taxes will rise too. I am not sure whether it is individual or corporate, but let me assure my colleagues, though some believe that health care is free, somebody pays for it. Look at the systems around the world where the government is in control of their health care, and the beneficiaries may think it is free, but one of the problems—one of the reasons they are ratcheting back the scope of coverage they have is the fact that as the government runs out of money and can't find ways to raise revenues, they have a choice. They can tax individuals, they can tax corporations, or they can reduce benefits. When you look at the prevailing tax rate they have now, you understand why their only choice is to cut benefits. The likelihood is that we will be faced with the same thing as socialized medicine is just around the corner, and I think time is actually running out.

The current tax structure for health care benefits exists for employer-focused plans. Employers get a tax deduction for the amount of the health care benefit provided for their employees, but the deduction unfortunately doesn't exist for individuals who shop in the marketplace. We spend 50 percent more of our GDP—16 percent—on health care than the next three spenders—Germany, Japan, and France—but we aren't any healthier. It is time we begin to focus on how our system becomes more efficient, healthier, and more affordable.

One out of every four dollars in health care spent in this country does nothing to help patients. It is actually wasted on defensive medicine, unnecessary paperwork, and outright fraud. When you put individuals in charge of

their health care—not just constructing it or negotiating it, but responsible for whether the system is efficient and effective—you would be amazed at how you wring out that 25 percent, that one out of four. The source of the problem is runaway health care costs which is caused by a lack of choice and a lack of government control.

Now, let me assure you that in Sweden today, heart patients wait 25 weeks to be seen. In England today, Heritage said cancer patients sometimes wait a year between their diagnosis and their chemotherapy treatment. Canada's Supreme Court Justice, Beverly McLachlin, said it best in a 2005 ruling:

> Access to a waiting list is not access to health care.

We have a roadmap as to where we are going, and we have an opportunity to change that today.

What happens if the Senate, if the Congress of the United States, becomes the visionary body that it needs to be and the reform body that it has to be if, in fact, you want to protect the delivery system in this country? Americans have to have three things: They have to have choice, they have to have ownership, and they have to have control. They have to have the ability to construct their insurance policies to meet their age, their income, and their health condition. Health care needs to be portable, just like a 401(k).

When you give an individual ownership of a 401(k), they are no longer strapped to an employer about their pension or retirement; they have the ability to take that money with them to the next job. Well, we have reached the point now that health care should be the same thing. It should be ownership, and we should have the ability to take that health care from employer to employer where we are not locked in, and for the first time Americans would have the freedom to make decisions about their future and about the future of their families.

Innovation works. We all know it. A year ago, a 46-inch plasma TV cost as much as $11,000, but today you can buy the same TV for $2,839. In 1908, Henry Ford made a car for $850. Eight years later, Henry Ford produced the same car for $360.

Innovation also works in health care—don't fool yourself. Between 1999 and 2004, the cost of LASIK surgery, which is set by the market forces and outside the current system, went down 20 percent while health care expenditures per person increased by more than 44 percent. LASIK surgery is this new surgery that individuals have on their eyes. If they have a certain condition, they can have LASIK and throw their glasses away. A controversial thing, and innovation brought it. It went through and FDA approved it. The cost was very high to begin with, and as more people have sought LASIK surgery, the price has come down and down and down and down and down. I am sure Dr. Coburn will talk more about it as we go through this debate.

Duke University set up a program to manage congestive heart failure. Half of all of the congestive heart failure patients typically have a 5-year life expectancy, and costs are a total of $22.5 billion for congestive heart failure annually in the United States. Duke developed a program that integrated the care to develop best practice models for congestive heart failure patients. The approach resulted in better patient outcomes, increased patient compliance with their doctor's recommendations and, most importantly, a 32-percent drop in the cost per patient of treating congestive heart failure. Innovation allows incredible things to happen but only when we have a marketplace that rewards innovation.

I said when I stood up I had an amendment that I didn't intend to call up, and I am not going to call it up. That amendment is the Every American Insured Health Act. I want to just briefly talk about it.

Hopefully, this accomplishes everything I have spent the last 20 minutes talking about. It provides the resources for every American not on a government plan to access the coverage they need. Let me say that again. It provides the resources for all the uninsured in America to negotiate the coverage they need in the private marketplace.

No. 2, it eliminates cost shifting. It eliminates that bill we get through our premium costs or through the cost of a service delivered that we can't figure out who used it, but somebody didn't pay because they weren't insured and it got shifted to everybody else. We eliminate that by providing the resources for every American to negotiate coverage. We estimate that it may be $200 billion a year that we eliminate in cost shifting.

Now, how do we accomplish it? Because one might say: I know how expensive SCHIP expansion for 3.3 million children is going to be. Can we afford what it is going to cost us to insure everybody who is uninsured in America? Well, here is what we do. We address the tax inequity. Through that we treat those who get insurance provided by an employer the same way we do individuals. Then we turn around to every American who is not on a government plan and we do this: We give them a refundable, advanced, flat tax credit. For an individual, it is $2,160 a year. If it is a family, it is $5,400 a year.

Now, if, in fact, you had tax consequences from this new equality in treating individuals and employer plans the same, the likelihood is that if your health benefit from your employer doesn't exceed $15,000 from the employer on a family plan, then $5,400 is more than enough to cover the tax consequences.

If, in fact, you are an individual who is uninsured and you get a refundable tax credit on an annual basis of $2,160, then you can go out and negotiate in the private sector for health care coverage that on average today is between $1,500 and $1,700 nationally for an individual plan and about $4,500 to $4,600 for a family plan. You could insure yourself as an individual or as a family, and you could do that all within the confines of the refundable tax credit we have allowed.

Now, people have questioned whether there is a little bit of a shift in wealth. Yes, there is. We are taking people who have rich health care plans, more health care than they need, plans that are priced because there are no out-of-pocket costs—there are a lot of things that we know we need to do from the standpoint of making sure Americans know they have skin in the game every time they go to the doctor's office for the facts of utilization—and we are shifting it down to where we give people refundable tax credits that are barely over the Medicaid qualifications, and we are going to give them a soup-to-nuts plan—$2,160 for an individual or $5,400 for a family annually, a refundable tax credit that is only good for health care.

When they sign up with an insurer, the money will go directly from the U.S. Government to the insurer. If money is left over, it would automatically transfer over into a health savings account for that individual to use for other health care benefits, whether it be for copayments, deductibles, whatever the structure of the plan is, and they are allowed to design a plan that meets their age, their income, and their health conditions.

We give States incentives to make sure that in every marketplace there is an affordable plan. It is absolutely crucial that you begin to have insurance reform at the same time you are creating a marketplace that is driven by individuals.

Our goals are to give Americans the resources and the right to purchase health care in the private marketplace, to end the tax discrimination, to encourage individuals to take control, to eliminate the current cost shift, so that every American's health care begins to come down because of this new benefit, and to ensure the accessibility and affordability of high-quality health care.

By the way, this plan I have just described that did this for the first time—insured everybody who is uninsured, provided annually a $2,160 refundable tax credit for individuals and $5,400 for a family—I still didn't tell you how much it costs. I am like the guy on the infomercials who waits until the end to spring on you how great of a bargain it is.

Well, this is budget neutral. It doesn't cost the American taxpayer one new dollar. That doesn't take into account that there may be $200 billion worth of cost-shifting going on in the system. We get no scoring for the fact that we could potentially drive $200 billion of costs out of the health care for everyone else in the system by making sure everybody is insured. We get absolutely no credit for being able to put

together plans that promote prevention and wellness, that begin to drive down utilization and make Americans healthier, that begin to create data for us so we know exactly what the right reimbursements are for doctors, nurses, hospitals, and community health centers. We pull that out of the sky today, and they complain. And they should because there is no relation to that in reality.

This, by creating a real marketplace, real competition from the insurer all the way through to the service delivered will begin to build the database of information we need to know what reimbursements the marketplace says are fair to the people who provide it. Then they can make a decision. I believe we will find that every doctor, nurse, hospital, and community health center will receive this in a warm way because now they believe that this is a system which will evaluate what they deliver and what cost they are reimbursed for.

Mr. President, I am sure the chairman of the committee and the ranking member would have preferred to have this solely focused on SCHIP tonight. I know that. I think it is also rational to understand that when you are talking about expanding the rolls of Government insurance coverage to 3.3 million kids, somebody ought to stand up and ask: What about the other 45 million Americans? If, in fact, Members find there is value to the reform for the entire system, then why would we put the 3.3 million kids in a program that CBO already told us would cost $3,930 per child, which we can buy in the private marketplace for $1,130 worth of coverage today? Why don't we integrate them into the last system, which is reform our health care system.

Let's bring equity to the tax side and provide every American who is uninsured with the resources they need to go out and negotiate their coverage, whether they are individuals or families. Let's give the health care delivery system the confidence of knowing we are willing to create a market. This is not an unusual thing for us. We did it with Part D Medicare. The chairman of the committee was very instrumental in its passage. Today, 1 year after enactment of Part D Medicare, we created transparency and competition on what was one of the most price-sensitive areas: prescription drugs. What has the net result been? Premiums reduced 28 percent the first year, and drugs were reduced 33 percent. It was because we created competition and transparency. We made people show their prices and made sure there were multiple plans that people could choose from. The net result of that is exactly what we are trying to mirror here, but do it in a way that treats health care in its entirety. You cannot do that without prevention and wellness being the main pieces of it.

I thank the chairman for the fact that he listened. I appreciate that. I plan to be on the floor probably several times this week. I will try to do it when it doesn't interrupt the SCHIP debate. I think it is an important time to begin to educate our Members, to begin to educate America about the need for health care reform and how health care reform can actually enhance the future of the very special delivery system we have in this country.

I yield the floor.

Mr. BAUCUS. Mr. President, many Senators are waiting very patiently this evening. I see the Senator from Missouri, who has been extremely patient. We have done our best to protect Senators' places in line. Many Senators want to come to the floor and speak on this bill.

I ask unanimous consent that the following Senators be recognized in this order after Senator MCCASKILL and Senator GREGG: Senators WHITEHOUSE, COBURN, BROWN, CORKER, DURBIN, MARTINEZ, KLOBUCHAR, DOLE, and TESTER.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Missouri is recognized.

Mrs. MCCASKILL. Mr. President, I don't know that anybody could argue that the Children's Health Insurance Program hasn't been a success. Of course it has been a success. Frankly, successes have not come easily in the area of health care availability in this country over the last decade. So we have to protect it, we have to make sure it continues, and we need to make sure we expand it to as many children as possible.

I think this strong piece of bipartisanship we are debating today, in fact, does those things. The interesting thing is, I think back to a debate in this Chamber that occurred in November of 2003. In November of 2003, there was a piece of legislation concerning prescription drugs. Now, children's health insurance and prescription drugs are both noble and good causes to the Senate—to try to lower the cost of prescription drugs, to try to provide more insurance for children. What are the differences between the two debates? It is really interesting to look, because that is when that ugly head of politics begins to rear and people begin to see that sometimes, unfortunately, in this building it is about politics instead of public policy. Both goals of public policy, prescription drugs with lower costs and children's health insurance—everybody has to be for those goals. But how you get there and what complaints you have on the way is where politics come in.

Medicare Part D was a $400 billion program. Interestingly enough, it was passed in November of 2003 as we were approaching a Presidential election and a cycle of election. Interestingly enough, the President was running for reelection. Not a whisper of a veto threat was heard even though it was $400 billion that had no way to be paid for. There was no cigarette tax in Medicare Part D. It was guaranteeing a profit to the pharmaceutical industry. In fact, it went so far as to make sure you could not negotiate for lower prices—a bold thing, for a country where the free market is supposed to be something we relish. Negotiating for lower prices? That is pretty all-American. But, oh, no, we made sure there was no negotiation for lower prices on the part of the Government in Medicare Part D. There was no mechanism to pay for it.

Yet I hear Senators today speaking against this bill with righteous indignation, saying: Well, the tobacco tax in here is not going to be enough. The vast majority of the Republican party voted for Medicare Part D. I will note that the Senator who will follow me on the floor was one of the brave souls who voted no, and I am willing to bet it was because he was trying to be responsible relating to the budget. Most of his colleagues didn't agree with him, and certainly the President of the United States didn't agree. Not only did he sign the bill, he signed it with relish and he campaigned on it, even though the way the program is going to be implemented was not going to hit home for seniors for years in advance.

I think we can all be proud that there are some savings with Medicare Part D. We have to be honest that the Government is paying a price for it, just like we are going to pay a price for enhancing and protecting the Children's Health Insurance Program in this country. Other than Medicare Part D, we have not lifted a pinky finger in the area of health care during this administration.

Most Americans are now scared. They are scared about getting care for their children, getting care for their parents, and they are scared about whether they are going to be able to afford health care, knowing that any minute their employer may drop their coverage. The expansion of this program has more to do with the unavailability of health care from an employer than it has to do with some effort on the part of the Government to insure every person.

This is a public-private effort that has been a success. It is a block grant, not an entitlement. It allows the States flexibility. It is everything a Government program should be. It is getting to a very important need. There are so many reasons to be for this bill. I will not take the time tonight to go into them all because my colleagues will and they have today. I listened for a couple of hours when I was sitting in the chair. I am sure this will go on tomorrow with many people talking about important things.

I want to mention one part of the bill that I think is very important, which has not been talked about—mental health parity. We have spent a lot of time talking about our children being at risk for drugs and alcohol. We have talked a lot about how we have to teach them the dangers of drugs and alcohol. Truth be known, one of the biggest failures in our health care system

in this country is the complete unavailability of mental health services for children.

Right now, in America, if you have health insurance and you know people and you are educated, it is difficult to find a mental health professional that specializes in children. If you are a poor working family and your child has gotten involved with drugs or alcohol and you want to get them mental health assistance, a treatment program, forget about it. It is literally almost impossible to access programs that can help adolescents and teens get off drugs and alcohol if they turn down that path at a young age.

This will allow those programs to get the parity they need in the States. Speaking from experience, in terms of watching the expensive price tag on what happens to these young people if they get addicted to drugs or alcohol at a young age, the costs to the Government are huge because of what it means down the line in terms of wasted productivity, criminal conduct, the prison systems, and other health care costs down the line.

There are very few kids who are addicted to drugs and alcohol who can get help when they are young, and a vast majority of them who do not end up charging us a heftier pricetag down the line, in terms of Government programs and assistance.

This is a very wise investment of the public dollar, to get not only the physical health care but the mental health care to the children of this country who desperately need it. We have talked about dental care and emergency rooms and broken arms, but I think it is time we realized we are abandoning our children when it comes to important mental health care services. This bill will go a long way toward fixing it.

I hope my friends on the other side of the aisle will not be situationally worried about the budget. When this was a program that was passed in 2003, $400 billion with no offsets, no way to pay for it, they lined up to vote for it, and the President signed it gleefully. It will be a bitter pill for America's children to swallow if, in a responsible way, we move forward to protect this program and this President decides to veto it. But if he does, he should know there are many of us here who will stand and fight with all the might we can muster on behalf of the kids of this country who deserve a chance at health care, deserve a chance for peace of mind for their parents.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, first, I appreciate the acknowledgment of the Senator from Missouri of my views on the Part D proposal. She is correct, I did not vote for that proposal because it was not paid for. I don't think one expensive program deserves another expensive program, especially when the second expensive program is backed with very poor policy.

What I wish to talk about tonight is the policy. The issue, of course, should be how we get more children insured and how we get fewer people uninsured in this country. There are a variety of ways to do that. I have had a number of proposals of my own in this arena. However, it is not a good idea to approach this issue of how we get more children insured by suggesting that the best way to do it is to take a lot of kids off private insurance and move them on to public insurance or to, under the nomenclature of protecting children, which is, of course, very popular—and we have had lots of pictures on this floor already of children who have gone through very serious health concerns who need to have the support of the health community, of using children and pictures of children and anecdotal stories about children for the purposes of using a Federal program which is entitled children—to cover adults, some adults who, in fact, do not even have children. There are a lot of serious policy problems with this initiative.

The irony, of course, is this initiative is not about insuring more children, although that is a stated goal. The purpose of this initiative is to essentially take another large step down the road toward Federal control and delivery of health care in this country, universal health care, as it is popularly referred to. That is not me phrasing that. The chairman of the Finance Committee, who is always very forthright, always very honest about what he is doing around here, said exactly that: SCHIP is a major step on the road to a universal, one-payer, Federal health care system. There are a lot of folks on the other side of the aisle who especially believe that should be the proper way to insure people in this country or take care of health care needs in this country, and I respect that viewpoint.

However, I do not think it accomplishes what the goal is, which is to deliver high-quality health care to the most people in this country, to make health care affordable to most people in this country, and to give people in this country the opportunity to get good health care. What it does is what was described earlier in one of the starkest and most effective attacks on universal health care I have heard on this floor, when the Senator from North Dakota essentially explained the Indian health care program and what a disaster it is.

What is the Indian health care program? The Indian health care program is single-payer Federal health care. He was talking about kids not being able to see dentists, kids not being able to get broken arms fixed, kids put in serious situations and adults in equally serious situations and no resources, no capability to take care of these people who are having serious health care problems. Interestingly enough, he used the word which is most often associated with those studies which have looked at universal health care or federally mandated health care or single-payer health care. He used the word ''rationing.'' He said rationing was occurring on the Indian reservations. He is right. He is right because that is what happens when you go to a single-payer system and the Federal Government becomes the payer. That is what they have in England, they have rationing. If you have certain situations, if you have a hip replacement, you are going to be rationed, depending on your age. If you have cancer and you are under a certain age, you are going to get hit with rationing. If you have to have some sort of invasive procedure which is optional, you are going to get hit with rationing.

The same thing happens in Canada. Why do you think Canadians come to America for health care? In New Hampshire, we see it fairly regularly, Canadians coming over the border to get their health care at Boston, at one of the many extraordinary medical facilities in Boston or at Dartmouth-Hitchcock, one of the best, most extraordinary facilities in New England, in the country quite obviously. Why? Because there is quality there, because things are being done there that are not being done in Canada, and you can get served. You don't have to wait in lines 2, 3, 4, 5 years for some sort of elective surgery, or if you have to have something done that is a major, complicated issue, you don't have to worry that the people doing it maybe do not have the expertise you need because the Government hasn't paid for the science behind the necessary research to produce that service.

This SCHIP fight is as much a debate about whether we are going to move to a single-payer system with the Federal Government taking complete control over health care as it is about how we pick up coverage of children in this country who don't have coverage.

Coverage for children in this country is affordable. We can do it without going to a single-payer system. We don't need to take 2.2 million kids off one system and put them on the SCHIP system. We don't need to take, I believe it is 1.7 million kids off private insurance and put them on public insurance.

The total amount of children who are going to be covered by this $35 billion in new program over the next 5 years—do you know how much? Mr. President, 4.5 million children. But of that number, 2.2 million already have coverage. So actually there are only 2.3 million children you are picking up, and it is costing you $35 billion to do that. That works out to something akin to $3,200 per child.

You can go on the Internet today and buy an insurance policy for a child for about $1,300. So in the classic way that the Federal Government works, we are going to spend twice as much of your tax dollars to pay for insurance for children, and we are going to take people who are already covered and move them from having the private sector bear the cost of that coverage over to

the public sector so the public sector bears the cost of that coverage. Does that make sense? Is that common sense? Is that a good use of resources? Of course, it isn't.

The practical effect is also that under this proposal, the program is not paid for. In the second 5 years, in order to avoid the pay-go discipline which is allegedly on the other side of the aisle, the Holy Grail that is supposed to be followed in every instance—of course, they have waived it now nine times on domestic spending they like—they take the cost of this program and project that in year 6 of this program, a program which will have been built up to $16 billion in spending annually will suddenly drop back to $3.5 billion in spending. Now that doesn't pass the smell test. That is the laugh test. That is absurd on its face. No Federal program ever disappears around here, and you don't take one that supposedly is benefiting children and cut it by almost $12.35 billion. That is not going to happen, but that is the assumption that is made in this bill in order to avoid having to pay for this bill.

So this big white area, which is all the area that isn't covered of the projected costs—and this is actually a conservative number, by the way, this projected cost, that represents $40 billion, $40 billion that is unpaid for—is a cost we pass on to our children, by the way.

Ironically, we say we are going to insure our children by paying twice as much as it costs to insure them and by taking a bunch of kids off private insurance and move them to the public sector, and then at the same time we are going to create a $40 billion debt which our children will have to pay for. I am not sure our children are getting all that good a deal, to be very honest with you, in this exercise.

Plus, the ultimate goal of the exercise—I believe the ultimate goal has been stated by the chairman of the committee—the ultimate goal is to move toward a universal, single-payer system, where the Federal Government pays for health care. Here is the goal: You have all these folks on Medicare on one end, the elderly folks—that is me. I shouldn't call them too elderly—and then you have all these people on SCHIP, taken off private sector and being put in the public sector, such as this bill does, you have compressed the number of people available in the private insurance market, you are going to crowd out the private market. That is the game plan, crowd out the private market so you end up with a single-payer plan.

As I have already gone through, single-payer plans make very little sense from a standpoint of quality and rationing. I don't think this country will be very comfortable with a single-payer plan, any more comfortable than, for example, the Indian population appears to be on the Indian reservations, as was explained to us by the Senator from North Dakota, who was describing a single-payer plan, otherwise known as Indian health care.

So within this proposal, not only does it have this $40 billion gap in funds in spending, which it doesn't pay for in order to avoid the pay-go rule, not only does it take a bunch of kids who already have private insurance and move them to the public side, 1.7 million kids, and then end up paying twice as much to insure them as it is probably costing the private sector and sticking themselves with that bill because they don't pay for the program in the outyears, not only does it do all that, which is terrible policy, but it compounds this by taking a program which is supposed to insure children and using it to insure adults.

Both the predecessor program, State Children's Health Insurance Program, and the present program as proposed under this legislation, Children's Health Insurance Program, do not say anything in their title about insuring adults. They are supposed to be insuring children. That is the idea. But some of our States, in a very creative exercise, have decided to expand this program to insure adults. That makes some people in this body quite happy because it fulfills this exercise of moving toward universal health care. You can use the SCHIP program or the CHIP program, which is supposed to be for children, to pick up adults, and then we will even narrow further the population of people who would be available for private sector insurance and, thus, move even more aggressively toward public, single-payer insurance, public single-payer plans, universal health care, rationing, reduction in quality. It makes no sense that this should be allowed to continue.

Now, actually, the committee knows this. In fact, they sort of tacitly recognized it, because they put in place language which attempts to partially phase out this coverage of adults. They say over 3 years these waivers will end that cover adults, but adults will be insured, instead of at the rate of Medicaid, which is what the States have a right to reimbursement for when they insure adults who qualify, they will get some new blended rate that is higher than Medicaid but less than what you pay for children. So in a tacit way the committee has sort of acknowledged that they shouldn't be insuring adults with a program called Children's Health Insurance.

The only adults who could possibly and appropriately—and I have no problem with this—be covered under that would be pregnant women. Obviously, there is a clear issue of insuring a child if a woman is pregnant. She has a child. She is with child and, therefore, clearly that coverage is reasonable. But adults are supposed to be covered, if they qualify for Federal coverage, under Medicaid, not under the children's health insurance system.

So the amendment I am offering essentially completes the thought of the committee on this point by saying: No, we are not going to reimburse States. This isn't about insuring so much as about what the reimbursement rate is to the State—what sort of windfall a State gets when they move adults on to the SCHIP program.

There are a lot of State Governors who have figured out, I can get more money for my State, which I can use to help me balance my budget, if I put more adults under SCHIP because my reimbursement rate from the Federal Government is significantly higher. So that is why this happens.

Well, it is not right. It is gaming the Federal system to do that. Waivers shouldn't be granted to allow that to happen, and this administration bears many of the problems when it comes to that. They do not come to this issue with clean hands, that is for sure, because they have given a lot of these waivers. But the committee at least recognized this was not good policy and has tried to mute it a little bit so that States, when they do game this, will only be able to game it for another 3 years and then reduce it to about half of what gaming goes on in the outyears.

But there shouldn't be any of this. There is no reason to give States a breathing spell here on this issue. There is no reason to encourage States to put more adults into the system in the interim or to put more adults in the system in the future because you are reimbursing at a higher rate than Medicaid reimburses at. No reason at all. There is no good policy reason. The States have certainly had a good run of money coming in to them that they didn't deserve, because the Children's Health Insurance Program was not supposed to insure adults, it was supposed to insure children. So we are not doing them a disservice and we are not treating them unfairly by saying: All right, that policy ends. The SCHIP program, the new CHIP program, will be for children, not for adults.

So my amendment essentially does this. It says: Adults will not be covered under this program at the SCHIP rate. They can still be covered under the Medicaid rate but not under the SCHIP rate, which seems to be a very reasonable approach to a program entitled children's health insurance.

AMENDMENT NO. 2587 TO AMENDMENT NO. 2530

Mr. President, I send an amendment to the desk, and I ask unanimous consent that the pending amendment be set aside and my amendment be reported.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

The Senator from New Hampshire [Mr. GREGG] proposes an amendment numbered 2587.

Mr. GREGG. Mr. President, I ask unanimous consent that further reading of the amendment be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To limit the matching rate for coverage other than for low-income children or pregnant women covered through a waiver and to prohibit any new waivers for coverage of adults other than pregnant women)

Beginning on page 42, strike line 4 and all that follows through page 66, line 25, and insert the following:

SEC. 106. LIMITATIONS ON MATCHING RATES FOR POPULATIONS OTHER THAN LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.

(a) LIMITATION ON PAYMENTS.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATIONS ON MATCHING RATE FOR POPULATIONS OTHER THAN TARGETED LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.—For child health assistance or health benefits coverage furnished in any fiscal year beginning with fiscal year 2008:

''(A) FMAP APPLIED TO PAYMENTS ONLY FOR NONPREGNANT CHILDLESS ADULTS AND PARENTS AND CARETAKER RELATIVES ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—The Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to payments for child health assistance or health benefits coverage provided under the State child health plan for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES ENROLLED UNDER A WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(ii) NONPREGNANT CHILDLESS ADULTS ENROLLED UNDER A WAIVER ON SUCH DATE.—A nonpregnant childless adult enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project described in section 6102(c)(3) of the Deficit Reduction Act of 2005 (42 U.S.C. 1397gg note) on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(iii) NO REPLACEMENT ENROLLEES.—Nothing in clauses (i) or (ii) shall be construed as authorizing a State to provide child health assistance or health benefits coverage under a waiver described in either such clause to a nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child, or a nonpregnant childless adult, who is not enrolled under the waiver on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

''(B) NO FEDERAL PAYMENT FOR ANY NEW NONPREGNANT ADULT ENROLLEES OR FOR SUCH ENROLLEES WHO NO LONGER SATISFY INCOME ELIGIBILITY REQUIREMENTS.—Payment shall not be made under this section for child health assistance or other health benefits coverage provided under the State child health plan or under a waiver under section 1115 for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES UNDER A SECTION 1115 WAIVER APPROVED AFTER THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child under a waiver, experimental, pilot, or demonstration project that is approved on or after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

''(ii) PARENTS, CARETAKER RELATIVES, AND NONPREGNANT CHILDLESS ADULTS WHOSE FAMILY INCOME EXCEEDS THE INCOME ELIGIBILITY LEVEL SPECIFIED UNDER A SECTION 1115 WAIVER APPROVED PRIOR TO THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child whose family income exceeds the income eligibility level referred to in subparagraph (B)(i), and any nonpregnant childless adult whose family income exceeds the income eligibility level referred to in subparagraph (B)(ii).

''(iii) NONPREGNANT CHILDLESS ADULTS, PARENTS, OR CARETAKER RELATIVES NOT ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(i) on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, and any nonpregnant childless adult who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(ii)(I) on such date.

''(C) DEFINITION OF CARETAKER RELATIVE.—In this subparagraph, the term 'caretaker relative' has the meaning given that term for purposes of carrying out section 1931.

''(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as implying that payments for coverage of populations for which the Federal medical assistance percentage (as so determined) is to be substituted for the enhanced FMAP under subsection (a)(1) in accordance with this paragraph are to be made from funds other than the allotments determined for a State under section 2104.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

(c) NONAPPLICATION OF CERTAIN REFERENCES.—Subsections (e), (i), (j), and (k) of section 2104 (42 U.S.C. 1397dd), as added by this Act, shall be applied without regard to any reference to section 2111.

SEC. 107. PROHIBITION ON NEW SECTION 1115 WAIVERS FOR COVERAGE OF ADULTS OTHER THAN PREGNANT WOMEN.

(a) IN GENERAL.—Section 2107(f) (42 U.S.C. 1397gg(f)) is amended—

(1) by striking '', the Secretary'' and inserting '':

''(1) The Secretary''; and

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

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for any other adult other than a pregnant woman whose family income does not exceed the income eligibility level specified for a targeted low-income child in that State under a waiver or project approved as of such date.

''(3) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2105(c)(8).''.

(b) CLARIFICATION OF AUTHORITY FOR COVERAGE OF PREGNANT WOMEN.—Section 2106 (42 U.S.C. 1397ff) is amended by adding at the end the following new subsection:

''(f) NO AUTHORITY TO COVER PREGNANT WOMEN THROUGH STATE PLAN.—For purposes of this title, a State may provide assistance to a pregnant woman under the State child health plan only—

''(1) by virtue of a waiver under section 1115; or

''(2) through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.''.

(c) ASSURANCE OF NOTICE TO AFFECTED ENROLLEES.—The Secretary of Health and Human Services shall establish procedures to ensure that States provide adequate public notice for parents, caretaker relatives, and nonpregnant childless adults whose eligibility for child health assistance or health benefits coverage under a waiver under section 1115 of the Social Security Act will be terminated as a result of the amendments made by subsection (a), and that States otherwise adhere to regulations of the Secretary relating to procedures for terminating waivers under section 1115 of the Social Security Act.

Mr. President, I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DURBIN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. Mr. President, I ask unanimous consent to be allowed to take the time already allocated to the Senator from Rhode Island, Mr. WHITEHOUSE.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Illinois.

Mr. DURBIN. Mr. President, what an interesting debate this has been. If you want to know how Congress is likely to react to the fact that we have 47 million uninsured Americans and millions more with health insurance that is almost worthless, if you want to know what Congress is likely to say about the plight of families who struggle each year with premiums rising and coverage falling, you should listen to this debate. Because my friends on the Republican side of the aisle—not all of them, but a number of them—want to argue for the proposition that we ought to be careful we don't insure too many people in America.

It is an easy thing for a Member of the Senate to argue. We are some of the luckiest people in America. We are covered by the Federal Employees

Health Benefit Program. That may be the sweetest deal in terms of health insurance anyone can dream of. It covers 8 million Federal employees, including Congressmen, Senators, and their families, and it allows us—if you can believe it, those watching this debate across America—it allows us once each year to decide if we want to change companies. If we don't like the way we were treated last year, if a particular company didn't cover something important to our family, we can say: That is it, we are buying a new product. It is like shopping for a car and we are in the driver's seat because we have options.

In my State of Illinois, my wife and I can choose from nine different health insurance plans. If we want to get more coverage, we can have more taken out of my check; less coverage, a lower amount. Our choice. Real consumers. Boy, there aren't very many Americans who can say that, are there? How few Americans can stand up and say: If I don't like my health insurance company, I will buy another. But we can do it. The Senators coming to the floor today arguing against children's health insurance being extended to too many people have that luxury. They are part of the Federal Employees Health Benefit Program.

Most of us here in the Senate bring our life experience to the floor. In this bill, there are two life experiences I have been through that come to mind. The first relates to the way we pay for children's health insurance, and that is with the tobacco tax. Well, tobacco has been a big issue in my congressional career. It was 20 years ago that I decided to introduce a bill to ban smoking on airplanes. It was considered a radical idea, that we would have no smoking on airplanes. Back in those days, they split the plane up, smoking and nonsmoking, and argued if you sat in the nonsmoking section that you were protected. Everybody knew better, but nobody questioned it. So I introduced a bill to take smoking off airplanes. My interest in that went beyond the fact that I was a frequent flyer, as most Members of Congress are. It even went beyond the fact that I had read the statistics about secondhand smoke and the damage it had caused to so many innocent people. It went to a personal life experience. My father smoked two packs of Camels a day. He was an addicted smoker for as long as I knew him, and I didn't know him very long. When I was 14, he died. He was 53 years old, and he died of lung cancer. I stood by his bed and watched as he took his last breath on November 13, 1959, at noon. I didn't swear then and there that I would get even with tobacco companies. But looking back, and as a young boy, I never got it out of my mind that that product, that tobacco product, had taken his life and taken him from me.

I remembered it whenever I would fight the tobacco companies, and I have quite a few times. I would think about all the other young people, men and women across America whose lives had been touched by tobacco disease.

My dad started smoking when he was a kid—most people do. So how do we stop kids from making that terrible choice in their lives? There is a simple way—raise the cost of the product. The more expensive a pack of cigarettes is, the less likely a younger child will start smoking and the less likely they will be addicted. That is simple economics. We have proven that over and over again.

We have these charts here that show U.S. cigarette prices versus consumption. As the price goes up, the consumption goes down. It is that basic. So we pay for this bill for children's health insurance across America by imposing a higher tax on tobacco products and cigarettes. It is no surprise that my Senate colleagues from tobacco-producing States don't like the idea at all. For years, they have come to the floor of the House and Senate and argued against tobacco taxes for a variety of different reasons, but they can't argue against this reality. The higher the cost, the lower the consumption. Certainly among children it is even more dramatic.

So for many who have come to argue against our approach to expanding children's health insurance, saying it is not fiscally responsible, it is as responsible as you can ask for. We are going to pay for it, and we pay for it with a tax on a product that claims over half a million American lives each year. Tobacco is still the No. 1 preventable cause of death and disease in America. Sparing a child from addiction to tobacco is sparing them the 1-in-3 likelihood that they will die from that addiction.

The second life experience that brings me to this issue goes back to my time in law school here in Washington at Georgetown Law Center. My wife and I were married after my first year in law school, and a baby came along rather quickly. Our daughter was born at the end of my second year, and I didn't have health insurance. I was a law student. We were happy to have our little girl, but a little surprised and unprepared. So we had to save up the money to pay for her delivery. Luckily, in those days, it wasn't as expensive as today, but for a law student it was still a lot of money. My wife worked during the pregnancy, I tried to save a few dollars, and we had enough money to pay the obstetrician and pay the hospital for my daughter's delivery while I was still in law school. But something happened 30 days after that which made a big difference. My daughter was diagnosed with a serious illness. Still, we had no health insurance. I found out what it was like to be the parent of a child and to have no health insurance. It was a humbling experience. I used to leave law school and drive over to Children's Hospital here in Washington, DC, pick up my wife and baby, drive over there and sit in the clinic. The clinic was, I guess, the place for those of us who didn't have health insurance, and we would wait our turns. There were a lot of people in that clinic, and it meant waiting a long time. I was glad to wait, because I wanted some doctor, some competent physician, to come see my daughter.

Well, we usually ended up with a resident who took the history, which we gave over and over and over again. But that is the price you pay when you don't have a regular doctor and a regular appointment. So the chart of my daughter's background grew and grew, and I sat there with my wife time after time waiting for a doctor to examine my baby. It wasn't a reassuring feeling for a father, because you want to believe that the doctor who is going to be there for your baby is the best. If you don't have health insurance, you may be tossing the dice. I learned what it was like. It was a humbling experience. I have never forgotten it, and I never will.

We are talking about children across America now who have no health insurance. Of the 47 million who are uninsured in America, about 9 million are children. We decided about 10 years ago to create a special program to provide uninsured kids with healthcare coverage. It worked. It worked very well. Over 6 million kids across America today have health insurance because of this program, and it is a program that people like because Governors and others can work to make it fit into their State, to fit their needs. There are Government guidelines, but there is flexibility through waivers that are offered. So a lot of States are trying different ways to bring more children in and cover more uninsured people. I think that is a good thing. I hope that whoever the next President of the United States may be—and we all have our favorites in this Chamber—whoever it may be, they will start their administration by saying they are going to challenge America to eliminate the uninsured over a specific period of time. And wouldn't they start with the kids?

The bill that came out of the Finance Committee is a bipartisan bill. I want to salute not only Senator BAUCUS of Montana, the chairman, but Senator GRASSLEY of Iowa, the ranking minority member, and others, Senator HATCH of Utah, Senator ROCKEFELLER of West Virginia, and Senator SNOWE of Maine, who have all made a real bipartisan effort. What we are trying to do is to take this bill and reauthorize this Children's Health Insurance Program so that we cover even more children. In fact, we have the opportunity to add another 3.2 million to the 6.6 currently covered. That is almost 10 million kids who will have health insurance, if we are successful. It will still leave almost 6 million uninsured. That is still too many, as far as I am concerned. But we are moving forward. We are dealing with political realities and budget realities and doing the best we can under these circumstances.

But Senator MCCONNELL, the Republican leader, is going to come to the floor and suggest spending dramatically less money on this program. The net result of it is that Senator MCCONNELL and others are going to argue let's not increase the number of uninsured kids covered by this program. At the end of the day it is going to mean that just about 9 million kids in America will be uninsured instead of the 6 million that will remain if we pass this proposal. Senator MCCONNELL has made a calculation that he is willing to leave millions of uninsured kids behind.

He doesn't like the tobacco tax. Being from Kentucky, I am not surprised. But for many of us it is a small price to pay, increasing the cost of tobacco products so that kids have more health insurance. The important thing about this debate is it is a precursor of a much bigger debate that is to come over whether America is going to get serious about the shortcomings when it comes to health insurance.

I know there are a lot of people with a lot of different theories. I see my friend from Oklahoma, a medical doctor. He and I have talked about this. He has a much different view about this issue than I do. I hope his approach, if it is ever tested, works. But I believe this approach will work because what we are doing is taking those who have been unfortunate enough not to have health insurance and giving them a chance for coverage.

We know the poorest kids in America are eligible for Medicaid, a program that we share with the States all across the Nation. We know that the kids from wealthier families usually have health insurance through some worker in the household. But what about the kids caught in the middle? What about the kids where the parents do go to work but don't make enough money? What about the kids from families who, because of an existing medical condition or some other complication, can't afford health insurance, can't buy health insurance? That is what this program is all about.

There has been a lot of criticism of this program—I have heard it on the Senate floor today repeatedly—that it just covers too many children. We really ought to cut back on the number of kids covered. That really betrays an approach to this issue which I think we will hear more of. There are some people who, for a variety of reasons, philosophical and economic, would leave a lot of kids and a lot of uninsured Americans behind and say: That's life.

I don't accept that. I don't think that should be life in America. We live in a much better nation than that. Our values are stronger than that. We exalt family in America. We say that is the strength of our Nation. How can you exalt families and say that you want to make them stronger and not provide one of the basics in life—health insurance?

I know what it is like sitting in that waiting room, worrying about my own daughter's care, with no health insurance. I try to think of millions of other families who face that every single day. We were lucky. We got through it. My daughter is 39 years old now and has her own family. We were blessed in many ways.

But it was a tough experience I wouldn't wish on anybody. Those who vote against this proposal are wishing it on millions of Americans. In fact, they know millions of Americans will continue to have no health insurance and they accept it.

There is a young teenager in Naperville, IL, I am honored to represent. His name is Michael, and he is 17 years old. When he was in the fourth grade, he was friends with a young boy named Joey. He used to talk about Joey as his friend with the megawatt smile. They shared lunch together and kept their secrets safe for one another. But, unfortunately, Joey complained a lot about just not feeling right. He missed a lot of school. He was tired, his knees hurt, he bruised easily.

It came as a shock one day when Michael was told that Joey had been diagnosed with acute lymphocytic leukemia, a devastating, life-threatening disease. Then they learned another piece of alarming news: Joey's dad, who was a house painter, was self-employed and like millions of other self-employed Americans, was uninsured.

In the 4 years that followed, Joey with leukemia, would come to school when he could. He lost his hair with the treatment he received. He was frail, and he wore his Cubs cap to cover his bald head. Sometimes he only stayed for a couple of hours, but all the kids remember they were good hours. They were happy to see him.

Then, on January 8, 2003, the school counselor came in and told Michael and his class that Joey was not going to return. That is not an unusual story in America—but it should be.

What does this say about America, that 9 million children do not have the most basic health protection in our country? We are so proud of so many achievements that we have registered in the course of our history. We are so proud of the opportunities in our country. But how would we explain to future generations that we would just walk away from those kids and this opportunity to provide them with coverage? If Senator MCCONNELL's alternative prevails, we will walk away from 9 million uninsured children. If the committee proposal prevails, we at least will take care of about 3.2 million of those kids. I wish we would take care of more.

We also know that if kids don't receive basic health care, a lot of simple things can become complicated; a lot of things that can be treated successfully will be ignored and unfortunately become worse. As Michael puts it, how many Joeys could be saved if only affordable health insurance was available to all children?

What do Americans think about this general concept of helping States cover more uninsured children? In a country that is sharply divided along political lines on so many issues, this is one that is overwhelmingly popular. Ninety-one percent of the American people get it. They think this is the right thing to do, to cover more children. Eighty-four percent specifically support covering all uninsured children with the Children's Health Insurance Program. It is hard to believe that number exists, when you hear some of the speeches against this program from the other side of the aisle. With this program we have reduced the number of uninsured children in America by a third.

States have worked to design programs that work best for them. My State is one of them. Illinois now provides coverage to over 130,000 parents under CHIP, and because of the increased outreach and enrollment, 250,000 more parents than it did prior to receiving a waiver from our Government to offer that coverage.

You say to yourself, if this is a children's program, why are you covering parents? They found the vast majority of parents had no health insurance or couldn't afford the health insurance they had, and by offering them insurance, it brought their children into coverage as well. Some will say it is not what the program is about; it is the children's health insurance program. But for these people, they consider it somehow a violation of trust that we would expand the program to bring in uninsured parents. To me, it is striving to reach a national goal, where every American, regardless of their economic situation, has health insurance. That is something I support and most Americans support, and something this program tries to achieve.

We give the States such as New Jersey and Illinois and many others the option to cover more parents. What is striking is, during the same time period that the state covered these parents, Illinois has added more than 360,00 children to Medicaid and CHIP coverage, so this program has worked. It has become an outreach program to let parents know they have an option. They may qualify for Medicaid. They may qualify for the Children's Health Insurance Program. It is a 38-percent increase in the number of kids covered by health insurance in my State. Is that working, a 38-percent increase? I think, frankly, the figures are obvious.

Just last week, Illinois State officials hosted delegations from around the country, briefing them on how our program works and maybe exchanging some ideas on how to make it better in their States and ours as well. Illinois was telling other states how to do it because Illinois has a successful model.

This is not a perfect piece of legislation. I wish it were larger. I would spend more than $35 billion. I would raise the tobacco taxes higher, if necessary. I would find other ways to offset the cost because I think we should be striving for full coverage of all uninsured children in America. What a

great day that would be. What a celebration it would be for us to be able to say, on a bipartisan basis, Republicans and Democrats have reached that goal.

This bill doesn't quite reach the goal. But let's celebrate what it does. It moves us forward. It preserves a program which would expire on September 30, and it expands it. With these new funds and an accurate formula, combined with the incentive bonuses proposed, Illinois could cover as many as 123,400 children who are uninsured today over the next 5 years. That is a dramatic expansion. It is one which I would be happy to vote for and will vote for.

The Finance Committee bill increases eligibility levels for children covered under this Children's Health Insurance Program to 300 percent of Federal poverty. Some people on the floor have talked about 300 percent of Federal poverty level as a higher income. Do you know what it means to have a family of four and be at 300 percent of poverty? It means an income of $62,000 a year. That is a little over $1,000 a week. That is maybe a little more than $5,000 a month. It is hard to imagine people are living in the lap of luxury, after they pay their taxes and their basic expenses, paying for the higher price of gasoline and utility bills, paying for whatever it takes to have a safe and sound place to live in.

I think most of us who are blessed with a lot more income should reflect on a family of four struggling with $62,000 a year. I don't think there are many vacations or trips to the movies with that kind of income. For the State of Illinois, this change in eligibility level would bring in an additional $26.5 million to cover thousands of additional kids, which is certainly a positive step forward.

I can tell you that Senator MCCONNELL, who is offering a Republican alternative—as I mentioned earlier, is not offering an alternative embraced by all Republicans. Many support the bipartisan bill that came out of the committee and see it as strengthening a successful bipartisan program. Senator MCCONNELL sees it as a slippery slope to universal coverage.

The Republican leader yesterday invoked all the right words when he described his Republican alternative: low-income children, fiscally responsible, providing a safety net. He criticized the bill from the committee as a ''dramatic departure from current SCHIP law.''

What he failed to mention is his alternative is the dramatic departure. It includes a bare reauthorization of the program and adds in small business health plans and health savings account reform. Incidentally, the health savings account is the refuge for all of my friends on the Republican side of the aisle. When they can't think of anything to say about covering more people with health insurance, they come in with these health savings accounts—an idea once waltzed out by Speaker Gingrich that has gone around the track many times and has not shown the success that they promised.

Here it is again—no surprise. The Republican proposal by Senator MCCONNELL would likely cause hundreds of thousands of people to lose coverage.

I am encouraged that the reauthorization bill before us has sparked a national conversation, not only about the kids who are uninsured but others as well. My counterparts on the other side of the aisle have not always been open to that conversation, but that is not what is before us. The bill we are considering will reauthorize the Children's Health Insurance Program before it expires on September 30.

This is not the time or vehicle to try to add all kinds of health care proposals, but that day should come. This is the time to take care of our nation's children and we will pay for it as we go. As I said earlier, this new tobacco tax is a smart thing from a health point of view. In a poll conducted by the Campaign for Tobacco Free Kids, two-thirds, 67 percent, of those interviewed favored such a tax increase. Only 28 percent opposed it. Moreover nearly half, 49 percent, strongly favored it. Only 20 percent strongly opposed it. It is the right thing to do. We know what tobacco does to the health of America. Discouraging its use is a move in the right direction.

This is an historic debate, one that is long overdue. We know health care is the most important issue to Americans next to the war in Iraq, and very rarely if ever do we seriously address it. We know the business community is begging us to move forward and expand health insurance coverage in this country to help them find a way to move to universal coverage which will not be at the expense of competitiveness. We know that working families, those in labor unions and those who are not, all understand the cost of health insurance and its value to every family, and we know from our own personal experiences and the people we meet in our States that this is long overdue. It is about time we opened up this discussion.

I am heartened by the work of the Finance Committee. The fact they brought this bill to us with strong bipartisan support on the floor of the Senate is an indication that there is some promise to this debate. I thank my colleagues who worked so hard on the committee to bring this bill forward. I hope we can build on it, cover more uninsured children, and move to the day that every single American, regardless of their income, has basic health insurance coverage so that every American has peace of mind when it comes to their health and the health of their family, so that no American, whether a law student or someone who has a low-income job, has to wait and pray that there will be good professional health care for their children.

I yield the floor.

The PRESIDING OFFICER (Mr. BROWN). The junior Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, I am going to spend a little bit of time first discussing health care in America. I have a little bit of experience, having practiced for 24 years. The children the majority whip talked about, I delivered 4,000 of them. I cared for well over a third of those through their infancy and into childhood.

Let's be clear about what this debate is. There is no difference. I agree with Senator DURBIN. I want every person in this country to have health insurance. Actually, every problem that Senator DURBIN mentioned could be solved by equalizing the tax treatment under the Tax Code so that everybody is treated the same under the Tax Code in this country.

Let's talk about where we are in health care in America today, then let's talk about what the possible solutions are.

What we have today is the best health care in the world. It is very expensive, there is no question about it. Eighty percent of all of the innovation in health care in the world comes out of our health care system. We have survival rates on prostate cancer, breast cancer, and colon cancer that far exceed anywhere else in the world. Our treatments for coronary artery disease are better than anywhere else in the world. If you have a heart attack in this country, you are more likely to live 5 years than anywhere else in the world. But we have a system that is designed to treat chronic disease instead of designed to prevent disease.

I know that the President this evening is supportive of prevention in terms of how do we change the focus in this country. You see, what we have coming to us is a storm. It is not going to be a storm that affects myself or the Senator from Ohio; it is going to affect our kids and our grandchildren. Here is what the storm is. If you are born today, born today, you are born owing $500,000 for the health care of everybody who was born before you under Medicare. Think of that. Listen to me—$500,000 is the cost we are laying on the next generation for the health care system we have under Medicare. That is not talking about Medicaid, that is not about SCHIP, that is about Medicare only. If you are born today, that is what you are going to bear over and above what our present tax rate is. That is called stealing opportunity from the next generation.

We also have a health care system under which 7 percent of the costs of health care comes about from tests that are ordered for you that you do not need. There is no reason you need them, but the tests get ordered because your doctor needs them or your hospital needs them. It is a full $170 billion a year we spend on tests that nobody needs except the doctors to protect themselves in the case of ''what if.'' And this body refuses to look at tort

changes that will make us order tests based on what you need rather than on the threat of a malpractice suit.

So we have liability costs, we have unfunded costs from Medicare, we do not have prevention. We spend tens of billions of dollars a year on disease prevention in this country, $7.1 billion at the NIH, $8.4 billion at the CDC, and then billions more that we can't quantify across many Federal agencies where you cannot measure that we did anything on prevention.

The average American does not know that at age 50, they should have a colonoscopy; they do not know that at age 35, they should have a mammogram; they do not know that if they have a family history of breast cancer, they should have that mammogram sooner; they do not know that every month, they should be doing a self breast exam; they do not know the symptoms of prostate disease in older men; they do not know what they need to know about prevention. We are totally inept in the programs we have today to communicate that to America.

So that is where we find ourselves today—the best health care system in the world, with the most innovation, but also 50 percent more expensive than anywhere else in the world.

Now, when you match up those two statistics I talked about, in terms of greater life expectancy, in terms of all of the cancers, in terms of heart disease, against the cost, what is the difference in all the countries that have universal, single-payor, government-run, bureaucratic-controlled health care? They let you die. That is the difference. If you need a knee replacement, like the Senator from North Dakota talked about, you do not get it because there is no money. Let's talk about some statistics. Average waiting time in Sweden: 25 months for heart surgery. How many people do you think live 25 months? How about an average of 10 months before the onset of chemotherapy for breast cancer in England. The reason their costs are down is because they are not caring for people at the end of life.

We can get all of that back if we emphasize prevention. Prevention. For every dollar we spend on prevention in this country, we are going to get 100 back. Yet we do not have effective prevention programs. So what is this debate really about?

There is not anybody in this Chamber who does not want to see kids have great access to health care, preventative or otherwise. There is not anybody in this Chamber who wants anybody not to have available health care. What is the real debate? Well, there are actually three.

The first debate is: Do we want the Government that cannot get you a passport, that cannot control the border, that cannot take care of the problems associated with a hurricane when we have a major emergency, do you want them running your health care? A government that is failing so many fronts because the bureaucracy is so big, the oversight is so poor from this body, the oversight is so poor, we do not do our jobs. We can find lots of ways to spend new money, but we cannot spend the effort to find out if money we are spending is working. The oversight is so poor that we have ineffective programs all over the place.

There is a columnist by the name of P.J. O'Rourke. He said, if you think health care is expensive now, wait until it is free. And there is a lot of truth to that. When it becomes free, it is going to be tremendously expensive.

So the debate is not about whether we should cover children and whether children ought to have great health care. They should. We have the resources to do it. What the debate is about is whether we are going to put into the hands of an incompetent government in many other areas your health care. And this is the first step in moving it all in that direction.

Now, the Senator from Illinois talked about the young child with acute lymphoblastic leukemia. We have moved to where we have about an 80-percent cure rate with that right now. We did not do that through the Government; we did that through the private sector. But he also noted that he did get this care. He did get chemotherapy. He did get it. So the other point that needs to be made about—the system we have now is shifting a quarter of a trillion dollars a year into a system because we are absorbing costs rather than giving individuals their care based on freedom.

The second point is, if we do this expansion of SCHIP, are we getting good value for what we are paying? There is a chart I want to put up that shows—these are CBO numbers. The reference to the private care comes from data about the individual health insurance market. The $1,532 comes from average of a $500 deductible added to the average premium for a private children's policy: $1,032. One in three will pay a $1,500 deductible, two will pay no deductible. So for $1,532, you can buy private coverage, but with this bill we are talking about spending $3,950 for government care for the same thing. That expense will be charged to your children and your grandchildren. I think it is probably not a great deal, not great value, for us to do it this way.

The other thing the Senator from Illinois recognized is that he wanted everybody to have insurance. All he has to do is cosponsor the Burr-Corker bill because that gives everybody in this country, if you are an individual, a $2,160 tax credit, refundable flat tax credit. If you are a family, it gives a $5,400 refundable tax credit.

Now, what does that mean? If you are earning $61,950, a bureaucrat is going to decide what your health care is and who your doctor is going to be and whether or not you have care versus you deciding. It is about freedom to choose.

So the Senator from Illinois can have every one of the desires he listed and meet every one of the goals by us equalizing the benefit under the Tax Code for all of us. That means it does not matter if you are rich or poor; you get the same treatment under the Tax Code. In other words, we are going to guarantee 100 percent universal access for everybody in this country, and it is not going to cost a penny.

The other thing this debate is about is, Do we really want to have a debate in this country on health care? If we do, let's have a total debate.

Mr. President, so this debate is about whether we get value, this debate is about whether we really are going to fix health care, and finally, this debate is about the dishonesty in this bill about how it is paid for. And what we are doing—you saw Senator GREGG with the chart out here. We are going to assume that in year 6, the cost of this is $3.5 billion, but the new program is 12. There has never been a program that is going to go down from that. So rather than violate their own rules, they cut it down and said it does not exist at the same level for the second 5 years of this authorization. That is exactly what America has come to expect of us—being intellectually dishonest with them about the true costs of programs.

So, as Senator GREGG said, the debate really is about the starting of the debate, about what we are going to do in health care. We have good health care. We have 43.6 million Americans who do not have it. This bill purports to put 3.3 million of them on SCHIP. The only problem with that is 1.1 million of them have insurance now, so there is a double cost. So we got back to the $3,900, which is what the American taxpayer, one way or the other, is going to pay for $1,532 worth of care. How does that make sense? It makes sense only if you are moving in a direction to have the Government run it all.

So if you want the personal freedom to be able to choose what your health care should be and you want the Government to equalize the tax basis under which we all receive care so that everybody gets the same benefit—not the wealthy, one, and the poor, a different one; the difference is $2,700 if you are well off and $102 if you are not—that is how the Tax Code discriminates against you now. What we do and what we suggest is everybody gets the same treatment. And what happens is, under this bill, CBO scores that it will add maybe 3.3 million kids. Under the Burr-Corker, we add 24 million people in coverage over the first 10 years of that program, according to JCT.

So if this is about covering all of the children and about covering those who do not have health care, we ought to be addressing it in a totally different way. We ought to be saying we want a universal flat tax credit that is refundable to everyone in this country so they can all have access.

Senator WYDEN has proposed that on the other side with some minor differences in what we are suggesting through the Burr-Corker bill. But the fact is, you cannot have it both ways. Which way is better? Do you want the freedom to choose or do you want an organization that right now has proven to be terribly incompetent?

Some statistics about the incompetence: the doctor shortage in this country 15 years from now is going to be 200,000 doctors. Why is that? Why are the best and brightest not going into medicine today?

Why is that? It is the same reason that you see all the European single-payer systems moving toward what we have, as we try to move toward them. We are going in exactly the opposite direction. The reason is, by the time you finish 12 years of college and graduate and postgraduate and post-postgraduate education, you can't earn enough under Medicare or Medicaid to even repay your loans. So what is happening is, our best and brightest, instead of going into medicine, are going into other areas where they can be remunerated for their investment in education. This drives us further that away.

What is the statistic behind it? Fifty percent of the doctors don't see Medicare or Medicaid patients now. If you move to a new city and you are on Medicare, good luck on finding a new Medicare doctor. Why? Because the reimbursement is about 50 percent of what they can earn seeing somebody who is not on Medicare. So we will have a shrinking number of doctors, a government-run program that is going to control cost by saying, as the Senator from North Dakota said: Here is the amount of money. Guess what. We are not paying for it. It is going to get rationed. That is exactly what is going to happen to us. Consequently, we are going to take the best health care system in the world, with all its defects, and we are going to turn it on its ear. We are going to take the system that develops 80 percent of all new innovations in health care and run it away.

Example: M.D. Anderson Clinic spends more on research in health care than all of Canada. Think about that. One private outfit in this country spends more than the whole nation of Canada on health research. Why? Because we have a system that rewards innovation. We are going to kill that system. We are going to destroy it. The question is not whether children ought to be covered. Sure, they should. But so should their parents and everybody else but not in a way that destroys the system. The system will work if we create access for everyone. The system will work without raising a tax dollar to anybody. We will give everyone free choice to have what is best for them.

The numbers don't lie. If you doubt what I am saying about this being a step toward national health care, here is what they say. Question: Is this the first step toward a government-run, bureaucratic-controlled single-payer health care system? Senate Finance Committee: Absolutely not.

Now let's hear what the chairman said:

> We're the only country in the industrialized world that does not have universal coverage. I think the Children's Health Insurance Program is another step to move toward universal coverage.

AKA government-run health care in this country. So the system that gives us great innovation, that creates 80 percent of the new drugs, new techniques, new technologies, we are going to poke our finger in its eye because of what it has done.

We heard the Senator from Illinois say all the big businesses want to solve this. They have made commitments to health care. They now want to dump on the American public rather than on their shareholders. General Motors, Ford, Chrysler, they want us to pay for it. They had an obligation for it. They took plenty of bonuses when the profits were good. Now they want you as taxpayers to pay for it. That is why all the Governors want the SCHIP program, because it is going to expand their ability to solve their other budget problems. But what we are charged with is doing what is best for the country in the long run. I will promise you, a government-run, bureaucratic-controlled health care system is not the best thing for this country. And that is what we will get. What we to have do is go back and use a little common sense and look at what is happening.

In my State of Oklahoma, we have 117,000 kids on SCHIP. Oklahoma chose to make it a Medicaid expansion. The problem is, Medicaid doesn't pay enough so kids can't get access in Oklahoma under the rates which they pay. So have we given children access? We have a SCHIP program. Can they get care on a timely basis, can they get the same thing somebody through a private insurance firm can get? No. Is that the kind of care we want? I want everybody to have the same access. I don't want a Medicaid stamp on anybody's forehead. I want them to be treated equally under the Tax Code so they have exactly the same opportunity for access to care that the richest or the best union member or the best business offers. We can do that, but we can't do it by going in this direction.

We heard from the majority whip that we don't like kids. I don't care how much tobacco is taxed. The problem is their numbers are foolish, because we know as we raise the tax, the amount of volume goes down or it goes to the black market or it goes through Indian tribes who don't pay the Federal excise tax even though they owe it.

So what we know is the way we are going to fund this isn't going to work, but we are going to be on the hook anyhow. Except it is not us on the hook. It is your kids. The very kids we are going to insure, we are going to come back and say: By the way, you have to pay for your insurance through increased tax rates.

We should be very careful about what we are doing. I care dearly about children. I have four grandchildren, 10 and under. I look at them, and I see all the kids I have delivered through the last 20-some years. I see all the kids I have cared for, diagnosed major diseases on, treated broken bones, taken their appendix out. I look at all those, and not once were they ever turned down. The vast majority of physicians don't turn somebody down in need, but we are coming to a screeching halt. No longer can we continue to cut the incentive to have people going into the medical field. Take 200,000 doctors and see what would happen if, in fact, we had them there in the future.

The biggest problem facing hospitals today, they can't find a nurse. Why? Because the reimbursement rates are so low we can't incentivize enough people to go into nursing because they can't pay the costs to do it and the hours are terrible. You work four 12-hour shifts. You are off for 3 days, and you come back and work four 12-hour shifts. It is not a great life. So the people in medicine today, the vast majority, care deeply about kids, but they also care deeply about having some rest, having access to a normal life outside of that. My nurse added it up. During my 20 years, my average time in practicing medicine was over 80 hours a week. That is not uncommon in this country. It is not uncommon for doctors to spend 80 hours a week taking care of folks. But we are going to be short 200,000 because we are going to see less dedication because there is not the financial reward for people to invest that much time and their assets to get the education they need.

Let's talk about who is going to get on the system and who is not. Under the old system with this expansion, we are going to add 4.1 million kids. But we are going to take 2.1 million off private insurance. So in Oklahoma, I don't know what the exact numbers will be, but we are going to take kids off private insurance and then put them on a Medicaid system they can't get access to. We will feel good. We gave them insurance. We give them coverage, but they don't have access. Unless you are getting seen, it is not access.

Also under the new system, the newly eligible, they will add 600,000 kids, but there is a 1-for-1 trade. We will take 600,000 off private insurance. So tell me what we are doing? We are shrinking the pie so that the cost for everybody in private insurance is going to go up. That is what is going to happen. We are going to move it over to a government-run system that doesn't reimburse at a rate to give you access. Why would we do that? Why would we pay 2.5 times what it costs to get it in the private sector?

There are a lot of changes that need to happen in health care. We need to complete transparency as far as price

and quality so you as a consumer can make a decision. I am for that. We need true insurance market reform so that instead of big health insurance companies taking 40 percent of the premium dollars you pay and keeping it through administration of profits, we actually put it into health care.

We need a change in the insurance industry, where a bureaucrat sitting at a computer, either at Medicaid, Medicare or an insurance firm, isn't denying your care because they have never put their hands on you to say you need this or not.

What we are talking about is giving individuals the freedom to handle their own health care, the freedom to choose, the security to know that through this tax credit, everyone will have access in this country, no matter who you are, no matter what you make. You are equal footing with everybody else.

When the majority whip comes out and says that is what he wants, my challenge to him is, sign on to the Burr-Corker bill. That is exactly what it does. It gives equal access to everyone. Instead of an additional 130,000 kids in Illinois, he will have all the kids covered. Instead of the adults who are not covered in Illinois, he will have them all covered. He would not raise taxes on a soul. Will it shift some? Sure.

The question is, are our kids worth it? That is the question that has been raised by the Finance Committee and Senator DURBIN and those who have spoken. I say they are. But if you go back to the numbers, which is $3,950, and you apply that and you take the 4.2 million children, we could cover all of the uninsured children if we did it at the cost of the private sector right now. If we said we will take the same amount of money we are going to spend under the SCHIP program and we will buy them all a private policy, we can cover every kid who is not covered today because we spend 2.5 times more doing a government program than the same thing you can do on your own in the private sector. Why wouldn't we do that?

We wouldn't do that because this is the first step in moving toward universal, government-run, bureaucratic-controlled health care.

One other point I wish to make. We have a Medicaid program today. We have a SCHIP program today. There are 680,000 kids right now who are not covered who are eligible for those programs. Tell me how effective we are at covering those 680,000 kids. They are eligible, but we don't have them? That is because of the failure of the Government bureaucracy to fully get a benefit out to those who are deserving of the benefit. So what do we do? We are going to go in the opposite direction.

The other important point is, what SCHIP does is separate you from your family. If you make $60,900 in this country—that is higher than the average family income in 21 of our States—your child is going to be eligible for SCHIP. So your child is going to go on SCHIP. They will have a different insurance plan than you. They will have different doctors. There is not going to be a family doctor who cares for the whole family. The child will have one, and the parents will have a different one. We will separate them and divide them. We are going to totally separate them. Then guess what is going to happen. Parents are saying: I could put my kid on SCHIP, and I will get a decline in my premium. But it would not decline because we would not have done any insurance market reform. We will not have created a competitive market where they have to bid for your care. We will not have done what we need to do to fix health care.

So I welcome this debate. This is a debate we ought to have in this country. Health care is important, and it is one of the things that is limiting our competition. But the reason it is limiting competition is because we aren't investing in prevention and nearly $1 out of every $3 spent in health care does not go toward helping anybody get well. The reason it is that way is because we have the Government in the middle of the market. We are about to make that worse.

What we do know in this country is markets work. Individuals in this country figure out how to buy a car that is good for them. They figure out how to buy auto insurance. They figure out how to buy homeowners insurance. But we assume if we give everybody a level playing field, they are not capable. How arrogant of us. Markets work.

What we will see is this $250 billion—this quarter of a trillion dollars in transfer payments, cost shifting—go completely out. The $250 billion will drop everybody's insurance cost in this country by $1,000 per person. So not only will we insure everybody who is not insured, we will lower their cost of insurance by $1,000, by eliminating the cost shifting, and we are paying for that already. So we will have great benefits if, in fact, we move to a true competitive market.

The last thing I will say is, if we do a tax credit—a flat tax credit, a refundable tax credit—it keeps families together. It keeps mama and papa and brothers and sisters going to the same clinic, with the same doctors, with constancy of care, knowledge of their history, knowledge that is important in terms of giving great care.

I look forward to this debate. I plan on being on the floor. I plan on asking questions. The fact is, this is the issue this country is dealing with both in terms of how hard it is to get health care in this country and how expensive it is. There are two ways of solving it. One says the Government is going to run it and the bureaucrats are going to control it and we are going to control the costs by rationing the care. The other way says we are going to let vibrant markets create transparent information and competition that lowers the cost and increases the quality for everybody. On the way, we are not going to be inefficient in the way we spend money, spending $3,950 for $1,500 worth of product. That is what we typically do up here. There is no reason we should do that again.

LEGISLATIVE TRANSPARENCY AND ACCOUNTABILITY ACT OF 2007

Mr. REID. I ask that the Chair lay before the Senate the message from the House on S. 1, the lobbying reform bill.

The Presiding Officer laid before the Senate the following message from the House of Representatives:

Resolved that the bill from the Senate (S. 1) entitled ''An Act to Provide Greater Transparency in the Legislative Process'' do pass with an amendment:

S. 1

Resolved, That the bill from the Senate (S. 1) entitled ''An Act to provide greater transparency in the legislative process'', do pass with the following amendment:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Honest Leadership and Open Government Act of 2007''.

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

Sec. 1. Short title and table of contents.

TITLE I—CLOSING THE REVOLVING DOOR

Sec. 101. Amendments to restrictions on former officers, employees, and elected officials of the executive and legislative branches.

Sec. 102. Wrongfully influencing a private entity's employment decisions or practices.

Sec. 103. Notification of post-employment restrictions.

Sec. 104. Exception to restrictions on former officers, employees, and elected officials of the executive and legislative branch.

Sec. 105. Effective date.

TITLE II—FULL PUBLIC DISCLOSURE OF LOBBYING

Sec. 201. Quarterly filing of lobbying disclosure reports.

Sec. 202. Additional disclosure.

Sec. 203. Semiannual reports on certain contributions.

Sec. 204. Disclosure of bundled contributions.

Sec. 205. Electronic filing of lobbying disclosure reports.

Sec. 206. Prohibition on provision of gifts or travel by registered lobbyists to Members of Congress and to congressional employees.

Sec. 207. Disclosure of lobbying activities by certain coalitions and associations.

Sec. 208. Disclosure by registered lobbyists of past executive branch and congressional employment.

Sec. 209. Public availability of lobbying disclosure information; maintenance of information.

Sec. 210. Disclosure of enforcement for noncompliance.

Sec. 211. Increased civil and criminal penalties for failure to comply with lobbying disclosure requirements.

Sec. 212. Electronic filing and public database for lobbyists for foreign governments.

Sec. 213. Comptroller General audit and annual report.

Sec. 214. Sense of Congress.
Sec. 215. Effective date.
TITLE III—MATTERS RELATING TO THE HOUSE OF REPRESENTATIVES
Sec. 301. Disclosure by Members and staff of employment negotiations.
Sec. 302. Prohibition on lobbying contacts with spouse of Member who is a registered lobbyist.
Sec. 303. Treatment of firms and other businesses whose members serve as House committee consultants.
Sec. 304. Posting of travel and financial disclosure reports on public website of Clerk of the House of Representatives.
Sec. 305. Prohibiting participation in lobbyist-sponsored events during political conventions.
Sec. 306. Exercise of rulemaking Authority.
TITLE IV—CONGRESSIONAL PENSION ACCOUNTABILITY
Sec. 401. Loss of pensions accrued during service as a Member of Congress for abusing the public trust.
TITLE V—SENATE LEGISLATIVE TRANSPARENCY AND ACCOUNTABILITY
Subtitle A—Procedural Reform
Sec. 511. Amendments to rule XXVIII.
Sec. 512. Notice of objecting to proceeding.
Sec. 513. Public availability of Senate committee and subcommittee meetings.
Sec. 514. Amendments and motions to recommit.
Sec. 515. Sense of the Senate on conference committee protocols.
Subtitle B—Earmark Reform
Sec. 521. Congressionally directed spending.
Subtitle C—Revolving Door Reform
Sec. 531. Post-employment restrictions.
Sec. 532. Disclosure by Members of Congress and staff of employment negotiations.
Sec. 533. Elimination of floor privileges for former Members, Senate officers, and Speakers of the House who are registered lobbyists or seek financial gain.
Sec. 534. Influencing hiring decisions.
Sec. 535. Notification of post-employment restrictions.
Subtitle D—Gift and Travel Reform
Sec. 541. Ban on gifts from registered lobbyists and entities that hire registered lobbyists.
Sec. 542. National party conventions.
Sec. 543. Proper valuation of tickets to entertainment and sporting events.
Sec. 544. Restrictions on registered lobbyist participation in travel and disclosure.
Sec. 545. Free attendance at a constituent event.
Sec. 546. Senate privately paid travel public website.
Subtitle E—Other Reforms
Sec. 551. Compliance with lobbying disclosure.
Sec. 552. Prohibit official contact with spouse or immediate family member of Member who is a registered lobbyist.
Sec. 553. Mandatory Senate ethics training for Members and staff.
Sec. 554. Annual report by Select Committee on Ethics.
Sec. 555. Exercise of rulemaking powers.
Sec. 555. Effective date and general provisions.
TITLE VI—PROHIBITED USE OF PRIVATE AIRCRAFT
Sec. 601. Restrictions on Use of Campaign Funds for Flights on Noncommercial Aircraft.
TITLE VII—MISCELLANEOUS PROVISIONS
Sec. 701. Sense of the Congress that any applicable restrictions on congressional officials and employees should apply to the executive and judicial branches.
Sec. 702. Knowing and willful falsification or failure to report.
Sec. 703. Rule of construction.

TITLE I—CLOSING THE REVOLVING DOOR

SEC. 101. AMENDMENTS TO RESTRICTIONS ON FORMER OFFICERS, EMPLOYEES, AND ELECTED OFFICIALS OF THE EXECUTIVE AND LEGISLATIVE BRANCHES.

(a) VERY SENIOR EXECUTIVE PERSONNEL.—The matter after subparagraph (C) in section 207(d)(1) of title 18, United States Code, is amended by striking ''within 1 year'' and inserting ''within 2 years''.

(b) RESTRICTIONS ON LOBBYING BY MEMBERS OF CONGRESS AND EMPLOYEES OF CONGRESS.—Subsection (e) of section 207 of title 18, United States Code, is amended—

(1) by redesignating paragraph (7) as paragraph (9);

(2) by redesignating paragraphs (2) through (6) as paragraphs (3) through (7), respectively;

(3) by striking paragraph (1) and inserting the following:

''(1) MEMBERS OF CONGRESS AND ELECTED OFFICERS OF THE HOUSE.—

''(A) SENATORS.—Any person who is a Senator and who, within 2 years after that person leaves office, knowingly makes, with the intent to influence, any communication to or appearance before any Member, officer, or employee of either House of Congress or any employee of any other legislative office of the Congress, on behalf of any other person (except the United States) in connection with any matter on which such former Senator seeks action by a Member, officer, or employee of either House of Congress, in his or her official capacity, shall be punished as provided in section 216 of this title.

''(B) MEMBERS AND OFFICERS OF THE HOUSE OF REPRESENTATIVES.—(i) Any person who is a Member of the House of Representatives or an elected officer of the House of Representatives and who, within 1 year after that person leaves office, knowingly makes, with the intent to influence, any communication to or appearance before any of the persons described in clause (ii) or (iii), on behalf of any other person (except the United States) in connection with any matter on which such former Member of Congress or elected officer seeks action by a Member, officer, or employee of either House of Congress, in his or her official capacity, shall be punished as provided in section 216 of this title.

''(ii) The persons referred to in clause (i) with respect to appearances or communications by a former Member of the House of Representatives are any Member, officer, or employee of either House of Congress and any employee of any other legislative office of the Congress.

''(iii) The persons referred to in clause (i) with respect to appearances or communications by a former elected officer are any Member, officer, or employee of the House of Representatives.

''(2) OFFICERS AND STAFF OF THE SENATE.—Any person who is an elected officer of the Senate, or an employee of the Senate to whom paragraph (7)(A) applies, and who, within 1 year after that person leaves office or employment, knowingly makes, with the intent to influence, any communication to or appearance before any Senator or any officer or employee of the Senate, on behalf of any other person (except the United States) in connection with any matter on which such former elected officer or former employee seeks action by a Senator or an officer or employee of the Senate, in his or her official capacity, shall be punished as provided in section 216 of this title.'';

(4) in paragraph (3) (as redesignated by paragraph (2) of this subsection)—

(A) in subparagraph (A), by striking ''of a Senator or an employee of a Member of the House of Representatives'' and inserting ''of a Member of the House of Representatives to whom paragraph (7)(A) applies''; and

(B) in subparagraph (B)—

(i) in clause (i), by striking ''Senator or''; and

(ii) in clause (ii), by striking ''Senator or'';

(5) in paragraph (4) (as redesignated by paragraph (2) of this subsection)—

(A) by striking ''committee of Congress'' and inserting ''committee of the House of Representatives, or an employee of a joint committee of the Congress whose pay is disbursed by the Clerk of the House of Representatives, to whom paragraph (7)(A) applies''; and

(B) by inserting ''or joint committee (as the case may be)'' after ''committee'' each subsequent place that term appears;

(6) in paragraph (5) (as redesignated by paragraph (2) of this subsection)—

(A) in subparagraph (A), by striking ''or an employee on the leadership staff of the Senate'' and inserting ''to whom paragraph (7)(A) applies'' ; and

(B) in subparagraph (B), by striking ''the following:'' and all that follows through the end of clause (ii) and inserting ''any Member of the leadership of the House of Representatives and any employee on the leadership staff of the House of Representatives.'';

(7) in paragraph (6)(A) (as redesignated by paragraph (2) of this subsection), by inserting ''to whom paragraph (7)(B) applies'' after ''office of the Congress'';

(8) in paragraph (7) (as redesignated by paragraph (2) of this subsection)—

(A) in subparagraph (A), by striking ''and (4)'' and inserting ''(4), and (5)''; and

(B) in subparagraph (B)—

(i) by striking ''(5)'' and inserting ''(6)'';

(ii) in subparagraph (B), by striking ''(or any comparable adjustment pursuant to interim authority of the President)''; and

(iii) by striking ''level 5 of the Senior Executive Service'' and inserting ''level IV of the Executive Schedule'';

(9) by inserting after paragraph (7) (as redesignated by paragraph (2) of this subsection) the following:

''(8) EXCEPTION.—This subsection shall not apply to contacts with the staff of the Secretary of the Senate or the Clerk of the House of Representatives regarding compliance with lobbying disclosure requirements under the Lobbying Disclosure Act of 1995.'' ; and

(10) in paragraph (9)(G) (as redesignated by paragraph (1) of this subsection)—

(A) by striking ''the Copyright Royalty Tribunal,''; and

(B) by striking ''or (4)'' and inserting ''(4), or (5)''.

SEC. 102. WRONGFULLY INFLUENCING A PRIVATE ENTITY'S EMPLOYMENT DECISIONS OR PRACTICES.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''§ 227. Wrongfully influencing a private entity's employment decisions by a Member of Congress

''Whoever, being a Senator or Representative in, or a Delegate or Resident Commissioner to, the Congress or an employee of either House of Congress, with the intent to influence, solely on the basis of partisan political affiliation, an employment decision or employment practice of any private entity—

''(1) takes or withholds, or offers or threatens to take or withhold, an official act, or

''(2) influences, or offers or threatens to influence, the official act of another,

shall be fined under this title or imprisoned for not more than 15 years, or both, and may be disqualified from holding any office of honor, trust, or profit under the United States.''.

(b) NO INFERENCE.—Nothing in section 227 of title 18, United States Code, as added by this section, shall be construed to create any inference with respect to whether the activity described in section 227 of title 18, United States Code, was a criminal or civil offense before the enactment of this Act, including under section 201(b), 201(c), any of sections 203 through 209, or section 872, of title 18, United States Code.

(c) CONFORMING AMENDMENT.—The table of sections for chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''227. Wrongfully influencing a private entity's employment decisions by a Member of Congress.''.

SEC. 103. NOTIFICATION OF POST-EMPLOYMENT RESTRICTIONS.

(a) NOTIFICATION OF POST-EMPLOYMENT RESTRICTIONS.—After a Member of Congress or an elected officer of either House of Congress leaves office, or after the termination of employment with the House of Representatives or the Senate of an employee who is covered under paragraph (2), (3), (4), or (5) of section 207(e) of title 18, United States Code, the Clerk of the House of Representatives, after consultation with the Committee on Standards of Official Conduct, or the Secretary of the Senate, as the case may be, shall notify the Member, officer, or employee of the beginning and ending date of the prohibitions that apply to the Member, officer, or employee under section 207(e) of that title.

(b) POSTING ON INTERNET.—The Clerk of the House of Representatives, with respect to notifications under subsection (a) relating to Members, officers, and employees of the House, and the Secretary of the Senate, with respect to such notifications relating to Members, officers, and employees of the Senate, shall post the information contained in such notifications on the public Internet site of the Office of the Clerk or the Secretary of the Senate, as the case may be, in a format that, to the extent technically practicable, is searchable, sortable, and downloadable.

SEC. 104. EXCEPTION TO RESTRICTIONS ON FORMER OFFICERS, EMPLOYEES, AND ELECTED OFFICIALS OF THE EXECUTIVE AND LEGISLATIVE BRANCH.

(a) IN GENERAL.—Section 207(j)(1) of title 18, United States Code, is amended—

(1) by striking ''The restrictions'' and inserting the following:

''(A) IN GENERAL.—The restrictions'';

(2) by moving the remaining text 2 ems to the right; and

(3) by adding at the end the following:

''(B) TRIBAL ORGANIZATIONS AND INTER-TRIBAL CONSORTIUMS.—The restrictions contained in this section shall not apply to acts authorized by section 104(j) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450i(j)).''.

(b) CONFORMING AMENDMENT.—Section 104(j) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450i(j)) is amended to read as follows:

''(j) Anything in sections 205 and 207 of title 18, United States Code, to the contrary notwithstanding—

''(1) an officer or employee of the United States assigned to a tribal organization (as defined in section 4(l)) or an inter-tribal consortium (as defined in section 501), as authorized under section 3372 of title 5, United States Code, or section 2072 of the Revised Statutes (25 U.S.C. 48) may act as agent or attorney for, and appear on behalf of, such tribal organization or inter-tribal consortium in connection with any matter related to a tribal governmental activity or Federal Indian program or service pending before any department, agency, court, or commission, including any matter in which the United States is a party or has a direct and substantial interest: Provided, That such officer or employee must advise in writing the head of the department, agency, court, or commission with which the officer or employee is dealing or appearing on behalf of the tribal organization or inter-tribal consortium of any personal and substantial involvement with the matter involved; and

''(2) a former officer or employee of the United States who is carrying out official duties as an employee or as an elected or appointed official of a tribal organization (as defined in section 4(l)) or inter-tribal consortium (as defined in section 501) may act as agent or attorney for, and appear on behalf of, such tribal organization or intra-tribal consortium in connection with any matter related to a tribal governmental activity or Federal Indian program or service pending before any department, agency, court, or commission, including any matter in which the United States is a party or has a direct and substantial interest: Provided, That such former officer or employee must advise in writing the head of the department, agency, court, or commission with which the former officer or employee is dealing or appearing on behalf of the tribal organization or inter-tribal consortium of any personal and substantial involvement the he or she may have had as an officer or employee of the United States in connection with the matter involved.''.

(c) EFFECT OF SECTION.—Except as expressly identified in this section and in the amendments made by this section, nothing in this section or the amendments made by this section affects any other provision of law.

SEC. 105. EFFECTIVE DATE.

(a) SECTION 101.—The amendments made by section 101 shall apply to individuals who leave Federal office or employment to which such amendments apply on or after the date of adjournment of the first session of the 110th Congress sine die or December 31, 2007, whichever date is earlier.

(b) SECTION 102.—The amendments made by section 102 shall take effect on the date of the enactment of this Act.

(c) SECTION 103.—

(1) NOTIFICATION OF POST-EMPLOYMENT RESTRICTIONS.—Subsection (a) of section 103 shall take effect on the 60th day after the date of the enactment of this Act.

(2) POSTING OF INFORMATION.—Subsection (b) of section 103 shall take effect January 1, 2008, except that the Secretary of the Senate and the Clerk of the House of Representatives shall post the information contained in notifications required by that subsection that are made on or after the effective date provided under paragraph (1) of this subsection.

(d) SECTION 104.—The amendments made by section 104 shall take effect on the date of the enactment of this Act, except that section 104(j)(2) of the Indian Self-Determination and Education Assistance Act (as amended by section 104(b)) shall apply to individuals who leave Federal office or employment to which such amendments apply on or after the 60th day after the date of the enactment of this Act.

TITLE II—FULL PUBLIC DISCLOSURE OF LOBBYING

SEC. 201. QUARTERLY FILING OF LOBBYING DISCLOSURE REPORTS.

(a) QUARTERLY FILING REQUIRED.—Section 5 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1604) is amended—

(1) in subsection (a)—

(A) by striking ''SEMIANNUAL'' and inserting ''QUARTERLY'';

(B) by striking ''45 days'' and all that follows through ''section 4,'' and inserting ''20 days after the end of the quarterly period beginning on the first day of January, April, July, and October of each year in which a registrant is registered under section 4, or on the first business day after such 20th day if the 20th day is not a business day,''; and

(C) by striking ''such semiannual period'' and inserting ''such quarterly period''; and

(2) in subsection (b)—

(A) in the matter preceding paragraph (1), by striking ''semiannual report'' and inserting ''quarterly report'';

(B) in paragraph (2), by striking ''semiannual filing period'' and inserting ''quarterly period'';

(C) in paragraph (3), by striking ''semiannual period'' and inserting ''quarterly period''; and

(D) in paragraph (4), by striking ''semiannual filing period'' and inserting ''quarterly period''.

(b) CONFORMING AMENDMENTS.—

(1) DEFINITION.—Section 3(10) of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1602) is amended by striking ''six month period'' and inserting ''3-month period''.

(2) REGISTRATION.—Section 4 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1603) is amended—

(A) in subsection (a)(1), by inserting after ''earlier,'' the following: ''or on the first business day after such 45th day if the 45th day is not a business day,'' ; and

(B) in subsection (a)(3)(A), by striking ''semiannual period'' and inserting ''quarterly period''.

(3) ENFORCEMENT.—Section 6 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1605) is amended in paragraph (6) by striking ''semiannual period'' and inserting ''quarterly period''.

(4) ESTIMATES.—Section 15 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1610) is amended—

(A) in subsection (a)(1), by striking ''semiannual period'' and inserting ''quarterly period''; and

(B) in subsection (b)(1), by striking ''semiannual period'' and inserting ''quarterly period''.

(5) DOLLAR AMOUNTS.—Section 4 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1603) is further amended—

(A) in subsection (a)(3)(A)(i), by striking ''$5,000'' and inserting ''$2,500'';

(B) in subsection (a)(3)(A)(ii), by striking ''$20,000'' and inserting ''$10,000'';

(C) in subsection (b)(3)(A), by striking ''$10,000'' and inserting ''$5,000''; and

(D) in subsection (b)(4), by striking ''$10,000'' and inserting ''$5,000''.

(6) REPORTS.—Section 5(c) of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1604(c)) is further amended—

(A) in paragraph (1), by striking ''$10,000'' and ''$20,000'' and inserting ''$5,000'' and ''$10,000'', respectively; and

(B) in paragraph (2), by striking ''$10,000'' both places such term appears and inserting ''$5,000''.

SEC. 202. ADDITIONAL DISCLOSURE.

Section 5(b) of The Lobbying Disclosure Act of 1995 (2 U.S.C. 1604(b)) is amended—

(1) in paragraph (3), by striking ''and'' after the semicolon;

(2) in paragraph (4), by striking the period and inserting ''; and''; and

(3) by adding at the end of the following:

''(5) for each client, immediately after listing the client, an identification of whether the client is a State or local government or a department, agency, special purpose district, or other instrumentality controlled by one or more State or local governments.''.

SEC. 203. SEMIANNUAL REPORTS ON CERTAIN CONTRIBUTIONS.

(a) OTHER CONTRIBUTIONS.—Section 5 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1604) is further amended by adding at the end the following:

''(d) SEMIANNUAL REPORTS ON CERTAIN CONTRIBUTIONS.—

''(1) IN GENERAL.—Not later than 30 days after the end of the semiannual period beginning on the first day of January and July of each year, or on the first business day after such 30th day if the 30th day is not a business day, each person or organization who is registered or is required to register under paragraph (1) or (2) of section 4(a), and each employee who is or is required to be listed as a lobbyist under section 4(b)(6) or subsection (b)(2)(C) of this section, shall file a report with the Secretary of the Senate and the Clerk of the House of Representatives containing—

''(A) the name of the person or organization;

''(B) in the case of an employee, his or her employer;

''(C) the names of all political committees established or controlled by the person or organization;

''(D) the name of each Federal candidate or officeholder, leadership PAC, or political party committee, to whom aggregate contributions equal to or exceeding $200 were made by the person or organization, or a political committee established or controlled by the person or organization within the semiannual period, and the date and amount of each such contribution made within the semiannual period;

''(E) the date, recipient, and amount of funds contributed or disbursed during the semiannual period by the person or organization or a political committee established or controlled by the person or organization—

''(i) to pay the cost of an event to honor or recognize a covered legislative branch official or covered executive branch official;

''(ii) to an entity that is named for a covered legislative branch official, or to a person or entity in recognition of such official;

''(iii) to an entity established, financed, maintained, or controlled by a covered legislative branch official or covered executive branch official, or an entity designated by such official; or

''(iv) to pay the costs of a meeting, retreat, conference, or other similar event held by, or in the name of, 1 or more covered legislative branch officials or covered executive branch officials,

except that this subparagraph shall not apply if the funds are provided to a person who is required to report the receipt of the funds under section 304 of the Federal Election Campaign Act of 1971 (2 U.S.C. 434);

''(F) the name of each Presidential library foundation, and each Presidential inaugural committee, to whom contributions equal to or exceeding $200 were made by the person or organization, or a political committee established or controlled by the person or organization, within the semiannual period, and the date and amount of each such contribution within the semiannual period; and

''(G) a certification by the person or organization filing the report that the person or organization—

''(i) has read and is familiar with those provisions of the Standing Rules of the Senate and the Rules of the House of Representatives relating to the provision of gifts and travel; and

''(ii) has not provided, requested, or directed a gift, including travel, to a Member of Congress or an officer or employee of either House of Congress with knowledge that receipt of the gift would violate rule XXXV of the Standing Rules of the Senate or rule XXV of the Rules of the House of Representatives.

''(2) DEFINITION.—In this subsection, the term 'leadership PAC' has the meaning given such term in section 304(i)(8)(B) of the Federal Election Campaign Act of 1971.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to the first semiannual period described in section 5(d)(1) of the Lobbying Disclosure Act of 1995 (as added by this section) that begins after the date of the enactment of this Act and each succeeding semiannual period.

(c) REPORT ON REQUIRING QUARTERLY REPORTS.—The Clerk of the House of Representatives and the Secretary of the Senate shall submit a report to the Congress, not later than 1 year after the date on which the first reports are required to be made under section 5(d) of the Lobbying Disclosure Act of 1995 (as added by this section), on the feasibility of requiring the reports under such section 5(d) to be made on a quarterly, rather than a semiannual, basis.

(d) SENSE OF CONGRESS.—It is the sense of the Congress that after the end of the 2-year period beginning on the day on which the amendment made by subsection (a) of this section first applies, the reports required under section 5(d) of the Lobbying Disclosure Act of 1995 (as added by this section) should be made on a quarterly basis if it is practicably feasible to do so.

SEC. 204. DISCLOSURE OF BUNDLED CONTRIBUTIONS.

(a) DISCLOSURE.—Section 304 of the Federal Election Campaign Act of 1971 (2 U.S.C. 434) is amended by adding at the end the following new subsection:

''(i) DISCLOSURE OF BUNDLED CONTRIBUTIONS.—

''(1) REQUIRED DISCLOSURE.—Each committee described in paragraph (6) shall include in the first report required to be filed under this section after each covered period (as defined in paragraph (2)) a separate schedule setting forth the name, address, and employer of each person reasonably known by the committee to be a person described in paragraph (7) who provided 2 or more bundled contributions to the committee in an aggregate amount greater than the applicable threshold (as defined in paragraph (3)) during the covered period, and the aggregate amount of the bundled contributions provided by each such person during the covered period.

''(2) COVERED PERIOD.—In this subsection, a 'covered period' means, with respect to a committee—

''(A) the period beginning January 1 and ending June 30 of each year;

''(B) the period beginning July 1 and ending December 31 of each year; and

''(C) any reporting period applicable to the committee under this section during which any person described in paragraph (7) provided 2 or more bundled contributions to the committee in an aggregate amount greater than the applicable threshold.

''(3) APPLICABLE THRESHOLD.—

''(A) IN GENERAL.—In this subsection, the 'applicable threshold' is $15,000, except that in determining whether the amount of bundled contributions provided to a committee by a person described in paragraph (7) exceeds the applicable threshold, there shall be excluded any contribution made to the committee by the person or the person's spouse.

''(B) INDEXING.—In any calendar year after 2007, section 315(c)(1)(B) shall apply to the amount applicable under subparagraph (A) in the same manner as such section applies to the limitations established under subsections (a)(1)(A), (a)(1)(B), (a)(3), and (h) of such section, except that for purposes of applying such section to the amount applicable under subparagraph (A), the 'base period' shall be 2006.

''(4) PUBLIC AVAILABILITY.—The Commission shall ensure that, to the greatest extent practicable—

''(A) information required to be disclosed under this subsection is publicly available through the Commission website in a manner that is searchable, sortable, and downloadable; and

''(B) the Commission's public database containing information disclosed under this subsection is linked electronically to the websites maintained by the Secretary of the Senate and the Clerk of the House of Representatives containing information filed pursuant to the Lobbying Disclosure Act of 1995.

''(5) REGULATIONS.—Not later than 6 months after the date of enactment of the Honest Leadership and Open Government Act of 2007, the Commission shall promulgate regulations to implement this subsection. Under such regulations, the Commission—

''(A) may, notwithstanding paragraphs (1) and (2), provide for quarterly filing of the schedule described in paragraph (1) by a committee which files reports under this section more frequently than on a quarterly basis;

''(B) shall provide guidance to committees with respect to whether a person is reasonably known by a committee to be a person described in paragraph (7), which shall include a requirement that committees consult the websites maintained by the Secretary of the Senate and the Clerk of the House of Representatives containing information filed pursuant to the Lobbying Disclosure Act of 1995;

''(C) may not exempt the activity of a person described in paragraph (7) from disclosure under this subsection on the grounds that the person is authorized to engage in fundraising for the committee or any other similar grounds; and

''(D) shall provide for the broadest possible disclosure of activities described in this subsection by persons described in paragraph (7) that is consistent with this subsection.

''(6) COMMITTEES DESCRIBED.—A committee described in this paragraph is an authorized committee of a candidate, a leadership PAC, or a political party committee.

''(7) PERSONS DESCRIBED.—A person described in this paragraph is any person, who, at the time a contribution is forwarded to a committee as described in paragraph (8)(A)(i) or is received by a committee as described in paragraph (8)(A)(ii), is—

''(A) a current registrant under section 4(a) of the Lobbying Disclosure Act of 1995;

''(B) an individual who is listed on a current registration filed under section 4(b)(6) of such Act or a current report under section 5(b)(2)(C) of such Act; or

''(C) a political committee established or controlled by such a registrant or individual.

''(8) DEFINITIONS.—For purposes of this subsection, the following definitions apply:

''(A) BUNDLED CONTRIBUTION.—The term 'bundled contribution' means, with respect to a committee described in paragraph (6) and a person described in paragraph (7), a contribution (subject to the applicable threshold) which is—

''(i) forwarded from the contributor or contributors to the committee by the person; or

''(ii) received by the committee from a contributor or contributors, but credited by the committee or candidate involved (or, in the case of a leadership PAC, by the individual referred to in subparagraph (B) involved) to the person through records, designations, or other means of recognizing that a certain amount of money has been raised by the person.

''(B) LEADERSHIP PAC.—The term 'leadership PAC' means, with respect to a candidate for election to Federal office or an individual holding Federal office, a political committee that is directly or indirectly established, financed, maintained or controlled by the candidate or the individual but which is not an authorized committee of the candidate or individual and which is not affiliated with an authorized committee of the candidate or individual, except that such term does not include a political committee of a political party.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to reports filed under section 304 of the Federal Election Campaign Act after the expiration of the 3-month period which begins on the date that the regulations required to be promulgated by the Federal Election Commission under section 304(i)(5) of such Act (as added by subsection (a)) become final.

SEC. 205. ELECTRONIC FILING OF LOBBYING DISCLOSURE REPORTS.

Section 5 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1604) is further amended by adding at the end the following:

''(e) ELECTRONIC FILING REQUIRED.—A report required to be filed under this section shall be filed in electronic form, in addition to any other form that the Secretary of the Senate or the Clerk of the House of Representatives may require or allow. The Secretary of the Senate and the Clerk of the House of Representatives shall use the same electronic software for receipt and recording of filings under this Act.''.

SEC. 206. PROHIBITION ON PROVISION OF GIFTS OR TRAVEL BY REGISTERED LOBBYISTS TO MEMBERS OF CONGRESS AND TO CONGRESSIONAL EMPLOYEES.

(a) PROHIBITION.—The Lobbying Disclosure Act of 1995 (2 U.S.C. 1601 et seq.) is amended by adding at the end the following:

"SEC. 25. PROHIBITION ON PROVISION OF GIFTS OR TRAVEL BY REGISTERED LOBBYISTS TO MEMBERS OF CONGRESS AND TO CONGRESSIONAL EMPLOYEES.

''(a) PROHIBITION.—Any person described in subsection (b) may not make a gift or provide travel to a covered legislative branch official if the person has knowledge that the gift or travel may not be accepted by that covered legislative branch official under the Rules of the House of Representatives or the Standing Rules of the Senate (as the case may be).

''(b) PERSONS SUBJECT TO PROHIBITION.—The persons subject to the prohibition under subsection (a) are any lobbyist that is registered or is required to register under section 4(a)(1), any organization that employs 1 or more lobbyists and is registered or is required to register under section 4(a)(2), and any employee listed or required to be listed as a lobbyist by a registrant under section 4(b)(6) or 5(b)(2)(C).''.

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

SEC. 207. DISCLOSURE OF LOBBYING ACTIVITIES BY CERTAIN COALITIONS AND ASSOCIATIONS.

(a) IN GENERAL.—

(1) DISCLOSURE.—Section 4(b)(3) of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1603(b)(3)) is amended—

(A) by amending subparagraph (A) to read as follows:

''(A) contributes more than $5,000 to the registrant or the client in the quarterly period to fund the lobbying activities of the registrant; and''; and

(B) by amending subparagraph (B) to read as follows:

''(B) actively participates in the planning, supervision, or control of such lobbying activities;''.

(2) UPDATING OF INFORMATION.—Section 5(b)(1) of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1604(b)(1)) is amended by inserting '', including information under section 4(b)(3)'' after ''initial registration''.

(b) NO DONOR OR MEMBERSHIP LIST DISCLOSURE.—Section 4(b) of The Lobbying Disclosure Act of 1995 (2 U.S.C. 1603(b)) is amended by adding at the end the following:

''No disclosure is required under paragraph (3)(B) if the organization that would be identified as affiliated with the client is listed on the client's publicly accessible Internet website as being a member of or contributor to the client, unless the organization in whole or in major part plans, supervises, or controls such lobbying activities. If a registrant relies upon the preceding sentence, the registrant must disclose the specific Internet address of the web page containing the information relied upon. Nothing in paragraph (3)(B) shall be construed to require the disclosure of any information about individuals who are members of, or donors to, an entity treated as a client by this Act or an organization identified under that paragraph.''.

SEC. 208. DISCLOSURE BY REGISTERED LOBBYISTS OF PAST EXECUTIVE BRANCH AND CONGRESSIONAL EMPLOYMENT.

Section 4(b)(6) of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1603(b)(6)) is amended by striking ''in the 2 years'' and all that follows through ''Act)'' and inserting ''in the 20 years before the date on which the employee first acted''.

SEC. 209. PUBLIC AVAILABILITY OF LOBBYING DISCLOSURE INFORMATION; MAINTENANCE OF INFORMATION.

(a) PUBLIC AVAILABILITY.—Section 6 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1605) is further amended—

(1) in paragraph (7), by striking ''and'' at the end;

(2) in paragraph (8), by striking the period at the end and inserting a semicolon; and

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

''(9) maintain all registrations and reports filed under this Act, and make them available to the public over the Internet, without a fee or other access charge, in a searchable, sortable, and downloadable manner, to the extent technically practicable, that—

''(A) includes the information contained in the registrations and reports;

''(B) is searchable and sortable to the maximum extent practicable, including searchable and sortable by each of the categories of information described in section 4(b) or 5(b); and

''(C) provides electronic links or other appropriate mechanisms to allow users to obtain relevant information in the database of the Federal Election Commission; and

''(10) retain the information contained in a registration or report filed under this Act for a period of 6 years after the registration or report (as the case may be) is filed.''.

(b) AVAILABILITY OF REPORTS.—Section 6(4) of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1605) is amended by inserting before the semicolon at the end the following: ''and, in the case of a report filed in electronic form under section 5(e), make such report available for public inspection over the Internet as soon as technically practicable after the report is so filed''.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out paragraph (9) of section 6 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1605), as added by subsection (a) of this section.

SEC. 210. DISCLOSURE OF ENFORCEMENT FOR NONCOMPLIANCE.

Section 6 of The Lobbying Disclosure Act of 1995 (2 U.S.C. 1605) is further amended—

(1) by striking ''The Secretary'' and inserting ''(a) IN GENERAL.—The Secretary''; ;

(2) in paragraph (9), by striking ''and'' at the end;

(3) in paragraph (10), by striking the period and inserting ''; and'';

(4) by adding after paragraph (10) the following:

''(11) make publicly available, on a semiannual basis, the aggregate number of registrants referred to the United States Attorney for the District of Columbia for noncompliance as required by paragraph (8).''; and

(5) by adding at the end the following:

''(b) ENFORCEMENT REPORT.—

''(1) REPORT.—The Attorney General shall report to the congressional committees referred to in paragraph (2), after the end of each semiannual period beginning on January 1 and July 1, the aggregate number of enforcement actions taken by the Department of Justice under this Act during that semiannual period and, by case, any sentences imposed, except that such report shall not include the names of individuals, or personally identifiable information, that is not already a matter of public record.

''(2) COMMITTEES.—The congressional committees referred to in paragraph (1) are the Committee on Homeland Security and Governmental Affairs and the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives.''.

SEC. 211. INCREASED CIVIL AND CRIMINAL PENALTIES FOR FAILURE TO COMPLY WITH LOBBYING DISCLOSURE REQUIREMENTS.

(a) IN GENERAL.—Section 7 of the Lobbying Disclosure Act of 1995 (2 U.S.C. 1606) is amended—

(1) by striking ''Whoever'' and inserting ''(a) CIVIL PENALTY.—Whoever'';

(2) by striking ''$50,000'' and inserting ''$200,000''; and

(3) by adding at the end the following:

''(b) CRIMINAL PENALTY.—Whoever knowingly and corruptly fails to comply with any provision of this Act shall be imprisoned for not more than 5 years or fined under title 18, United States Code, or both.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to any violation committed on or after the date of the enactment of this Act.

SEC. 212. ELECTRONIC FILING AND PUBLIC DATABASE FOR LOBBYISTS FOR FOREIGN GOVERNMENTS.

(a) ELECTRONIC FILING.—Section 2 of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 612), is amended by adding at the end the following new subsection:

''(g) ELECTRONIC FILING OF REGISTRATION STATEMENTS AND SUPPLEMENTS.—A registration statement or supplement required to be filed under this section shall be filed in electronic form, in addition to any other form that may be required by the Attorney General.''.

(b) PUBLIC DATABASE.—Section 6 of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 616), is amended by adding at the end the following new subsection:

''(d) PUBLIC DATABASE OF REGISTRATION STATEMENTS AND UPDATES.—

''(1) IN GENERAL.—The Attorney General shall maintain, and make available to the public over the Internet, without a fee or other access charge, in a searchable, sortable, and downloadable manner, to the extent technically practicable, an electronic database that—

''(A) includes the information contained in registration statements and updates filed under this Act; and

''(B) is searchable and sortable, at a minimum, by each of the categories of information described in section 2(a).

''(2) ACCOUNTABILITY.—The Attorney General shall make each registration statement and update filed in electronic form pursuant to section 2(g) available for public inspection over the Internet as soon as technically practicable after the registration statement or update is filed.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the 90th day after the date of the enactment of this Act.

SEC. 213. COMPTROLLER GENERAL AUDIT AND ANNUAL REPORT.

(a) ANNUAL AUDITS AND REPORTS.—The Lobbying Disclosure Act of 1995 (2 U.S.C. 1601 et seq.) is further amended by adding at the end the following:

"SEC. 26. ANNUAL AUDITS AND REPORTS BY COMPTROLLER GENERAL.

''(a) AUDIT.—On an annual basis, the Comptroller General shall audit the extent of compliance or noncompliance with the requirements of this Act by lobbyists, lobbying firms, and registrants through a random sampling of publicly available lobbying registrations and reports filed under this Act during each calendar year.

''(b) REPORTS TO CONGRESS.—

''(1) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General shall submit to the Congress a report on the review required by subsection (a) for the preceding calendar year. The report shall include the Comptroller General's assessment of the matters required to be emphasized by that subsection and any recommendations of the Comptroller General to—

''(A) improve the compliance by lobbyists, lobbying firms, and registrants with the requirements of this Act; and

''(B) provide the Department of Justice with the resources and authorities needed for the effective enforcement of this Act.

''(2) ASSESSMENT OF COMPLIANCE.—The annual report under paragraph (1) shall include an assessment of compliance by registrants with the requirements of section 4(b)(3).

''(c) ACCESS TO INFORMATION.—The Comptroller General may, in carrying out this section, request information from and access to any relevant documents from any person registered under paragraph (1) or (2) of section 4(a) and each employee who is listed as a lobbyist under section 4(b)(6) or section 5(b)(2)(C) if the material requested relates to the purposes of this section. The Comptroller General may request such

person to submit in writing such information as the Comptroller General may prescribe. The Comptroller General may notify the Congress in writing if a person from whom information has been requested under this subsection refuses to comply with the request within 45 days after the request is made.''.

(b) INITIAL AUDIT AND REPORT.—The initial audit under subsection (a) of section 26 of the Lobbying Disclosure Act of 1995 (as added by subsection (a) of this section) shall be made with respect to lobbying registrations and reports filed during the first calendar quarter of 2008, and the initial report under subsection (b) of such section shall be filed, with respect to those registrations and reports, not later than 6 months after the end of that calendar quarter.

SEC. 214. SENSE OF CONGRESS.

It is the sense of the Congress that—

(1) the use of a family relationship by a lobbyist who is an immediate family member of a Member of Congress to gain special advantages over other lobbyists is inappropriate; and

(2) the lobbying community should develop proposals for multiple self-regulatory organizations which could—

(A) provide for the creation of standards for the organizations appropriate to the type of lobbying and individuals to be served;

(B) provide training for the lobbying community on law, ethics, reporting requirements, and disclosure requirements;

(C) provide for the development of educational materials for the public on how to responsibly hire a lobbyist or lobby firm;

(D) provide standards regarding reasonable fees charged to clients;

(E) provide for the creation of a third-party certification program that includes ethics training; and

(F) provide for disclosure of requirements to clients regarding fee schedules and conflict of interest rules.

SEC. 215. EFFECTIVE DATE.

Except as otherwise provided in sections 203, 204, 206, 211, 212, and 213, the amendments made by this title shall apply with respect to registrations under the Lobbying Disclosure Act of 1995 having an effective date of January 1, 2008, or later and with respect to quarterly reports under that Act covering calendar quarters beginning on or after January 1, 2008.

TITLE III—MATTERS RELATING TO THE HOUSE OF REPRESENTATIVES

SEC. 301. DISCLOSURE BY MEMBERS AND STAFF OF EMPLOYMENT NEGOTIATIONS.

(a) IN GENERAL.—The Rules of the House of Representatives are amended by redesignating rules XXVII and XXVIII as rules XXVIII and XXIX, respectively, and by inserting after rule XXVI the following new rule:

''RULE XXVII

''DISCLOSURE BY MEMBERS AND STAFF OF EMPLOYMENT NEGOTIATIONS

''1. A Member, Delegate, or Resident Commissioner shall not directly negotiate or have any agreement of future employment or compensation until after his or her successor has been elected, unless such Member, Delegate, or Resident Commissioner, within 3 business days after the commencement of such negotiation or agreement of future employment or compensation, files with the Committee on Standards of Official Conduct a statement, which must be signed by the Member, Delegate, or Resident Commissioner, regarding such negotiations or agreement, including the name of the private entity or entities involved in such negotiations or agreement, and the date such negotiations or agreement commenced.

''2. An officer or an employee of the House earning in excess of 75 percent of the salary paid to a Member shall notify the Committee on Standards of Official Conduct that he or she is negotiating or has any agreement of future employment or compensation.

''3. The disclosure and notification under this rule shall be made within 3 business days after the commencement of such negotiation or agreement of future employment or compensation.

''4. A Member, Delegate, or Resident Commissioner, and an officer or employee to whom this rule applies, shall recuse himself or herself from any matter in which there is a conflict of interest or an appearance of a conflict for that Member, Delegate, Resident Commissioner, officer, or employee under this rule and shall notify the Committee on Standards of Official Conduct of such recusal. A Member, Delegate, or Resident Commissioner making such recusal shall, upon such recusal, submit to the Clerk for public disclosure the statement of disclosure under clause 1 with respect to which the recusal was made.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act, and shall apply to negotiations commenced, and agreements entered into, on or after that date.

SEC. 302. PROHIBITION ON LOBBYING CONTACTS WITH SPOUSE OF MEMBER WHO IS A REGISTERED LOBBYIST.

Rule XXV of the Rules of the House of Representatives is amended by adding at the end the following new clause:

''7. A Member, Delegate, or Resident Commissioner shall prohibit all staff employed by that Member, Delegate, or Resident Commissioner (including staff in personal, committee, and leadership offices) from making any lobbying contact (as defined in section 3 of the Lobbying Disclosure Act of 1995) with that individual's spouse if that spouse is a lobbyist under the Lobbying Disclosure Act of 1995 or is employed or retained by such a lobbyist for the purpose of influencing legislation.''.

SEC. 303. TREATMENT OF FIRMS AND OTHER BUSINESSES WHOSE MEMBERS SERVE AS HOUSE COMMITTEE CONSULTANTS.

Clause 18(b) of rule XXIII of the Rules of the House of Representatives is amended by adding at the end the following: ''In the case of such an individual who is a member or employee of a firm, partnership, or other business organization, the other members and employees of the firm, partnership, or other business organization shall be subject to the same restrictions on lobbying that apply to the individual under this paragraph.''.

SEC. 304. POSTING OF TRAVEL AND FINANCIAL DISCLOSURE REPORTS ON PUBLIC WEBSITE OF CLERK OF THE HOUSE OF REPRESENTATIVES.

(a) REQUIRING POSTING ON INTERNET.—The Clerk of the House of Representatives shall post on the public Internet site of the Office of the Clerk, in a format that is searchable, sortable, and downloadable, to the extent technically practicable, each of the following:

(1) The advance authorizations, certifications, and disclosures filed with respect to transportation, lodging, and related expenses for travel under clause 5(b) of rule XXV of the Rules of the House of Representatives by Members (including Delegates and Resident Commissioners to the Congress), officers, and employees of the House.

(2) The reports filed under section 103(h)(1) of the Ethics in Government Act of 1978 by Members of the House of Representatives (including Delegates and Resident Commissioners to the Congress).

(b) APPLICABILITY AND TIMING.—

(1) APPLICABILITY.—Subject to paragraph (2), subsection (a) shall apply with respect to information received by the Clerk of the House of Representatives on or after the date of the enactment of this Act.

(2) TIMING.—The Clerk of the House of Representatives shall—

(A) not later than August 1, 2008, post the information required by subsection (a) that the Clerk receives by June 1, 2008; and

(B) not later than the end of each 45-day period occurring after information is required to be posted under subparagraph (A), post the information required by subsection (a) that the Clerk has received since the last posting under this subsection.

(3) OMISSION OF PERSONALLY IDENTIFIABLE INFORMATION.—Members of the House of Representatives (including Delegates and Resident Commissioners to the Congress) shall be permitted to omit personally identifiable information not required to be disclosed on the reports posted on the public Internet site under this section (such as home address, Social Security numbers, personal bank account numbers, home telephone, and names of children) prior to the posting of such reports on such public Internet site.

(4) ASSISTANCE IN PROTECTING PERSONAL INFORMATION.—The Clerk of the House of Representatives, in consultation with the Committee on Standards of Official Conduct, shall include in any informational materials concerning any disclosure that will be posted on the public Internet site under this section an explanation of the procedures for protecting personally identifiable information as described in this section.

(c) RETENTION.—The Clerk shall maintain the information posted on the public Internet site of the Office of the Clerk under this section for a period of 6 years after receiving the information.

SEC. 305. PROHIBITING PARTICIPATION IN LOBBYIST-SPONSORED EVENTS DURING POLITICAL CONVENTIONS.

Rule XXV of the Rules of the House of Representatives, as amended by section 302, is amended by adding at the end the following new clause:

''8. During the dates on which the national political party to which a Member (including a Delegate or Resident Commissioner) belongs holds its convention to nominate a candidate for the office of President or Vice President, the Member may not participate in an event honoring that Member, other than in his or her capacity as a candidate for such office, if such event is directly paid for by a registered lobbyist under the Lobbying Disclosure Act of 1995 or a private entity that retains or employs such a registered lobbyist.''.

SEC. 306. EXERCISE OF RULEMAKING AUTHORITY.

The provisions of this title are adopted by the House of Representatives—

(1) as an exercise of the rulemaking power of the House; and

(2) with full recognition of the constitutional right of the House to change those rules at any time, in the same manner, and to the same extent as in the case of any other rule of the House.

TITLE IV—CONGRESSIONAL PENSION ACCOUNTABILITY

SEC. 401. LOSS OF PENSIONS ACCRUED DURING SERVICE AS A MEMBER OF CONGRESS FOR ABUSING THE PUBLIC TRUST.

(a) CIVIL SERVICE RETIREMENT SYSTEM.—Section 8332 of title 5, United States Code, is amended by adding at the end the following:

''(o)(1) Notwithstanding any other provision of this subchapter, the service of an individual finally convicted of an offense described in paragraph (2) shall not be taken into account for purposes of this subchapter, except that this sentence applies only to service rendered as a Member (irrespective of when rendered). Any such individual (or other person determined under section 8342(c), if applicable) shall be entitled to be paid so much of such individual's lump-sum credit as is attributable to service to which the preceding sentence applies.

''(2)(A) An offense described in this paragraph is any offense described in subparagraph (B) for which the following apply:

''(i) Every act or omission of the individual (referred to in paragraph (1)) that is needed to satisfy the elements of the offense occurs while the individual is a Member.

''(ii) Every act or omission of the individual that is needed to satisfy the elements of the offense directly relates to the performance of the individual's official duties as a Member.

''(iii) The offense is committed after the date of enactment of this subsection.

''(B) An offense described in this subparagraph is only the following, and only to the extent that the offense is a felony:

''(i) An offense under section 201 of title 18 (relating to bribery of public officials and witnesses).

''(ii) An offense under section 219 of title 18 (relating to officers and employees acting as agents of foreign principals).

''(iii) An offense under section 1343 of title 18 (relating to fraud by wire, radio, or television, including as part of a scheme to deprive citizens of honest services thereby).

''(iv) An offense under section 104(a) of the Foreign Corrupt Practices Act of 1977 (relating to prohibited foreign trade practices by domestic concerns).

''(v) An offense under section 1957 of title 18 (relating to engaging in monetary transactions in property derived from specified unlawful activity).

''(vi) An offense under section 1512 of title 18 (relating to tampering with a witness, victim, or an informant).

''(vii) An offense under chapter 96 of title 18 (relating to racketeer influenced and corrupt organizations).

''(viii) An offense under section 371 of title 18 (relating to conspiracy to commit offense or to defraud United States), to the extent of any conspiracy to commit an act which constitutes—

''(I) an offense under clause (i), (ii), (iii), (iv), (v), (vi), or (vii); or

''(II) an offense under section 207 of title 18 (relating to restrictions on former officers, employees, and elected officials of the executive and legislative branches).

''(ix) Perjury committed under section 1621 of title 18 in falsely denying the commission of an act which constitutes—

''(I) an offense under clause (i), (ii), (iii), (iv), (v), (vi), or (vii); or

''(II) an offense under clause (viii), to the extent provided in such clause.

''(x) Subornation of perjury committed under section 1622 of title 18 in connection with the false denial or false testimony of another individual as specified in clause (ix).

''(3) An individual convicted of an offense described in paragraph (2) shall not, after the date of the final conviction, be eligible to participate in the retirement system under this subchapter or chapter 84 while serving as a Member.

''(4) The Office of Personnel Management shall prescribe any regulations necessary to carry out this subsection. Such regulations shall include—

''(A) provisions under which interest on any lump-sum payment under the second sentence of paragraph (1) shall be limited in a manner similar to that specified in the last sentence of section 8316(b); and

''(B) provisions under which the Office may provide for—

''(i) the payment, to the spouse or children of any individual referred to in the first sentence of paragraph (1), of any amounts which (but for this clause) would otherwise have been nonpayable by reason of such first sentence, subject to paragraph (5); and

''(ii) an appropriate adjustment in the amount of any lump-sum payment under the second sentence of paragraph (1) to reflect the application of clause (i).

''(5) Regulations to carry out clause (i) of paragraph (4)(B) shall include provisions to ensure that the authority to make any payment to the spouse or children of an individual under such clause shall be available only to the extent that the application of such clause is considered necessary and appropriate taking into account the totality of the circumstances, including the financial needs of the spouse or children, whether the spouse or children participated in an offense described in paragraph (2) of which such individual was finally convicted, and what measures, if any, may be necessary to ensure that the convicted individual does not benefit from any such payment.

''(6) For purposes of this subsection—

''(A) the terms 'finally convicted' and 'final conviction' refer to a conviction (i) which has not been appealed and is no longer appealable because the time for taking an appeal has expired, or (ii) which has been appealed and the appeals process for which is completed;

''(B) the term 'Member' has the meaning given such term by section 2106, notwithstanding section 8331(2); and

''(C) the term 'child' has the meaning given such term by section 8341.''.

(b) FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—Section 8411 of title 5, United States Code, is amended by adding at the end the following:

''(l)(1) Notwithstanding any other provision of this chapter, the service of an individual finally convicted of an offense described in paragraph (2) shall not be taken into account for purposes of this chapter, except that this sentence applies only to service rendered as a Member (irrespective of when rendered). Any such individual (or other person determined under section 8424(d), if applicable) shall be entitled to be paid so much of such individual's lump-sum credit as is attributable to service to which the preceding sentence applies.

''(2) An offense described in this paragraph is any offense described in section 8332(o)(2)(B) for which the following apply:

''(A) Every act or omission of the individual (referred to in paragraph (1)) that is needed to satisfy the elements of the offense occurs while the individual is a Member.

''(B) Every act or omission of the individual that is needed to satisfy the elements of the offense directly relates to the performance of the individual's official duties as a Member.

''(C) The offense is committed after the date of enactment of this subsection.

''(3) An individual convicted of an offense described in paragraph (2) shall not, after the date of the final conviction, be eligible to participate in the retirement system under this chapter while serving as a Member.

''(4) The Office of Personnel Management shall prescribe any regulations necessary to carry out this subsection. Such regulations shall include—

''(A) provisions under which interest on any lump-sum payment under the second sentence of paragraph (1) shall be limited in a manner similar to that specified in the last sentence of section 8316(b); and

''(B) provisions under which the Office may provide for—

''(i) the payment, to the spouse or children of any individual referred to in the first sentence of paragraph (1), of any amounts which (but for this clause) would otherwise have been nonpayable by reason of such first sentence, subject to paragraph (5); and

''(ii) an appropriate adjustment in the amount of any lump-sum payment under the second sentence of paragraph (1) to reflect the application of clause (i).

''(5) Regulations to carry out clause (i) of paragraph (4)(B) shall include provisions to ensure that the authority to make any payment under such clause to the spouse or children of an individual shall be available only to the extent that the application of such clause is considered necessary and appropriate taking into account the totality of the circumstances, including the financial needs of the spouse or children, whether the spouse or children participated in an offense described in paragraph (2) of which such individual was finally convicted, and what measures, if any, may be necessary to ensure that the convicted individual does not benefit from any such payment.

''(6) For purposes of this subsection—

''(A) the terms 'finally convicted' and 'final conviction' refer to a conviction (i) which has not been appealed and is no longer appealable because the time for taking an appeal has expired, or (ii) which has been appealed and the appeals process for which is completed;

''(B) the term 'Member' has the meaning given such term by section 2106, notwithstanding section 8401(20); and

''(C) the term 'child' has the meaning given such term by section 8441.''.

TITLE V—SENATE LEGISLATIVE TRANSPARENCY AND ACCOUNTABILITY

Subtitle A—Procedural Reform

SEC. 511. AMENDMENTS TO RULE XXVIII.

(a) OUT OF SCOPE MATERIAL AMENDMENT.—Rule XXVIII of the Standing Rules of the Senate is amended by—

(1) redesignating paragraphs 4 through 6 as paragraphs 6 through 8, respectively; and

(2) striking paragraphs 2 and 3 and inserting the following:

''2. (a) Conferees shall not insert in their report matter not committed to them by either House, nor shall they strike from the bill matter agreed to by both Houses.

''(b) If matter which was agreed to by both Houses is stricken from the bill a point of order may be made against the report, and if the point of order is sustained, the report is rejected or shall be recommitted to the committee of conference if the House of Representatives has not already acted thereon.

''(c) If new matter is inserted in the report, a point of order may be made against the conference report and it shall be disposed of as provided under paragraph 4.

''3. (a) In any case in which a disagreement to an amendment in the nature of a substitute has been referred to conferees—

''(1) it shall be in order for the conferees to report a substitute on the same subject matter;

''(2) the conferees may not include in the report matter not committed to them by either House; and

''(3) the conferees may include in their report in any such case matter which is a germane modification of subjects in disagreement.

''(b) In any case in which the conferees violate subparagraph (a), a point of order may be made against the conference report and it shall be disposed of as provided under paragraph 4.

''4. (a) A Senator may raise a point of order that one or more provisions of a conference report violates paragraph 2 or paragraph 3, as the case may be. The Presiding Officer may sustain the point of order as to some or all of the provisions against which the Senator raised the point of order.

''(b) If the Presiding Officer sustains the point of order as to any of the provisions against which the Senator raised the point of order, then those provisions against which the Presiding Officer sustains the point of order shall be stricken. After all other points of order under this paragraph have been disposed of—

''(1) the Senate shall proceed to consider the question of whether the Senate should recede from its amendment to the House bill, or its disagreement to the amendment of the House, and concur with a further amendment, which further amendment shall consist of only that portion of the conference report that has not been stricken;

''(2) the question in clause (1) shall be decided under the same debate limitation as the conference report; and

''(3) no further amendment shall be in order.

''5. (a) Any Senator may move to waive any or all points of order under paragraph 2 or 3 with respect to the pending conference report by an affirmative vote of three-fifths of the Members, duly chosen and sworn. All motions to waive under this paragraph shall be debatable collectively for not to exceed 1 hour equally divided between the Majority Leader and the Minority

Leader or their designees. A motion to waive all points of order under this paragraph shall not be amendable.

''(b) All appeals from rulings of the Chair under paragraph 4 shall be debatable collectively for not to exceed 1 hour, equally divided between the Majority and the Minority Leader or their designees. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair under paragraph 4.''.

(b) PUBLIC AVAILABILITY AMENDMENT.—

(1) IN GENERAL.—Rule XXVIII of the Standing Rules of the Senate is amended by adding at the end the following:

''9. (a)(1) It shall not be in order to vote on the adoption of a report of a committee of conference unless such report has been available to Members and to the general public for at least 48 hours before such vote. If a point of order is sustained under this paragraph, then the conference report shall be set aside.

''(2) For purposes of this paragraph, a report of a committee of conference is made available to the general public as of the time it is posted on a publicly accessible website controlled by a Member, committee, Library of Congress, or other office of Congress, or the Government Printing Office, as reported to the Presiding Officer by the Secretary of the Senate.

''(b)(1) This paragraph may be waived in the Senate with respect to the pending conference report by an affirmative vote of three-fifths of the Members, duly chosen and sworn. A motion to waive this paragraph shall be debatable for not to exceed 1 hour equally divided between the Majority Leader and the Minority Leader or their designees.

''(2) An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph. An appeal of the ruling of the Chair shall be debatable for not to exceed 1 hour equally divided between the Majority and the Minority Leader or their designees

''(c) This paragraph may be waived by joint agreement of the Majority Leader and the Minority Leader of the Senate, upon their certification that such waiver is necessary as a result of a significant disruption to Senate facilities or to the availability of the Internet.''.

(2) IMPLEMENTATION.—Not later than 60 days after the date of enactment of this section, the Committee on Rules and Administration, in consultation with the Secretary of the Senate and the Clerk of the House of Representatives, and the Government Printing Office shall promulgate regulations for the implementation of the requirements of paragraph 9 of rule XXVIII of the Standing Rules of the Senate, as added by this section.

SEC. 512. NOTICE OF OBJECTING TO PROCEEDING.

(a) IN GENERAL.—The Majority and Minority Leaders of the Senate or their designees shall recognize a notice of intent of a Senator who is a member of their caucus to object to proceeding to a measure or matter only if the Senator—

(1) following the objection to a unanimous consent to proceeding to, and, or passage of, a measure or matter on their behalf, submits the notice of intent in writing to the appropriate leader or their designee; and

(2) not later than 6 session days after the submission under paragraph (1), submits for inclusion in the Congressional Record and in the applicable calendar section described in subsection (b) the following notice:

''I, Senator _____, intend to object to proceedings to _____, dated _____ for the following reasons_____.''.

(b) CALENDAR.—

(1) IN GENERAL.—The Secretary of the Senate shall establish for both the Senate Calendar of Business and the Senate Executive Calendar a separate section entitled ''Notice of Intent to Object to Proceeding''.

(2) CONTENT.—The section required by paragraph (1) shall include—

(A) the name of each Senator filing a notice under subsection (a)(2);

(B) the measure or matter covered by the calendar that the Senator objects to; and

(C) the date the objection was filed.

(3) NOTICE.—A Senator who has notified their respective leader and who has withdrawn their objection within the 6 session day period is not required to submit a notification under subsection (a)(2).

(c) REMOVAL.—A Senator may have an item with respect to the Senator removed from a calendar to which it was added under subsection (b) by submitting for inclusion in the Congressional Record the following notice:

''I, Senator _____, do not object to proceed to _____, dated _____.''.

SEC. 513. PUBLIC AVAILABILITY OF SENATE COMMITTEE AND SUBCOMMITTEE MEETINGS.

(a) IN GENERAL.—Paragraph 5(e) of rule XXVI of the Standing Rules of the Senate is amended by—

(1) inserting after ''(e)'' the following: ''(1)''; and

(2) adding at the end the following:

''(2)(A) Except with respect to meetings closed in accordance with this rule, each committee and subcommittee shall make publicly available through the Internet a video recording, audio recording, or transcript of any meeting not later than 21 business days after the meeting occurs.

''(B) Information required by subclause (A) shall be available until the end of the Congress following the date of the meeting.

''(C) The Committee on Rules and Administration may waive this clause upon request based on the inability of a committee or subcommittee to comply with this clause due to technical or logistical reasons.''.

(b) EFFECTIVE DATE.—This section shall take effect 90 days after the date of enactment of this Act.

SEC. 514. AMENDMENTS AND MOTIONS TO RECOMMIT.

Paragraph 1 of rule XV of the Standing Rules of the Senate is amended to read as follows:

''1. (a) An amendment and any instruction accompanying a motion to recommit shall be reduced to writing and read and identical copies shall be provided by the Senator offering the amendment or instruction to the desks of the Majority Leader and the Minority Leader before being debated.

''(b) A motion shall be reduced to writing, if desired by the Presiding Officer or by any Senator, and shall be read before being debated.''.

SEC. 515. SENSE OF THE SENATE ON CONFERENCE COMMITTEE PROTOCOLS.

It is the sense of the Senate that—

(1) conference committees should hold regular, formal meetings of all conferees that are open to the public;

(2) all conferees should be given adequate notice of the time and place of all such meetings;

(3) all conferees should be afforded an opportunity to participate in full and complete debates of the matters that such conference committees may recommend to their respective Houses; and

(4) the text of a report of a committee of conference shall not be changed after the Senate signature sheets have been signed by a majority of the Senate conferees.

Subtitle B—Earmark Reform

SEC. 521. CONGRESSIONALLY DIRECTED SPENDING.

The Standing Rules of the Senate are amended by adding at the end the following:

''RULE XLIV

''CONGRESSIONALLY DIRECTED SPENDING AND RELATED ITEMS

''1. (a) It shall not be in order to vote on a motion to proceed to consider a bill or joint resolution reported by any committee unless the chairman of the committee of jurisdiction or the Majority Leader or his or her designee certifies—

''(1) that each congressionally directed spending item, limited tax benefit, and limited tariff benefit, if any, in the bill or joint resolution, or in the committee report accompanying the bill or joint resolution, has been identified through lists, charts, or other similar means including the name of each Senator who submitted a request to the committee for each item so identified; and

''(2) that the information in clause (1) has been available on a publicly accessible congressional website in a searchable format at least 48 hours before such vote.

''(b) If a point of order is sustained under this paragraph, the motion to proceed shall be suspended until the sponsor of the motion or his or her designee has requested resumption and compliance with this paragraph has been achieved.

''2. (a) It shall not be in order to vote on a motion to proceed to consider a Senate bill or joint resolution not reported by committee unless the chairman of the committee of jurisdiction or the Majority Leader or his or her designee certifies—

''(1) that each congressionally directed spending item, limited tax benefit, and limited tariff benefit, if any, in the bill or joint resolution, has been identified through lists, charts, or other similar means, including the name of each Senator who submitted a request to the sponsor of the bill or joint resolution for each item so identified; and

''(2) that the information in clause (1) has been available on a publicly accessible congressional website in a searchable format at least 48 hours before such vote.

''(b) If a point of order is sustained under this paragraph, the motion to proceed shall be suspended until the sponsor of the motion or his or her designee has requested resumption and compliance with this paragraph has been achieved.

''3. (a) It shall not be in order to vote on the adoption of a report of a committee of conference unless the chairman of the committee of jurisdiction or the Majority Leader or his or her designee certifies—

''(1) that each congressionally directed spending item, limited tax benefit, and limited tariff benefit, if any, in the conference report, or in the joint statement of managers accompanying the conference report, has been identified through lists, charts, or other means, including the name of each Senator who submitted a request to the committee of jurisdiction for each item so identified; and

''(2) that the information in clause (1) has been available on a publicly accessible congressional website at least 48 hours before such vote.

''(b) If a point of order is sustained under this paragraph, then the conference report shall be set aside.

''4. (a) If during consideration of a bill or joint resolution, a Senator proposes an amendment containing a congressionally directed spending item, limited tax benefit, or limited tariff benefit which was not included in the bill or joint resolution as placed on the calendar or as reported by any committee, in a committee report on such bill or joint resolution, or a committee report of the Senate on a companion measure, then as soon as practicable, the Senator shall ensure that a list of such items (and the name of any Senator who submitted a request to the Senator for each respective item included in the list) is printed in the Congressional Record.

''(b) If a committee reports a bill or joint resolution that includes congressionally directed spending items, limited tax benefits, or limited tariff benefits in the bill or joint resolution, or in the committee report accompanying the bill or joint resolution, the committee shall as soon as practicable identify on a publicly accessible congressional website each such item through lists, charts, or other similar means, including the

name of each Senator who submitted a request to the committee for each item so identified. Availability on the Internet of a committee report that contains the information described in this subparagraph shall satisfy the requirements of this subparagraph.

''(c) To the extent technically feasible, information made available on publicly accessible congressional websites under paragraphs 3 and 4 shall be provided in a searchable format.

''5. For the purpose of this rule—

''(a) the term 'congressionally directed spending item' means a provision or report language included primarily at the request of a Senator providing, authorizing, or recommending a specific amount of discretionary budget authority, credit authority, or other spending authority for a contract, loan, loan guarantee, grant, loan authority, or other expenditure with or to an entity, or targeted to a specific State, locality or Congressional district, other than through a statutory or administrative formula-driven or competitive award process;

''(b) the term 'limited tax benefit' means—

''(1) any revenue provision that—

''(A) provides a Federal tax deduction, credit, exclusion, or preference to a particular beneficiary or limited group of beneficiaries under the Internal Revenue Code of 1986; and

''(B) contains eligibility criteria that are not uniform in application with respect to potential beneficiaries of such provision;

''(c) the term 'limited tariff benefit' means a provision modifying the Harmonized Tariff Schedule of the United States in a manner that benefits 10 or fewer entities; and

''(d) except as used in subparagraph 8(e), the term 'item' when not preceded by 'congressionally directed spending' means any provision that is a congressionally directed spending item, a limited tax benefit, or a limited tariff benefit.

''6. (a) A Senator who requests a congressionally directed spending item, a limited tax benefit, or a limited tariff benefit in any bill or joint resolution (or an accompanying report) or in any conference report (or an accompanying joint statement of managers) shall provide a written statement to the chairman and ranking member of the committee of jurisdiction, including—

''(1) the name of the Senator;

''(2) in the case of a congressionally directed spending item, the name and location of the intended recipient or, if there is no specifically intended recipient, the intended location of the activity;

''(3) in the case of a limited tax or tariff benefit, identification of the individual or entities reasonably anticipated to benefit, to the extent known to the Senator;

''(4) the purpose of such congressionally directed spending item or limited tax or tariff benefit; and

''(5) a certification that neither the Senator nor the Senator's immediate family has a pecuniary interest in the item, consistent with the requirements of paragraph 9.

''(b) With respect to each item included in a Senate bill or joint resolution (or accompanying report) reported by committee or considered by the Senate, or included in a conference report (or joint statement of managers accompanying the conference report) considered by the Senate, each committee of jurisdiction shall make available for public inspection on the Internet the certifications under subparagraph (a)(5) as soon as practicable.

''7. In the case of a bill, joint resolution, or conference report that contains congressionally directed spending items in any classified portion of a report accompanying the measure, the committee of jurisdiction shall, to the greatest extent practicable, consistent with the need to protect national security (including intelligence sources and methods), include on the list required by paragraph 1, 2, or 3 as the case may be, a general program description in unclassified language, funding level, and the name of the sponsor of that congressionally directed spending item.

''8. (a) A Senator may raise a point of order against one or more provisions of a conference report if they constitute new directed spending provisions. The Presiding Officer may sustain the point of order as to some or all of the provisions against which the Senator raised the point of order.

''(b) If the Presiding Officer sustains the point of order as to any of the provisions against which the Senator raised the point of order, then those provisions against which the Presiding Officer sustains the point of order shall be stricken. After all other points of order under this paragraph have been disposed of—

''(1) the Senate shall proceed to consider the question of whether the Senate should recede from its amendment to the House bill, or its disagreement to the amendment of the House, and concur with a further amendment, which further amendment shall consist of only that portion of the conference report that has not been stricken; and

''(2) the question in clause (1) shall be decided under the same debate limitation as the conference report and no further amendment shall be in order.

''(c) Any Senator may move to waive any or all points of order under this paragraph with respect to the pending conference report by an affirmative vote of three-fifths of the Members, duly chosen and sworn. All motions to waive under this paragraph shall be debatable collectively for not to exceed 1 hour equally divided between the Majority Leader and the Minority Leader or their designees. A motion to waive all points of order under this paragraph shall not be amendable.

''(d) All appeals from rulings of the Chair under this paragraph shall be debatable collectively for not to exceed 1 hour, equally divided between the Majority and the Minority Leader or their designees. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair under this paragraph.

''(e) The term 'new directed spending provision' as used in this paragraph means any item that consists of a specific provision containing a specific level of funding for any specific account, specific program, specific project, or specific activity, when no specific funding was provided for such specific account, specific program, specific project, or specific activity in the measure originally committed to the conferees by either House.

''9. No Member, officer, or employee of the Senate shall knowingly use his official position to introduce, request, or otherwise aid the progress or passage of congressionally directed spending items, limited tax benefits, or limited tariff benefits a principal purpose of which is to further only his pecuniary interest, only the pecuniary interest of his immediate family, or only the pecuniary interest of a limited class of persons or enterprises, when he or his immediate family, or enterprises controlled by them, are members of the affected class.

''10. Any Senator may move to waive application of paragraph 1, 2, or 3 with respect to a measure by an affirmative vote of three-fifths of the Members, duly chosen and sworn. A motion to waive under this paragraph with respect to a measure shall be debatable for not to exceed 1 hour equally divided between the Majority Leader and the Minority Leader or their designees. With respect to points of order raised under paragraphs 1, 2, or 3, only one appeal from a ruling of the Chair shall be in order, and debate on such an appeal from a ruling of the Chair on such point of order shall be limited to one hour.

''11. Any Senator may move to waive all points of order under this rule with respect to the pending measure or motion by an affirmative vote of three-fifths of the Members, duly chosen and sworn. All motions to waive all points of order with respect to a measure or motion as provided by this paragraph shall be debatable collectively for not to exceed 1 hour equally divided between the Majority Leader and the Minority Leader or their designees. A motion to waive all points of order with respect to a measure or motion as provided by this paragraph shall not be amendable.

''12. Paragraph 1, 2, or 3 of this rule may be waived by joint agreement of the Majority Leader and the Minority Leader of the Senate upon their certification that such waiver is necessary as a result of a significant disruption to Senate facilities or to the availability of the Internet.''.

Subtitle C—Revolving Door Reform

SEC. 531. POST-EMPLOYMENT RESTRICTIONS.

(a) APPLICATION TO ENTITY.—Paragraph 8 of rule XXXVII of the Standing Rules of the Senate is amended by—

(1) inserting after ''by such a registered lobbyist'' the following ''or an entity that employs or retains a registered lobbyist''; and

(2) striking ''one year'' and inserting ''2 years''.

(b) PROHIBITION.—Paragraph 9 of rule XXXVII of the Standing Rules of the Senate is amended—

(1) in the first sentence, by inserting after ''by such a registered lobbyist'' the following: ''or an entity that employs or retains a registered lobbyist'';

(2) in the second sentence, by inserting after ''by such a registered lobbyist'' the following: ''or an entity that employs or retains a registered lobbyist'';

(3) by designating the first and second sentences as subparagraphs (a) and (b), respectively; and

(4) by adding at the end the following:

''(c) If an officer of the Senate or an employee on the staff of a Member or on the staff of a committee whose rate of pay is equal to or greater than 75 percent of the rate of pay of a Member and employed at such rate for more than 60 days in a calendar year, upon leaving that position, becomes a registered lobbyist, or is employed or retained by such a registered lobbyist or an entity that employs or retains a registered lobbyist for the purpose of influencing legislation, such employee may not lobby any Member, officer, or employee of the Senate for a period of 1 year after leaving that position.''.

(c) EFFECTIVE DATE.—Paragraph 9(c) of rule XXXVII of the Standing Rules of the Senate shall apply to individuals who leave office or employment to which such paragraph applies on or after the date of adjournment of the first session of the 110th Congress sine die or December 31, 2007, whichever date is earlier.

SEC. 532. DISCLOSURE BY MEMBERS OF CONGRESS AND STAFF OF EMPLOYMENT NEGOTIATIONS.

Rule XXXVII of the Standing Rules of the Senate is amended by—

(1) redesignating paragraph 12 as paragraph 13; and

(2) adding after paragraph 11 the following:

''12. (a) A Member shall not negotiate or have any arrangement concerning prospective private employment until after his or her successor has been elected, unless such Member files a signed statement with the Secretary of the Senate, for public disclosure, regarding such negotiations or arrangements not later than 3 business days after the commencement of such negotiation or arrangement, including the name of the private entity or entities involved in such negotiations or arrangements, and the date such negotiations or arrangements commenced.

''(b) A Member shall not negotiate or have any arrangement concerning prospective employment for a job involving lobbying activities as defined by the Lobbying Disclosure Act of 1995 until after his or her successor has been elected.

''(c)(1) An employee of the Senate earning in excess of 75 percent of the salary paid to a Senator shall notify the Select Committee on Ethics

that he or she is negotiating or has any arrangement concerning prospective private employment.

''(2) The notification under this subparagraph shall be made not later than 3 business days after the commencement of such negotiation or arrangement.

''(3) An employee to whom this subparagraph applies shall—

''(A) recuse himself or herself from—

''(i) any contact or communication with the prospective employer on issues of legislative interest to the prospective employer; and

''(ii) any legislative matter in which there is a conflict of interest or an appearance of a conflict for that employee under this subparagraph; and

''(B) notify the Select Committee on Ethics of such recusal.''.

SEC. 533. ELIMINATION OF FLOOR PRIVILEGES FOR FORMER MEMBERS, SENATE OFFICERS, AND SPEAKERS OF THE HOUSE WHO ARE REGISTERED LOBBYISTS OR SEEK FINANCIAL GAIN.

Rule XXIII of the Standing Rules of the Senate is amended by—

(1) inserting ''1.'' before ''Other'';

(2) inserting after ''Ex-Senators and Senators-elect'' the following: '', except as provided in paragraph 2'';

(3) inserting after ''Ex-Secretaries and ex-Sergeants at Arms of the Senate'' the following: '', except as provided in paragraph 2'';

(4) inserting after ''Ex-Speakers of the House of Representatives'' the following: '', except as provided in paragraph 2''; and

(5) adding at the end the following:

''2. (a) The floor privilege provided in paragraph 1 shall not apply, when the Senate is in session, to an individual covered by this paragraph who is—

''(1) a registered lobbyist or agent of a foreign principal; or

''(2) in the employ of or represents any party or organization for the purpose of influencing, directly or indirectly, the passage, defeat, or amendment of any Federal legislative proposal.

''(b) The Committee on Rules and Administration may promulgate regulations to allow individuals covered by this paragraph floor privileges for ceremonial functions and events designated by the Majority Leader and the Minority Leader.

''3. A former Member of the Senate may not exercise privileges to use Senate athletic facilities or Member-only parking spaces if such Member is—

''(a) a registered lobbyist or agent of a foreign principal; or

''(b) in the employ of or represents any party or organization for the purpose of influencing, directly or indirectly, the passage, defeat, or amendment of any Federal legislative proposal.''.

SEC. 534. INFLUENCING HIRING DECISIONS.

Rule XLIII of the Standing Rules of the Senate is amended by adding at the end the following:

''6. No Member, with the intent to influence solely on the basis of partisan political affiliation an employment decision or employment practice of any private entity, shall—

''(a) take or withhold, or offer or threaten to take or withhold, an official act; or

''(b) influence, or offer or threaten to influence the official act of another.''.

SEC. 535. NOTIFICATION OF POST-EMPLOYMENT RESTRICTIONS.

(a) IN GENERAL.—After a Senator or an elected officer of the Senate leaves office or after the termination of employment with the Senate of an employee of the Senate, the Secretary of the Senate shall notify the Member, officer, or employee of the beginning and ending date of the prohibitions that apply to the Member, officer, or employee under rule XXXVII of the Standing Rules of the Senate.

(b) EFFECTIVE DATE.—This section shall take effect 60 days after the date of enactment of this Act.

Subtitle D—Gift and Travel Reform

SEC. 541. BAN ON GIFTS FROM REGISTERED LOBBYISTS AND ENTITIES THAT HIRE REGISTERED LOBBYISTS.

Paragraph 1(a)(2) of rule XXXV of the Standing Rules of the Senate is amended by—

(1) inserting ''(A)'' after ''(2)''; and

(2) adding at the end the following:

''(B) A Member, officer, or employee may not knowingly accept a gift from a registered lobbyist, an agent of a foreign principal, or a private entity that retains or employs a registered lobbyist or an agent of a foreign principal, except as provided in subparagraphs (c) and (d).''.

SEC. 542. NATIONAL PARTY CONVENTIONS.

Paragraph (1)(d) of rule XXXV of the Standing Rules of the Senate is amended by adding at the end the following:

''(5) During the dates of the national party convention for the political party to which a Member belongs, a Member may not participate in an event honoring that Member, other than in his or her capacity as the party's presidential or vice presidential nominee or presumptive nominee, if such event is directly paid for by a registered lobbyist or a private entity that retains or employs a registered lobbyist.''.

SEC. 543. PROPER VALUATION OF TICKETS TO ENTERTAINMENT AND SPORTING EVENTS.

Paragraph 1(c)(1) of rule XXXV of the Standing Rules of the Senate is amended by—

(1) inserting ''(A)'' before ''Anything''; and

(2) adding at the end the following:

''(B) The market value of a ticket to an entertainment or sporting event shall be the face value of the ticket or, in the case of a ticket without a face value, the value of the ticket with the highest face value for the event, except that if a ticket holder can establish in advance of the event to the Select Committee on Ethics that the ticket at issue is equivalent to another ticket with a face value, then the market value shall be set at the face value of the equivalent ticket. In establishing equivalency, the ticket holder shall provide written and independently verifiable information related to the primary features of the ticket, including, at a minimum, the seat location, access to parking, availability of food and refreshments, and access to venue areas not open to the public. The Select Committee on Ethics may make a determination of equivalency only if such information is provided in advance of the event.''.

SEC. 544. RESTRICTIONS ON REGISTERED LOBBYIST PARTICIPATION IN TRAVEL AND DISCLOSURE.

(a) PROHIBITION.—Paragraph 2 of rule XXXV of the Standing Rules of the Senate is amended—

(1) in subparagraph (a)(1), by—

(A) adding after ''foreign principal'' the following: ''or a private entity that retains or employs 1 or more registered lobbyists or agents of a foreign principal'';

(B) striking the dash and inserting ''complies with the requirements of this paragraph.''; and

(C) striking clauses (A) and (B);

(2) by redesignating subparagraph (a)(2) as subparagraph (a)(3) and adding after subparagraph (a)(1) the following:

''(2)(A) Notwithstanding clause (1), a reimbursement (including payment in kind) to a Member, officer, or employee of the Senate from an individual, other than a registered lobbyist or agent of a foreign principal, that is a private entity that retains or employs 1 or more registered lobbyists or agents of a foreign principal shall be deemed to be a reimbursement to the Senate under clause (1) if—

''(i) the reimbursement is for necessary transportation, lodging, and related expenses for travel to a meeting, speaking engagement, fact-finding trip, or similar event described in clause (1) in connection with the duties of the Member, officer, or employee and the reimbursement is provided only for attendance at or participation for 1-day (exclusive of travel time and an overnight stay) at an event described in clause (1); or

''(ii) the reimbursement is for necessary transportation, lodging, and related expenses for travel to a meeting, speaking engagement, fact-finding trip, or similar event described in clause (1) in connection with the duties of the Member, officer, or employee and the reimbursement is from an organization designated under section 501(c)(3) of the Internal Revenue Code of 1986.

''(B) When deciding whether to preapprove a trip under this clause, the Select Committee on Ethics shall make a determination consistent with regulations issued pursuant to section 544(b) of the Honest Leadership and Open Government Act of 2007. The committee through regulations to implement subclause (A)(i) may permit a longer stay when determined by the committee to be practically required to participate in the event, but in no event may the stay exceed 2 nights.'';

(3) in subparagraph (a)(3), as redesignated, by striking ''clause (1)'' and inserting ''clauses (1) and (2)'';

(4) in subparagraph (b), by inserting before ''Each'' the following: ''Before an employee may accept reimbursement pursuant to subparagraph (a), the employee shall receive advance written authorization from the Member or officer under whose direct supervision the employee works.'';

(5) in subparagraph (c)—

(A) by inserting before ''Each'' the following: ''Each Member, officer, or employee that receives reimbursement under this paragraph shall disclose the expenses reimbursed or to be reimbursed, the authorization under subparagraph (b) (for an employee), and a copy of the certification in subparagraph (e)(1) to the Secretary of the Senate not later than 30 days after the travel is completed.'';

(B) by striking ''subparagraph (a)(1)'' and inserting ''this subparagraph'';

(C) in clause (5), by striking ''and'' after the semicolon;

(D) by redesignating clause (6) as clause (7); and

(E) by inserting after clause (5) the following:

''(6) a description of meetings and events attended; and'';

(6) by redesignating subparagraphs (d) and (e) as subparagraphs (f) and (g), respectively;

(7) by adding after subparagraph (c) the following:

''(d)(1) A Member, officer, or employee of the Senate may not accept a reimbursement (including payment in kind) for transportation, lodging, or related expenses under subparagraph (a) for a trip that was—

''(A) planned, organized, or arranged by or at the request of a registered lobbyist or agent of a foreign principal; or

''(B)(i) for trips described under subparagraph (a)(2)(A)(i) on which a registered lobbyist accompanies the Member, officer, or employee on any segment of the trip; or

''(ii) for all other trips allowed under this paragraph, on which a registered lobbyist accompanies the Member, officer, or employee at any point throughout the trip.

''(2) The Select Committee on Ethics shall issue regulations identifying de minimis activities by registered lobbyists or foreign agents that would not violate this subparagraph.

''(e) A Member, officer, or employee shall, before accepting travel otherwise permissible under this paragraph from any source—

''(1) provide to the Select Committee on Ethics a written certification from such source that—

''(A) the trip will not be financed in any part by a registered lobbyist or agent of a foreign principal;

''(B) the source either—

''(i) does not retain or employ registered lobbyists or agents of a foreign principal and is not itself a registered lobbyist or agent of a foreign principal; or

''(ii) certifies that the trip meets the requirements of subclause (i) or (ii) of subparagraph (a)(2)(A);

''(C) the source will not accept from a registered lobbyist or agent of a foreign principal or a private entity that retains or employs 1 or more registered lobbyists or agents of a foreign principal, funds earmarked directly or indirectly for the purpose of financing the specific trip; and

''(D) the trip will not in any part be planned, organized, requested, or arranged by a registered lobbyist or agent of a foreign principal and the traveler will not be accompanied on the trip consistent with the applicable requirements of subparagraph (d)(1)(B) by a registered lobbyist or agent of a foreign principal, except as permitted by regulations issued under subparagraph (d)(2); and

''(2) after the Select Committee on Ethics has promulgated regulations pursuant to section 544(b) of the Honest Leadership and Open Government Act of 2007, obtain the prior approval of the committee for such reimbursement.''; and

(8) by striking subparagraph (g), as redesignated, and inserting the following:

''(g) The Secretary of the Senate shall make all advance authorizations, certifications, and disclosures filed pursuant to this paragraph available for public inspection as soon as possible after they are received, but in no event prior to the completion of the relevant travel.''.

(b) GUIDELINES.—

(1) IN GENERAL.—Except as provided in paragraph (4) and not later than 60 days after the date of enactment of this Act and at annual intervals thereafter, the Select Committee on Ethics shall develop and revise, as necessary—

(A) guidelines, for purposes of implementing the amendments made by subsection (a), on evaluating a trip proposal and judging the reasonableness of an expense or expenditure, including guidelines related to evaluating—

(i) the stated mission of the organization sponsoring the trip;

(ii) the organization's prior history of sponsoring congressional trips, if any;

(iii) other educational activities performed by the organization besides sponsoring congressional trips;

(iv) whether any trips previously sponsored by the organization led to an investigation by the Select Committee on Ethics;

(v) whether the length of the trip and the itinerary is consistent with the official purpose of the trip;

(vi) whether there is an adequate connection between a trip and official duties;

(vii) the reasonableness of an amount spent by a sponsor of the trip;

(viii) whether there is a direct and immediate relationship between a source of funding and an event; and

(ix) any other factor deemed relevant by the Select Committee on Ethics; and

(B) regulations describing the information it will require individuals subject to the requirements of the amendments made by subsection (a) to submit to the committee in order to obtain the prior approval of the committee for travel under paragraph 2 of rule XXXV of the Standing Rules of the Senate, including any required certifications.

(2) CONSIDERATION.—In developing and revising guidelines under paragraph (1)(A), the committee shall take into account the maximum per diem rates for official Federal Government travel published annually by the General Services Administration, the Department of State, and the Department of Defense.

(3) UNREASONABLE EXPENSE.—For purposes of this subsection, travel on a flight described in paragraph 1(c)(1)(C)(ii) of rule XXXV of the Standing Rules of the Senate shall not be considered to be a reasonable expense.

(4) EXTENSION.—The deadline for the initial guidelines required by paragraph (1) may be extended for 30 days by the Committee on Rules and Administration.

(c) REIMBURSEMENT FOR NONCOMMERCIAL AIR TRAVEL.—

(1) CHARTER RATES.—Paragraph 1(c)(1) of rule XXXV of the Standing Rules of the Senate is amended by adding at the end the following:

''(C)(i) Fair market value for a flight on an aircraft described in item (ii) shall be the pro rata share of the fair market value of the normal and usual charter fare or rental charge for a comparable plane of comparable size, as determined by dividing such cost by the number of Members, officers, or employees of Congress on the flight.

''(ii) A flight on an aircraft described in this item is any flight on an aircraft that is not—

''(I) operated or paid for by an air carrier or commercial operator certificated by the Federal Aviation Administration and required to be conducted under air carrier safety rules; or

''(II) in the case of travel which is abroad, an air carrier or commercial operator certificated by an appropriate foreign civil aviation authority and the flight is required to be conducted under air carrier safety rules.

''(iii) This subclause shall not apply to an aircraft owned or leased by a governmental entity or by a Member of Congress or a Member's immediate family member (including an aircraft owned by an entity that is not a public corporation in which the Member or Member's immediate family member has an ownership interest), provided that the Member does not use the aircraft anymore than the Member's or immediate family member's proportionate share of ownership allows.''.

(2) UNOFFICIAL OFFICE ACCOUNTS.—Paragraph 1 of rule XXXVIII of the Standing Rules of the Senate is amended by adding at the end the following:

''(c) For purposes of reimbursement under this rule, fair market value of a flight on an aircraft shall be determined as provided in paragraph 1(c)(1)(C) of rule XXXV.''.

(d) REVIEW OF TRAVEL ALLOWANCES.—Not later than 90 days after the date of enactment of this Act, the Subcommittee on the Legislative Branch of the Senate Committee on Appropriations, in consultation with the Committee on Rules and Administration of the Senate, shall consider and propose, as necessary in the discretion of the subcommittee, any adjustment to the Senator's Official Personnel and Office Expense Account needed in light of the enactment of this section, and any modifications of Federal statutes or appropriations measures needed to accomplish such adjustments.

(e) SEPARATELY REGULATED EXPENSES.—Nothing in this section or section 541 is meant to alter treatment under law or Senate rules of expenses that are governed by the Foreign Gifts and Decorations Act or the Mutual Educational and Cultural Exchange Act.

(f) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect 60 days after the date of enactment of this Act or the date the Select Committee on Ethics issues new guidelines as required by subsection (b), whichever is later. Subsection (c) shall take effect on the date of enactment of this Act.

SEC. 545. FREE ATTENDANCE AT A CONSTITUENT EVENT.

(a) IN GENERAL.—Paragraph 1(c) of rule XXXV of the Standing Rules of the Senate is amended by adding at the end the following:

''(24) Subject to the restrictions in subparagraph (a)(2)(A), free attendance at a constituent event permitted pursuant to subparagraph (g).''.

(b) IN GENERAL.—Paragraph 1 of rule XXXV of the Standing Rules of the Senate is amended by adding at the end the following:

''(g)(1) A Member, officer, or employee may accept an offer of free attendance in the Member's home State at a conference, symposium, forum, panel discussion, dinner event, site visit, viewing, reception, or similar event, provided by a sponsor of the event, if—

''(A) the cost of meals provided the Member, officer, or employee is less than $50;

''(B)(i) the event is sponsored by constituents of, or a group that consists primarily of constituents of, the Member (or the Member by whom the officer or employee is employed); and

''(ii) the event will be attended primarily by a group of at least 5 constituents of the Member (or the Member by whom the officer or employee is employed) provided that a registered lobbyist shall not attend the event; and

''(C)(i) the Member, officer, or employee participates in the event as a speaker or a panel participant, by presenting information related to Congress or matters before Congress, or by performing a ceremonial function appropriate to the Member's, officer's, or employee's official position; or

''(ii) attendance at the event is appropriate to the performance of the official duties or representative function of the Member, officer, or employee.

''(2) A Member, officer, or employee who attends an event described in clause (1) may accept a sponsor's unsolicited offer of free attendance at the event for an accompanying individual if others in attendance will generally be similarly accompanied or if such attendance is appropriate to assist in the representation of the Senate.

''(3) For purposes of this subparagraph, the term 'free attendance' has the same meaning given such term in subparagraph (d).''.

SEC. 546. SENATE PRIVATELY PAID TRAVEL PUBLIC WEBSITE.

(a) TRAVEL DISCLOSURE.—Not later than January 1, 2008, the Secretary of the Senate shall establish a publicly available website without fee or without access charge, that contains information on travel that is subject to disclosure under paragraph 2 of rule XXXV of the Standing Rules of the Senate, that includes, with respect to travel occurring on or after January 1, 2008—

(1) a search engine;

(2) uniform categorization by Member, dates of travel, and any other common categories associated with congressional travel; and

(3) forms filed in the Senate relating to officially related travel.

(b) RETENTION.—The Secretary of the Senate shall maintain the information posted on the public Internet site of the Office of the Secretary under this section for a period not longer than 4 years after receiving the information.

(c) EXTENSION OF AUTHORITY.—If the Secretary of the Senate is unable to meet the deadline established under subsection (a), the Committee on Rules and Administration of the Senate may grant an extension of the Secretary of the Senate.

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

Subtitle E—Other Reforms

SEC. 551. COMPLIANCE WITH LOBBYING DISCLOSURE.

Rule XXXVII of the Standing Rules of the Senate is amended by—

(1) redesignating paragraphs 10 through 13 as paragraphs 11 through 14, respectively; and

(2) inserting after paragraph 9, the following:

''10. Paragraphs 8 and 9 shall not apply to contacts with the staff of the Secretary of the Senate regarding compliance with the lobbying disclosure requirements of the Lobbying Disclosure Act of 1995.''.

SEC. 552. PROHIBIT OFFICIAL CONTACT WITH SPOUSE OR IMMEDIATE FAMILY MEMBER OF MEMBER WHO IS A REGISTERED LOBBYIST.

Rule XXXVII of the Standing Rules of the Senate is amended by—

(1) redesignating paragraphs 11 through 14 as paragraphs 12 through 15, respectively; and

(2) inserting after paragraph 10, the following:

''11. (a) If a Member's spouse or immediate family member is a registered lobbyist, or is employed or retained by such a registered lobbyist or an entity that hires or retains a registered lobbyist for the purpose of influencing legislation, the Member shall prohibit all staff employed or supervised by that Member (including

staff in personal, committee, and leadership offices) from having any contact with the Member's spouse or immediate family member that constitutes a lobbying contact as defined by section 3 of the Lobbying Disclosure Act of 1995 by such person.

''(b) Members and employees on the staff of a Member (including staff in personal, committee, and leadership offices) shall be prohibited from having any contact that constitutes a lobbying contact as defined by section 3 of the Lobbying Disclosure Act of 1995 by any spouse of a Member who is a registered lobbyist, or is employed or retained by such a registered lobbyist.

''(c) The prohibition in subparagraph (b) shall not apply to the spouse of a Member who was serving as a registered lobbyist at least 1 year prior to the most recent election of that Member to office or at least 1 year prior to his or her marriage to that Member.''.

SEC. 553. MANDATORY SENATE ETHICS TRAINING FOR MEMBERS AND STAFF.

(a) TRAINING PROGRAM.—The Select Committee on Ethics shall conduct ongoing ethics training and awareness programs for Members of the Senate and Senate staff.

(b) REQUIREMENTS.—The ethics training program conducted by the Select Committee on Ethics shall be completed by—

(1) new Senators or staff not later than 60 days after commencing service or employment; and

(2) Senators and Senate staff serving or employed on the date of enactment of this Act not later than 165 days after the date of enactment of this Act.

SEC. 554. ANNUAL REPORT BY SELECT COMMITTEE ON ETHICS.

The Select Committee on Ethics of the Senate shall issue an annual report due no later than January 31, describing the following:

(1) The number of alleged violations of Senate rules received from any source, including the number raised by a Senator or staff of the committee.

(2) A list of the number of alleged violations that were dismissed—

(A) for lack of subject matter jurisdiction or, in which, even if the allegations in the complaint are true, no violation of Senate rules would exist; or

(B) because they failed to provide sufficient facts as to any material violation of the Senate rules beyond mere allegation or assertion.

(3) The number of alleged violations in which the committee staff conducted a preliminary inquiry.

(4) The number of alleged violations that resulted in an adjudicatory review.

(5) The number of alleged violations that the committee dismissed for lack of substantial merit.

(6) The number of private letters of admonition or public letters of admonition issued.

(7) The number of matters resulting in a disciplinary sanction.

(8) Any other information deemed by the committee to be appropriate to describe its activities in the preceding year.

SEC. 555. EXERCISE OF RULEMAKING POWERS.

The Senate adopts the provisions of this title—

(1) as an exercise of the rulemaking power of the Senate; and

(2) with full recognition of the constitutional right of the Senate to change those rules at any time, in the same manner, and to the same extent as in the case of any other rule of the Senate.

SEC. 555. EFFECTIVE DATE AND GENERAL PROVISIONS.

Except as otherwise provided in this title, this title shall take effect on the date of enactment of this title.

TITLE VI—PROHIBITED USE OF PRIVATE AIRCRAFT

SEC. 601. RESTRICTIONS ON USE OF CAMPAIGN FUNDS FOR FLIGHTS ON NONCOMMERCIAL AIRCRAFT.

(a) RESTRICTIONS.—Section 313 of the Federal Election Campaign Act of 1971 (2 U.S.C. 439a) is amended by adding at the end the following new subsection:

''(c) RESTRICTIONS ON USE OF CAMPAIGN FUNDS FOR FLIGHTS ON NONCOMMERCIAL AIRCRAFT.—

''(1) IN GENERAL.—Notwithstanding any other provision of this Act, a candidate for election for Federal office (other than a candidate who is subject to paragraph (2)), or any authorized committee of such a candidate, may not make any expenditure for a flight on an aircraft unless—

''(A) the aircraft is operated by an air carrier or commercial operator certificated by the Federal Aviation Administration and the flight is required to be conducted under air carrier safety rules, or, in the case of travel which is abroad, by an air carrier or commercial operator certificated by an appropriate foreign civil aviation authority and the flight is required to be conducted under air carrier safety rules; or

''(B) the candidate, the authorized committee, or other political committee pays to the owner, lessee, or other person who provides the airplane the pro rata share of the fair market value of such flight (as determined by dividing the fair market value of the normal and usual charter fare or rental charge for a comparable plane of comparable size by the number of candidates on the flight) within a commercially reasonable time frame after the date on which the flight is taken.

''(2) HOUSE CANDIDATES.—Notwithstanding any other provision of this Act, in the case of a candidate for election for the office of Representative in, or Delegate or Resident Commissioner to, the Congress, an authorized committee and a leadership PAC of the candidate may not make any expenditure for a flight on an aircraft unless—

''(A) the aircraft is operated by an air carrier or commercial operator certificated by the Federal Aviation Administration and the flight is required to be conducted under air carrier safety rules, or, in the case of travel which is abroad, by an air carrier or commercial operator certificated by an appropriate foreign civil aviation authority and the flight is required to be conducted under air carrier safety rules; or

''(B) the aircraft is operated by an entity of the Federal government or the government of any State.

''(3) EXCEPTION FOR AIRCRAFT OWNED OR LEASED BY CANDIDATE.—

''(A) IN GENERAL.—Paragraphs (1) and (2) do not apply to a flight on an aircraft owned or leased by the candidate involved or an immediate family member of the candidate (including an aircraft owned by an entity that is not a public corporation in which the candidate or an immediate family member of the candidate has an ownership interest), so long as the candidate does not use the aircraft more than the candidate's or immediate family member's proportionate share of ownership allows.

''(B) IMMEDIATE FAMILY MEMBER DEFINED.—In this subparagraph (A), the term 'immediate family member' means, with respect to a candidate, a father, mother, son, daughter, brother, sister, husband, wife, father-in-law, or mother-in-law.

''(4) LEADERSHIP PAC DEFINED.—In this subsection, the term 'leadership PAC' has the meaning given such term in section 304(i)(8)(B).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to flights taken on or after the date of the enactment of this Act.

TITLE VII—MISCELLANEOUS PROVISIONS

SEC. 701. SENSE OF THE CONGRESS THAT ANY APPLICABLE RESTRICTIONS ON CONGRESSIONAL OFFICIALS AND EMPLOYEES SHOULD APPLY TO THE EXECUTIVE AND JUDICIAL BRANCHES.

It is the sense of the Congress that any applicable restrictions on congressional officials and employees in this Act should apply to the executive and judicial branches.

SEC. 702. KNOWING AND WILLFUL FALSIFICATION OR FAILURE TO REPORT.

Section 104(a) of the Ethics in Government Act of 1978 (5 U.S.C. App.) is amended—

(1) by inserting ''(1)'' after ''(a)'';

(2) in paragraph (1), as so designated, by striking ''$10,000'' and inserting ''$50,000''; and

(3) by adding at the end the following:

''(2)(A) It shall be unlawful for any person to knowingly and willfully—

''(i) falsify any information that such person is required to report under section 102; and

''(ii) fail to file or report any information that such person is required to report under section 102.

''(B) Any person who—

''(i) violates subparagraph (A)(i) shall be fined under title 18, United States Code, imprisoned for not more than 1 year, or both; and

''(ii) violates subparagraph (A)(ii) shall be fined under title 18, United States Code.''.

SEC. 703. RULE OF CONSTRUCTION.

Nothing in this Act or the amendments made by this Act shall be construed to prohibit any expressive conduct protected from legal prohibition by, or any activities protected by the free speech, free exercise, or free association clauses of, the First Amendment to the Constitution.

CLOTURE MOTION

Mr. REID. Mr. President, I move that the Senate concur in the amendment of the House, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to concur in the House amendment on S. 1, the Ethics Reform bill.

Joe Lieberman, Harry Reid, Byron L. Dorgan, Patty Murray, Mark Pryor, Jeff Bingaman, Jack Reed, Dick Durbin, Jon Tester, Tom Carper, Pat Leahy, Benjamin L. Cardin, Debbie Stabenow, John Kerry, Barbara Boxer, Ted Kennedy, Ken Salazar.

AMENDMENT NO. 2589

Mr. REID. Mr. President, I move to concur in the House amendment with the following amendment which is at the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Nevada [Mr. REID] moves to concur in the House amendment to S. 1 with an amendment numbered 2589.

The amendment is as follows:

At the end of the amendment add the following:

This section shall take effect 3 days after date of enactment.

Mr. REID. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 2590 TO AMENDMENT NO. 2589

Mr. REID. Mr. President, I send a second-degree amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The legislative clerk read as follows:

The Senator from Nevada [Mr. REID] proposes an amendment numbered 2590 to amendment No. 2589.

The amendment is as follows:

In the amendment strike 3 and insert 1.

Mr. REID. Mr. President, I ask unanimous consent that the Senate continue consideration of H.R. 976.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. Mr. President, the majority leader asked unanimous consent to bring the ethics bill to the floor. He filled the tree, limiting amendments. I wish to spend a minute talking about that.

I honestly believe we are never going to have the problems fixed in Washington until we have absolute and complete transparency on earmarks. Senator DEMINT and I have both, numerous times, asked for unanimous consent that what we voted on 96 to 0 in the Senate be the order of the day when it comes to transparency on earmarks. That was rejected. We had a Democratic conference, and what we actually did—and I am not saying this partisanly at all; this is not a partisan issue—but what we did is gutted the transparency portion of the earmark reform. If you think the problems are going to stop with the ethics bill that is going to be coming up, we have another thought coming.

What the leadership has done, the majority leader along with those in the other body, they have cleaned the outside of the cup to what looks like is a good deal for the American public, but when you look over the edge of the cup, what you see is filth, what you see is a lack of integrity, what you see is a planned method to skirt transparency. The only thing Americans should believe is the only way they are going to know everything is on the up and up in this body is with 100 percent transparency. Anything less than that will not get you the accountability, will not solve the ethical problems that are out there. We need to be about that.

I am going to work hard to talk about that more. I think it is uncompromising what we are seeing done at this time to pull the wool over the eyes of the American people when it comes to earmarks. That is not a partisan issue. I am against earmarks, especially if they are not 100 percent transparent. But if you look at every ethical lapse that has happened in this body, it always goes back to earmarks. When they are transparent, and fully transparent to where the American people can see it, you are going to start getting good Government again. Until then, you are not.

I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Ms. KLOBUCHAR. Thank you, Mr. President.

I am here today to talk about the State Children's Health Insurance Program. I, first, do wish to say I am very pleased we are advancing an ethics bill in the Senate. I am very pleased with the work the majority leader has done on this bill. As a freshman class, we came in with some energy, and we came in with a commitment that we cannot do business as usual in Washington.

This ethics bill, as many outside groups have stated, is the most sweeping ethics reform we have seen since Watergate. It is about banning gifts and free meals. It is about not allowing people to take advantage of corporate jets. It is about bringing transparency to the earmark process.

I am very glad this advanced. I did not agree with a few of our Members who tried to block this from going to conference committee. I am glad we found a way procedurally to bring this legislation to the Senate. I am very hopeful it will pass the Senate, as it passed the House today.

SMALL BUSINESS TAX RELIEF ACT OF 2007—Continued

Ms. KLOBUCHAR. Mr. President, I am here today to talk about health care. Today, 45 million Americans are living without access to affordable health care. In a nation of such tremendous wealth and opportunity, with such a strong belief in science and research and medical advancement—we certainly have that in our State, the State of Minnesota—one wonders how so many of our fellow citizens can be burdened with the daily worry of what to do should a health disaster strike themselves or a loved one.

Health insurance premiums have skyrocketed into orbits unreachable by an increasing number of middle-class families. We have seen this in our State, where we actually have a fairly high level of people covered. But health care premiums for the middle class are so many times out of reach. We have seen nearly a 100-percent increase in the last few years in our State.

The foundations of employer-based health insurance are buckling under enormous cost pressures. The result is that ever more Americans are squeezed by health care costs and face awful decisions about delaying or forgoing needed medical treatment and care.

I, in fact, woke up this morning trying to decide when my daughter would get her braces because of the health insurance policy we got that makes you wait 2 years to get that kind of care. Well, we are lucky to be able to even have that insurance because so many kids in this country do not have it.

In fact, nearly 9 million of the uninsured in America are children. Kids without access to health care are at an enormous disadvantage as they grow up and start to make their life in this world. Children without health coverage are less likely to get basic preventive care, less likely to see a doctor regularly, and less likely to perform well in school. Children without health coverage are also more likely to show up at the hospital sicker and more likely to develop costly chronic diseases.

Currently covering 6 million children, the Children's Health Insurance Program succeeded in improving their lives by giving them access to the health care services they need. It is a successful program that deserves to reach even more children. This is important because, first of all, it is the decent thing to do for America's children who, through no fault of their own, are growing up in families that cannot otherwise get affordable health insurance. But this is also important because it is something that is good for all of us.

That is because insuring our children is a smart investment. It is a smart investment to make sure America's children get preventive medical care. It is a smart investment to help America's children grow up as healthy as they can be. It is a smart investment to have America's children in school focused on learning rather than distracted by a sickness or an injury that has gone untreated. It is a smart investment to have America's children get medical care through a sensible system of health insurance rather than having them end up in a hospital emergency room as their health care provider of last resort, increasing the bill for the rest of us.

I have seen the direct impact at the local level. For 8 years, I was the county attorney. As county attorney, my office represented the largest safety net hospital in Minnesota. That is the Hennepin County Medical Center in Minneapolis. It is one of the Nation's premier public teaching and research hospitals. It has a nationally recognized level 1 trauma center with the largest emergency room in our State.

The hospital serves patients regardless of their ability to pay. As a result, in 2006, the Hennepin County Medical Center's level of uncompensated care added up to $38 million—almost double what it was in the year 2000. That is because the emergency room was these people's doctor. People say: Well, they do not have insurance. They cannot get a doctor. Well, they have a doctor. It is the emergency room. The taxpayers are paying for it, and it is the most expensive place to get health care. It is the clinic of last resort for the uninsured, whether it is for minor illnesses or for more serious conditions that went untreated or could have been prevented.

Both in the short run and over the long term, expanding health insurance coverage offers a better deal for our Nation's health and for our continued prosperity. The people of my State

have recognized this for a long time. Back in 1992, the leaders in my State voted to establish MinnesotaCare to provide children and their families with a new opportunity to secure health coverage.

The initiative was created with bipartisan support in our State legislature, and it was signed into law by Republican Governor Arne Carlson.

Within a decade—and thanks to the Children's Health Insurance Program—MinnesotaCare had grown to cover more than 150,000 Minnesotans and helped to make my State No. 1 in the Nation for the percentage of residents with health coverage.

But we are now losing the high ground we worked so hard to gain, as a growing number of Minnesotans, especially children, go without health coverage. Uncompensated health care costs for Minnesota's urban and rural hospitals have jumped substantially in recent years. Much of this increase in uncompensated care is due to a decline in health care coverage in our State.

For example, between 2001 and 2004, the proportion of Minnesotans who had health coverage through their employers declined from more than 68 percent to less than 63 percent. During the same period, the proportion of Minnesota children covered through their parents' employer also declined from roughly 77 percent to 69 percent.

Not surprisingly, the number of Minnesota children lacking health coverage increased significantly. Today, an estimated 82,000 Minnesota children are without health coverage.

At the time when thousands of Minnesotans are losing coverage from their employers, or they are being priced out of the insurance market by ever-higher premiums, MinnesotaCare's funding has also been scaled back.

In Congress, we have the opportunity to do something about this—starting with the reauthorization of the Children's Health Insurance Program.

Recently, the Senate Finance Committee approved bipartisan legislation to reauthorize the Children's Health Insurance Program. Although I believe it could be even stronger, this compromise legislation authorizes $35 billion over 5 years to expand the Children's Health Insurance Program and extend quality health insurance to an additional 3.2 million children who currently lack coverage.

This legislation provides much needed funding for States to maintain and expand their programs and ensure that States that have suffered Federal funding shortfalls, including Minnesota, will now experience a stable level of Federal dollars.

As a State-Federal partnership, Children's Health Insurance Program has granted States the ability to tailor their programs to meet the needs of their residents. Some States increased eligibility levels for children. Other States allowed pregnant women to be covered under the program.

With MinnesotaCare, my State was an early leader in covering children from working families who had incomes above the Federal poverty level but still could not afford health insurance. In 2001, Minnesota was granted a waiver to extend the coverage to parents with incomes up to twice the Federal poverty line.

I would like to make one point clear. In no way is Minnesota covering parents at the expense of children. When the Children's Health Insurance Program was established in 1997, Minnesota already had one of the highest levels of covering children. So why did Minnesota include low-income working parents? The reason is simple. Ample research shows that when parents have coverage, children also get coverage, and they are more likely to actually receive medical care.

I have to point out the Bush administration agrees—or at least at one time it did. Here is a quote from Health and Human Services Secretary Tommy Thompson in June of 2001, when his Department approved Minnesota's waiver. He said:

> I am thrilled today to extend the promise of health care insurance to parents. We know there is a greater likelihood that kids will stay insured if their parents also have coverage.

Agreeing with Secretary Thompson was Mark McClellan, the Administrator for the Centers for Medicare and Medicaid Services. Testifying in 2006 before the Finance Committee about the virtues of parent coverage, he said:

> Extending coverage to parents and caregivers may also increase the likelihood that their children remain enrolled in SCHIP.

So as recently as last year, top officials in the Bush administration were on record affirming the strong evidence of the role of parental coverage in the health care and well-being of children. Now the President and his allies have backtracked and would prefer to take coverage away from American families, including 34,000 parents in Minnesota alone.

I will tell my colleagues what seems odd to me. Both the President and the Vice President were recently in hospitals, and they were covered. That is good. But why would they want to deny millions of kids in this country the same right? Why would they want to deny 34,000 parents in Minnesota the same right?

As Congressional Budget Office Director Peter Orszag stated during a Finance Committee markup of this bill:

> When you remove parents from health coverage, you end up removing kids too.

It doesn't make sense. Our goal must be to secure health care access for more—not fewer—Americans.

The White House is living in the past instead of looking to the future. Leaders at the State level, including many Republican Governors, have already moved well beyond the President's constricted position and are committed to trying to expand health coverage to their residents.

Minnesota's Republican Governor, Gov. Tim Pawlenty, currently the chair of the National Governors Association, recently signed a letter to congressional leadership asking them to reauthorize the Children's Health Insurance Program. I have this letter in front of me and I wish to quote from it:

> The Nation's governors call on Congress and the administration to reauthorize the State Children's Health Insurance Program prior to September 30, 2007.

They talk about how the authorization is critical for the safety net.

Then they go on to say:

> While we have not taken a position on the actual overall funding amount or the sources of revenue used as offsets, we are encouraged by the Senate Finance Committee's efforts to move a bipartisan reauthorization bill that provides increased funding and reflects the general philosophy that State flexibility and options and incentives for States are preferable to mandates.

Not only did Gov. Tim Pawlenty sign this, I know the Governor of the Presiding Officer's home State of Ohio signed it. I also see that Governor Schwarzenegger of California signed this. There are dozens and dozens of signatures of the Nation's Governors.

I ask unanimous consent to have printed in the RECORD this letter from the National Governors Association, Gov. Tim Pawlenty, Chair.

There being no objection, the material was ordered to be printed in the Record, as follows:

Washington, DC, July 24, 2007.

Hon. HARRY REID,
Majority Leader, U.S. Senate, Washington, DC
Hon. MITCH MCCONNELL,
Minority Leader, U.S. Senate, Washington, DC
Hon. NANCY PELOSI,
Speaker, U.S. House of Representatives, Washington, DC
Hon. JOHN BOEHNER,
Minority Leader, U.S. House of Representatives, Washington, DC

DEAR SENATOR REID, SENATOR MCCONNELL, SPEAKER PELOSI AND REPRESENTATIVE BOEHNER: The nation's governors call on Congress and the Administration to reauthorize the State Children's Health Insurance Program (SCHIP) prior to September 30, 2007. The authorization for this critical safety net program will soon expire and urgent action is needed to ensure its continued success for the next five years. For many reasons, defaulting to a series of temporary extensions of the program would be untenable for states and the millions of children who rely upon the program.

While we have not taken a position on the actual overall funding amount or the sources of revenue used as offsets, we are encouraged by the Senate Finance Committee's efforts to move a bipartisan reauthorization bill that provides increased funding and reflects the general philosophy that state flexibility and options and incentives for states are preferable to mandates. Our recently enacted policy on SCHIP and a series of letters we have sent since February outline our positions on these issues in more detail.

We look forward to working with all of you to ensure that a sensible bipartisan SCHIP reauthorization can be signed into law in a timely and certain manner.

Sincerely,

Governor Tim Pawlenty; Governor James H. Douglas, Chair, Health and Human Services Committee; Governor Edward G. Rendell; Governor Jon S. Corzine, Vice Chair, Health and Human Services Committee; Governor Janet Napolitano, Arizona; Governor Ruth

Ann Minner, Delaware; Governor M. Jodi Rell, Connecticut; Governor Mike Beebe, Arkansas; Governor M. Michael Rounds, South Dakota; Governor John Baldacci, Maine; Governor Martin O'Malley, Maryland; Governor Rod Blagojevich, Illinois; Governor Christine O. Gregoire, Washington; Governor Deval Patrick, Massachusetts; Governor Jennifer M. Granholm, Michigan; Governor Brian Schweitzer, Montana; Governor Kathleen Babineaux Blanco, Louisiana; Governor Bill Ritter, Colorado; Governor Brad Henry, Oklahoma; Governor Benigno Fitial, Northern Mariana Islands; Governor Felix Perez Camacho, Guam; Governor Eliot Spitzer, New York; Governor Jim Doyle, Wisconsin; Governor Chester J. Culver, Iowa; Governor Jon M. Huntsman, Jr., Utah; Governor Kathleen Sebelius, Kansas; Governor Timothy M. Kaine, Virginia; Governor Ted Strickland, Ohio; Governor Don Carcieri, Rhode Island; Governor John Lynch, New Hamsphire; Governor Ernie Fletcher, Kentucky; Governor Sony Perdue, Georgia; Governor Bill Richardson, New Mexico; Governor Arnold Schwarzenegger, California; Governor Dave Heineman, Nebraska; Governor Michael F. Easley, North Carolina; Governor Jim Gibbons, Nevada; Governor Linda Lingle, Hawaii; Governor Theodore Kulongoski, Oregon; Governor Phil Bredesen, Tennessee; Governor Sarah Palin, Alaska; Governor Dave Freudenthal, Wyoming; Governor John Hoeven, North Dakota.

Ms. KLOBUCHAR. Mr. President, here is one more indicator of broad-based support for this insurance. A few days ago, a group of law enforcement leaders in my State came together to express their support for expanding the Children's Health Insurance Program. They included Minneapolis Police Chief Tim Dolan, my former colleague Dakota County Attorney Jim Backstrom, and Hennepin County Sheriff Rich Stanek, who also happens to be a former Republican State legislator. They believe that investing in health insurance for kids and their families is one of the best things we can do to fight crime and ensure safe, prosperous communities.

The time to act is now. In a few months, the Children's Health Insurance Program will expire. If that happens, our children will suffer. The President should reconsider his threat to veto. My Senate colleagues who say they are against this bipartisan compromise legislation should reconsider their opposition.

I thank the Finance Committee for its efforts to bring this bill to the floor and to expand this important and successful initiative. It is not only good for American kids, it is good for our families and for our local communities, and it is good for all of us, because it improves our Nation's health and prosperity.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The junior Senator from Tennessee is recognized.

Mr. CORKER. Mr. President, I rise this evening at this late hour to again talk about the SCHIP bill before us, but even talk a little further about health care for all Americans. I don't think there is anybody in this body who believes that at some point we are not going to extend children's health care coverage. I think everybody in this body realizes what we are doing right now is talking about how, in fact, that is going to be done. Even if the President were to veto this bill, I think all of us realize that again, in some form or fashion, we are going to come back together and we are going to make sure the children of America benefit from the SCHIP program that has been in place now since 1997. I think as we look at the issues we are dealing with on this SCHIP bill, as we look at the many issues we are dealing with involving Medicaid and Medicare, I know of no other moment for us to more fully be able to debate the future of health care in our country in general.

I think all of us know, as the Senator from Minnesota said and many Senators before her have said, there are 45 million Americans today who at some point in time during the year did not have health insurance. In my own State of Tennessee, we have 800,000 people in the State who do not have health insurance. The toll is enormous. I think all of us can tell a story about a friend or a neighbor or somebody we have seen in our cities as we go back into the States who does not have health care coverage and the insecurities they feel. We are having one of the most dynamic growths in markets in U.S. history, and yet so many people in America feel insecure. I am convinced one of the main reasons is because so many people feel insecure about their health care coverage.

I know that throughout the campaign, in the 95 counties of our State that I visited, I met so many Tennesseans who were concerned about the financial health of their family because they did not have health insurance, and about whether their husbands who might have had seizures would be able to get the proper care they might need. So I believe it is a moral obligation for us here in the Senate and for those in the Congress to deal with this issue in a much broader way even than as we are talking about during this SCHIP debate. I also believe as this Presidential race unfolds, almost every Presidential candidate will have to face Americans and talk about how they plan to deal with the fact that Americans today do not have the health insurance coverage they need.

That is why today I rise to join the Senator from North Carolina, Senator BURR, with Senate bill 1886, which is the Every American Insured Health Act. Americans want to control their own destiny. They don't like the fact that an employer might decide what kind of coverage they have, or if they have coverage at all. They don't like the fact that some bureaucrat in Washington may decide that they have coverage or not. Americans like to know they have their destiny in their own hands. There is something about American psyches that is grounded in that particular issue.

So what we propose through the Every American Insured Health Act is that every individual in America—every individual in America—who is not now covered by some existing governmental program would receive a $2,160 tax credit, and every family would receive $5,400. This is very different than many proposals in the past where we talked about a tax deduction. One of the things I think we all know we can talk about which are niceties—things that are decent—are health savings accounts. We can talk about other things that sort of nibble at the edges, if you will, as they relate to health care, but the only thing that allows people to own their own health insurance is the money to pay for it. So we, through what is called a refundable tax credit in this bill, caused that to be the case.

Unlike the other bills that are being discussed today, and unlike so many other health care acts we discussed, this actually is revenue neutral. This is one of those things that allows every American to be covered with health insurance, yet does not pile on a deficit, if you will, for the children of our future to have to deal with. It is absolutely revenue neutral.

Let me tell my colleagues how it works. A lot of people, such as we here in the Senate, receive our health insurance through our employer—the Federal Government. A lot of people receive health insurance through the employer they work for back in our home States. Let me give a little example. For an individual in Tennessee who might make $40,000 and receive a $5,000 health benefit, whereas now that is not taxable, in the future, if this bill were to be enacted, they would have to actually pay tax on that and their tax bill would be about $1,250. Under the provisions of this act, what we would propose is that every individual would receive $2,160, so they could pay their tax bill, and then have money left over to deal with whatever other health issues they might have.

The most important aspect of this, though, is it means that so many Americans today—Tennesseans, Ohioans, Minnesotans—who don't have health insurance, through this proposal would actually have the money, the money timed in a fashion to actually allow them to purchase health insurance. This would mean that virtually everybody in America, through this plan, would have the opportunity to own their own health insurance plan and they themselves would decide who the carrier would be. This would do something that was discussed by Dr. Coburn from Oklahoma. It would do away with what we call cost shifting.

Obviously, the 45 million citizens, as the Senator from Minnesota mentioned, get health care; they just happen to get it at the emergency room. Who pays for that? Well, all of those

people who go out and buy private health plans or employers who buy those, actually pay for that, because all of those costs are shifted to the other plans. What the Every American Insured Health Act would do is do away totally with cost shifting, because everybody in America would own their own plan and those plans would be paying for their health coverage.

This obviously includes a few other attributes. It includes reforms for States so that States can set up pools, so that individuals today who don't have access to other pools of insurance at lesser expensive rates, it allows the States to set up pools so that individuals can buy their insurance through those pools. It also incentivizes States to set up high-risk pools. There are obviously many people, by the grace of God, by the genes they are created from, who have health issues that some of us don't have to deal with, so their health care costs are higher, if you will, than other Americans. This would provide incentives for States to set up high-risk pools so that those people could benefit from the opportunity of being grouped with others.

One other attribute and incentive of this is it causes States to actually set up a plan—a plan in their State—that has of the cost 6 percent of the median income of the population of that State, so that you create a basic plan that certainly almost everyone—everyone in their State certainly, by virtue of the plan we are laying out, would obviously be able to afford. This obviously, as I mentioned, would reduce the cost to people around our country who are trying to do the right thing by their employees. It obviously gives people the opportunity—every American—to determine their own destiny as it relates to health care.

I know this bill is not perfect; no bill is. I want to say in closing that the reason I have joined Senator BURR and others to offer this bill is I do believe this country continues and continues and continues to have a debate about the fringes, if you will. We talk about children. We talk about other populations. We offer in many ways what I think is empty rhetoric around the issue of health care. This is a solution. It may not be a perfect solution. But I ask my colleagues to please join the debate about health care in a way that ensures that every American has access to health care.

We are very fortunate in this body. We have health care. All of us know of people who truly are concerned about the next day and the next day and the next day, about how they are going to survive because a loved one in their family has health care issues that are not covered. So I ask my colleagues, please, don't turn away from this plan. Join the debate and let's make sure that this body puts forth an act, a bill, a solution, if you will, to make sure that every American—every American—has the same benefit we here in the Senate have.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. WHITEHOUSE). The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, the Children's Health Insurance Program is a success story. It was created in 1996 during my second term in the House of Representatives under a Republican-controlled Congress and signed into law by President Clinton. It was exactly what voters sent people to Washington to do. It was bipartisan, with a Democratic President working with a Republican Congress, with wide support within Congress from large numbers of both Democrats and Republicans.

Since then, the program has reduced the number of uninsured children in working families by one-third; 6.6 million children are covered nationally. More than 218,000 children are covered in my State of Ohio, from Galion to Gallipolis, from Mansfield to Middletown, from Xenia to Zanesville. These children now get care in their doctors' offices but not, as the President suggests, in the emergency rooms. Their care is delivered when it is needed, not when it is too late. They go to their family physician with an ear infection, and they get an antibiotic that may cost $50 or $75 or $100. The child gets sent home with his or her mother or father, and the child is cured instead of the ear ache getting so bad for a child whose parent has no insurance, and the parent waiting and hoping it gets better. The child goes to the emergency room at the cost of several hundred dollars, and the child may have a permanent hearing loss as a result, with what that does to the child's future in school and to the child's future later in getting a job.

These children under the CHIP program have good, reliable health coverage. The Children's Health Insurance Program, in short, works. It works for our Ohio children, our Ohio parents, and for Ohio communities. But it does not work as well as it could.

Today we have the opportunity to make the Children's Health Insurance Program what it should be. Sadly, we all know millions of American children—far too many children in Dayton and Columbus and Toledo and Cleveland and Akron and Canton and Youngstown and Cincinnati—remain without health insurance, even though the law states they are eligible for it.

Eleven years ago, in 1996, Congress made a promise to America's children. Right now, today, this week, in the Senate and in the House, we have the opportunity to live up to that promise. We can pass this bill to provide health insurance to 3.2 million more children, children who have missed out on our promise—not their fault, ours—so far.

This is a bipartisan effort and bill, just like the original was a decade ago. That is because this legislation is about children, not politics. This bill is about helping children.

Let me tell a story about how the Children's Health Insurance Program has helped one family in Ohio. Seth Novak is a 3-year-old boy who lives in Lebanon, OH, in Warren County, outside Cincinnati, the southwestern part of the State. This is a picture of Seth. His dad is self-employed. He helps churches with their construction projects.

The family buys private health insurance for $444 a month that covers the parents and Seth's two older siblings. But Seth has Down Syndrome and other health problems. In addition, in an attempt to get health insurance for her son, Seth's mom checked with six different insurance companies. She was quoted rates from $1,200 to $1,800 per month for private insurance—just for Seth, not for Mr. and Mrs. Novak or the two older children.

The Novaks are a hard-working family, but they simply cannot afford $14,400 a year for a policy covering only one of their children, not to mention their own insurance, another $444. They cannot afford a policy of $14,000 a year for one of their children, which would cover only part of the cost, frankly, for only some of the care Seth needs.

Just this week, the Novak family learned that Seth's eligibility for Medicaid/SCHIP has been denied effective August 31. That is why we have work to do. Where will Seth go for medical care? What if something happens?

There is hope for Seth, though. In Ohio, Governor Strickland and legislative leadership—again, in Ohio, it is a bipartisan effort—by increasing eligibility for the Children's Health Insurance Program to children up to 300 percent of the Federal poverty level. As Assistant Majority Leader Durbin pointed out about an hour and a half ago, these are not people living in the lap of luxury when you say 300 percent of the poverty level. These are middle-class families with significant health problems, who simply cannot afford, on their middle-class salaries and wages, their health insurance.

In January, the legislature and the Governor, understanding the plight that families like Seth's find themselves in, when the new eligibility for the program goes into effect, the Novaks of Lebanon, OH, will be able to restore his health insurance and still pay their bills and take care of their family.

Ohio's leaders have taken care of Seth and thousands like him. They need Congress and the President this week to do the same.

I have a picture of another Ohio family—a success story—who can attest to how the Children's Health Insurance Program helped them. This is Latonya Shoulders of Kent, OH, and her son Phillip Grant, Jr.

In 1996, Latonya was a pregnant, full-time student at Kent State University, my wife's alma mater. She didn't have health insurance or the resources to afford medical care. She enrolled in Ohio's Medicaid Program about halfway through her pregnancy. Her son had Medicaid/SCHIP coverage until he

was 5 years old. That is when she finished her bachelor's degree and got a job as a nurse with insurance benefits.

The Children's Health Insurance Program was there for Phillip in the first years of his life. The program provided for him in several medical emergencies. At 2 years old, he was bitten by another child at daycare and developed acute cellulitis. He spent 2 days in the hospital. When he was about 4, he cut his arm and had a recurrence of cellulitis. This required two surgeries, both inpatient and outpatient treatment.

As any parent knows, raising children means all too many visits to the hospital. These hospital stays could have devastated this family's finances and so much that went with it, right when Latonya was working so hard to get her nursing degree and to get ahead. Latonya is proud that she no longer needs Medicaid/Children's Health Insurance Program coverage for her son.

As I said, she is now a nurse and has health insurance. The program helped Latonya when she and Phillip needed it. Today she is a productive taxpaying citizen, and he is a healthy boy. The goal now is to let other families experience the same benefit.

President Bush came to Cleveland recently—about 25, 20 miles from my home—and told an audience of Ohioans:

> People have access to health care in America. After all, you just go to an emergency room.

The President doesn't seem to realize that is exactly the problem. We all know emergency care is much more expensive than a scheduled visit to a doctor or a clinic. When people go to emergency rooms and hospitals, they end up with large costs which insurance companies bear and then raise their premiums, or the hospital eats the cost. It is a huge burden on hospitals, especially hospitals in places such as rural Appalachia, in southeast Ohio, and places such as Zanesville and Morgan County and Athens and Gallia County and Lawrence County. It is a burden on hospitals such as Metro in Cleveland, which serves our community so well, or Akron General or the Summa or Lorain's community health center. These hard-working families cannot afford health insurance for children, much less if the child has a serious health issue.

I want to make sure children like Seth Novak and Phillip Grant receive the care they need. This is a picture of Seth playing on a slide. I want him to be strong and healthy so he can continue playing and getting his exercise and enjoying his childhood, with health insurance; or this picture of Phillip with his mother at her graduation. I want him to grow up healthy so he can pursue a bachelor's degree just like his mom did. I want every child in Ohio to thrive and develop to his or her full potential.

Ohio families should be able to take care of their bills without worrying about whether they will get their most basic health care needs met. Every eligible child should be able to benefit from the Children's Health Insurance Program—every eligible child in this country. That requires the additional $35 billion that this bill authorizes. That is about how many weeks in Iraq? We spend $2.5 billion a week in Iraq, and here we are asking for $35 billion over 5 years. That requires that additional $35 billion.

I want our President to see past relying on emergency rooms, thinking that is the best option to provide the basic medical care that our low-income families need, and instead, to provide it through an insurance program so a mother can take her child to a family practitioner and get the kind of preventive care that my friend from Oklahoma, Senator COBURN, talked about. Even though he doesn't agree with this legislation, he talked about getting the care that these children need that only health insurance—not emergency room treatment—will get them.

This bill is about children, not about politics. It needs to pass.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

(Mr. BROWN assumed the Chair.)

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. Mr. President, I speak today in support of the Children's Health Insurance Program. I want to first applaud the Finance Committee for its bipartisan 17-to-4 vote to approve this bill. I thank Senators BAUCUS, ROCKEFELLER, GRASSLEY, and HATCH, Majority Leader REID, and also the staff of the Finance Committee for all their hard work through the very difficult negotiations that made it possible to bring this critical measure so strongly to the floor.

I also recognize Rhode Island's role in this piece of legislation, going all the way back to the distinguished Senator John Chafee, one of the early bipartisan sponsors of the bill. Now on the floor today, my senior Senator, JACK REED, has been one of the most powerful and outstanding advocates for this program in this institution. I am proud to join him in supporting this bill and in this fight.

I am proud also to represent a State with one of the lowest rates of uninsured adults and children in the Nation. There is a reason. Rhode Island has worked over the past 15 years to achieve this success, beginning with the RIteCare program in 1993. In 2001, the creation of this Children's Health Insurance Program allowed Rhode Island to further reduce the number of uninsured children in the State. I am proud to have been part of Gov. Bruce Sundlun's team when he started the original RIteCare program in 1993.

As health care costs skyrocket, and the number of people in this country who lack health insurance approaches the staggering number of 50 million, we in Congress have an obligation to strengthen initiatives like RIteCare that make health care more accessible.

For years, the Children's Health Insurance Program has given millions of uninsured American families access to health care for their kids. And pretty much everyone has thought this was a good thing. But now, setting aside reason, and driven by ideology, President Bush has threatened to lift his veto pen for only the fourth time in his Presidency to take that security and peace of mind away from these children and from their worried moms and dads, from families similar to the ones the Senator from Ohio highlighted in his eloquent remarks a moment ago.

The President claims the $35 billion improvement over 5 years is too expensive. The President would prefer only the $5 billion he included in his budget. But that funding level would result in 1 million American children losing their health insurance. We certainly cannot look to President Bush for leadership.

How ironic, after all we have heard from this administration praising the State Children's Health Insurance Program and even taking credit for expanding coverage, for encouraging State flexibility, and for spurring innovation at the State level.

Listen to what they used to say. In the administration's plan outlining the President's second term, their fact sheet boasted:

> The year before President Bush took office, some 3.3 million low-income children were enrolled in SCHIP. By 2003, that number had risen to 5.8 million, a 75 percent increase. Over that same period, by working cooperatively with State Governors, the Department of Health and Human Services increased the number of low-income adults on Medicaid by 6.8 million.

That was then, this is now.

After that, the administration went on to lament the fact that ''millions of children who are eligible for SCHIP or Medicaid coverage are not yet enrolled. Billions in Federal dollars available to the States to insure these children remain unspent because these children haven't been signed up.''

Then, at the 2004 Republican National Convention, President Bush promised this:

> In a new term, we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for the Government's health insurance programs. We will not allow a lack of attention or information to stand between these children and the health care they need.

But now the same Bush administration, the same President, is aggressively planning to deny health insurance to poor children. How does this make any sense?

The President's rationale for this new parsimony was revealed before an audience in Cleveland on July 10. Here is the President's approach to health

insurance for America. You just pointed this out, Mr. President:

I mean, people have access to health care in America; after all, you just go to an emergency room.

Well, that is a thoughtful approach. Once again, we cannot look to our President for any leadership on this issue.

The administration has also expressed its opposition to the cigarette tax that will fund the increases in children's health insurance, calling it—get this—among the most regressive revenue-raising measures one could propose. That is from a letter from Secretary Leavitt to Chairman BAUCUS and Senator GRASSLEY.

The irony department is open late in the Bush administration. In evaluating their crocodile tears about regressive tax measures, consider that this Nation will spend $233 billion in 2008 on the Bush tax cuts, 30 percent of which will go to the top 1 percent of income earners. From 2008 through 2011, the period we are talking about for children's health care, those tax cuts will cost Americans, in lost revenue and interest on the debt, nearly $1 trillion, 22 percent of which will go to people who earn more than $1 million a year.

This chart illustrates just how the cost of tax cuts for the top 1 percent of Americans compares to the cost of expanding health care for children in this country. We are spending vastly more each year on tax cuts for the Nation's highest income earners than we are fighting for in children's health care.

Here it is, $2.1 billion for children's health care in 2008, $70 billion for the richest 1 percent; $5 billion in fiscal year 2009 for children's health care, $72 billion for the richest 1 percent; and in 2010, gosh, we go all the way to $7.9 billion for children's health care with only $82 billion for the richest 1 percent.

The Congressional Budget Office estimates that in just this year alone—just this year alone—we are paying an extra $46 billion in interest, not paying back the debt, just in interest, on the Bush tax cuts—$46 billion just in 1 year. And the whole thing we are arguing about here is $35 billion over 5 years for children's health care. It is truly mind-boggling.

But it doesn't end there. The President has also threatened to veto the bill based on its coverage of adults. This is a policy that the administration has previously, explicitly, repeatedly approved. This is a sudden ideological U-turn of stunning and deeply hypocritical proportions.

As recently as last summer at a Finance Committee hearing on children's health insurance, then CMS Administrator Mark McClellan said the following:

Extending coverage to parents and caretaker relatives not only serves to cover additional insured individuals, but it may also increase the likelihood that they will take the steps necessary to enroll their children. Extending coverage to parents and caretakers may also increase the likelihood that their children remain enrolled in SCHIP.

That was then, this is now.

This administration has approved waivers to cover parents in New Mexico, Illinois, Oregon, New Jersey, Michigan, and Wisconsin. Fewer than 2 months ago, on May 30 of this year, Leslie Norwalk, who was then Acting Administrator of CMS, was ''pleased to inform'' Wisconsin that its extension request for what they call BadgerCare—it is equivalent to RIteCare in Rhode Island—had been approved through March 31, 2010. BadgerCare covers roughly 67,000 parents. Again, this waiver was approved by the Bush administration 8 weeks ago, and now he is threatening a veto for care that covers adults.

Here is a copy of the letter that CMS Administrator Mark McClellan sent to my home State of Rhode Island on January 13, 2006. It reads:

We are pleased to inform you that your amendment to the RIteCare section 1115 demonstration, as modified by the Special Terms and Conditions accompanying this award letter, has been approved.

It also notes:

Rhode Island's request to renew title XXI, section 1115, demonstration project, dated July 15, 2005, with additional information . . . has also been approved.

Finally, it notes:

Individuals who, at the time of initial application, are custodial parents or relative caretakers of children who are eligible under the title XIX State plan or the title XXI State plan . . .

Are in the demonstration population and, of course, ''we look forward to continuing to work with you and your staff.'' Signed Mark B. McClellan, M.D., Ph.D., the Administrator of CMS. This was January of 2006. This is the Bush administration. This is them signing off on adults, custodial parents, or relative caretakers of children being in the plan.

Yet now the President is shocked—shocked—that this program may cover some adults. Who didn't send him the memo?

At the end of May, I spoke on the Senate floor about some of the major problems facing health care in this country. I talked about the lack of investment in quality improvements, the lack of a national information technology infrastructure, and a reimbursement system that pays doctors to perform procedures rather than to help patients get well. I took these issues to the Senate floor because the structure of our system is unsound, its underlying mechanism is broken, its signals are misaligned.

But there are a few shining lights in the American health care system, and the Children's Health Insurance Program is among the brightest. This program respects State flexibility, it encourages responsiveness to local needs, it fertilizes structural creativity in the health care arena, it safeguards the vulnerable, it unites families, and it invests in the future of our Nation.

The Children's Health Insurance Program means that children are more likely to receive medical care for common conditions such as asthma or ear infections. It means that children have higher school attendance rates. It means that children have higher academic achievement. It means that children have more contact with medical professionals and receive more preventive care. It means that children stay out of expensive urgent care settings, such as the emergency room.

We choose now in this bill and in this debate between providing our Nation's children with health insurance and not providing our Nation's children with health insurance. It is as simple as that. We choose now whether every individual in this Nation, regardless of age, gender, race, income, or health status deserves the stability and the safety that health insurance provides. We choose for millions of American families how much they have to worry, how much moms and dads have to worry about the health care of their children.

It is my duty as a representative of the people of Rhode Island, and it is our collective duty as representatives of a great Nation to stick up for the most vulnerable members of our society and for programs that protect those who cannot protect themselves. We must certainly not give up in the face of an administration that willingly violates its own principles in order to create an issue on which the President can deliver a veto as a desperate political stunt in the last bleak chapters of his collapsed Presidency—not at the cost of health care for children. That would be truly pathetic.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. TESTER. Mr. President, I rise in strong support of the reauthorization of the Children's Health Insurance Program. The reauthorization of this highly successful 10-year-old program would provide an additional $35 billion over the next 5 years to make sure that more of America's neediest children have access to one of their most basic needs—health care.

In fact, 6.6 million of our most vulnerable children—that is an increase of 3.2 million children—will be covered by this bill. I applaud the efforts of my senior Senator, MAX BAUCUS, for leading the charge to cover more children.

Reauthorizing the Children's Health Insurance Program is the right thing to do. Because of MAX BAUCUS and the good work of the Finance Committee, almost 12,000 more children in Montana will have coverage this year. Montanans know just how well this program works. As president of the Montana Senate, I worked to increase the number of children eligible for the Children's Health Insurance Program and pushed through full State funding of the Children's Health Insurance Program for Montana's children, expanding the enrollment from 10,900 to 13,900

children annually. As of this July, Montana's Children's Health Insurance Program is providing insurance for 14,304 children per month in the State of Montana.

It just makes sense. Only children who do not have private insurance are eligible. I am going to repeat that because I have heard contrary stuff on the floor. Only children who do not have private insurance are eligible for this program. No one is double-dipping, no one who has insurance can receive this coverage.

With this reauthorization of the Children's Health Insurance Program, we as a country are investing in our most valuable resource—our children. If children have regular checkups and receive the preventive care they need, they are sick less and in school more, and they grow up to be healthy, productive members of our society with less problems in middle age and healthier in their elderly years.

Mr. President, it is tough out there. Millions of children lack health insurance despite their parents' hard work and efforts to keep their heads above water. Many families cannot afford health insurance despite the fact that they have jobs. When it comes time for parents to pay the bills, health insurance comes after rent, food, clothing, utility bills, and gas for their car. Health insurance shouldn't be treated as a luxury, and access to health care shouldn't be a fantasy.

We must be focused on improving the overall quality of health care for low-income children. We know there are more children eligible for benefits than are currently enrolled. In order to find and provide coverage for those children, States should be able to use the information from food stamp programs, free and reduced lunches, and other initiatives in place for low-income families. Up to now, these programs could not share information, so those with the greatest need would have to apply for each program separately.

This Children's Health Insurance Program before us increases funding and outreach and enrollment efforts to find these uninsured kids. This is especially critical in rural States—rural States such as Montana. Rural children are more likely to be poor and less likely to have access to employer-based health plans even though most of their parents are employed. Nearly one-third of the kids in rural America rely upon CHIP and Medicare. The need is clear: Without children's health insurance, they would be uninsured.

There have been a lot of stories shared today on the floor. I want to share another one, of a fellow Montanan. Duran ''Junior'' Caferro from Helena, MT, is a boxer and has been fighting for 10 years. He is ranked in the 125-pound weight class and will compete in the Olympic trials next month in Houston, TX. Duran is also an enrolled member of the Northern Cheyenne tribe. His father, who works with at-risk youth, does not have health insurance and can't afford coverage for himself or his son. Helena has an urban Indian health clinic but not an Indian Health Service hospital, so Duran doesn't have access to emergency and hospital services with his IHS health benefits.

CHIP has allowed him to have a choice in where he receives medical care, and he recognizes the value of this coverage. When asked about CHIP, he said the following:

> It is important that I have Children's Health Insurance Program because I don't have to be afraid to push myself when I'm training or fighting. It gives me one less thing to worry about.

If Duran wins this tournament in Houston this summer, he will be a member of the U.S. Olympic boxing team. He will turn 19 soon and will age-out of CHIP. He expects to become uninsured because he and his dad are still struggling and can't afford to buy private health insurance.

Some may doubt the cost-effectiveness of this program, but this bill not only helps low-income children, it also helps middle America. Why is that the case? Because the coverage made available to low-income kids lowers the number of emergency room visits of uninsured children. Emergency room doctors no longer serve as primary care physicians for the uninsured, and that lowers the cost of health care for the rest of America—the middle class—who currently cover the cost of the uninsured emergency room visits.

We all know that the middle class is feeling the pinch too. If we can lower health costs for them and provide health care to more of our kids, it is a win-win.

The way to ensure the continued strength of our country for future generations is to improve the future of our most valuable asset—our young people—and this bill which reauthorizes the Children's Health Insurance Program does just that.

Once again, I thank the senior Senator from Montana, MAX BAUCUS, and the Finance Committee for championing this bill. They did some outstanding work. Hopefully, we will continue that work on the floor here tomorrow. We must pass this bill, and I urge my colleagues and the President to support it.

Mrs. BOXER. Mr. President, I rise today to support the reauthorization of the Children's Health Insurance Program—an essential effort to ensure the health of our Nation's children.

For the past 10 years, the Children's Health Insurance Program has helped provide health care for millions of children from working families that do not qualify for Medicaid but can't afford private insurance. These are the children of working families whose companies do not offer health insurance to their employees.

As the cost of health insurance rises and an increasing number of employers are unable or unwilling to provide health insurance to their employees and their families, the number of families who do not have health insurance has continued to rise.

While the number of the uninsured continues to rise, the percentage of low-income children without health insurance has dropped more than one-third since the creation of the Children's Health Insurance Program.

Currently the Children's Health Insurance Program provides coverage for 6.6 million children nationwide. This reauthorization would provide health care coverage for an additional 3.2 million children who are uninsured today. In California, an estimated 250,000 children will be added.

The Children's Health Insurance Program has always enjoyed the bipartisan support of our Congress, our Governors, and our President—which is why I am shocked by the inadequacy of this administration's plan to insure the children of our Nation's working families.

The President is spending $10 billion each month in Iraq but has threatened to veto a bill that will provide 10 million children with access to health care. Under the President's proposal, he is willing to fund the Children's Health Insurance Program with an increase of $1 billion a year—the cost of 3 days in Iraq.

Under the administration's proposal, we end up counting how many children will lose health insurance instead of how many we can enroll. In the first year, the President's plan would eliminate health care insurance for 200,000 children in California alone—and the number of uninsured children would continue to climb.

This shortfall in funding would result in 800,000 children who are currently enrolled to lose their coverage. I ask the President, what does he propose these children do when they are sick?

If we fail to renew this program or if the President vetoes this bill as he has threatened to do, it is the children who will pay the price.

There is not a man or woman in this Chamber who wouldn't do everything within their power to ensure the health of their own children—we should do no less for the children of our Nation.

The Members of this Congress have overwhelmingly expressed a commitment to children's health. Earlier this year, we passed a budget resolution which set aside $50 billion for the Children's Health Insurance Program, reaffirming our commitment to the continued success of this program.

We can still do more and we will, but this bill is a step forward in the right direction.

I would like to thank Senators BAUCUS and ROCKEFELLER, Senators GRASSLEY and HATCH and the members of the Finance Committee who worked so tirelessly to bring this legislation forward in a bipartisan way, and keep the focus of this bill where it should be—on the children.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. TESTER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. TESTER. Mr. President, I ask unanimous consent that there now be a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

HONORING THE LIFE OF DR. JOHN A. STROSNIDER

Mr. McCONNELL. Mr. President, I rise today to honor the life of John A. Strosnider, D.O., a respected Kentuckian who passed away on July 1, 2007, of cancer. Dr. Strosnider was the founding dean of the Pikeville College School of Osteopathic Medicine and also served as president of the American Osteopathic Association, AOA.

Dr. Strosnider accepted the challenge to create the Pikeville College School of Osteopathic Medicine in 1996. The school, located in eastern Kentucky, opened in 1997 with 60 students and has since produced more than 400 physicians. In keeping with the school's mission, many of them have stayed in the region to practice medicine. In fact, according to Pikeville College officials, 55 of the new physicians have opened offices within a 2-hour drive of the city.

Throughout his career, Dr. Strosnider was honored by several organizations for his dedication to the profession. At the time of his death, he was serving as president of the AOA, and, in 2005, he was named Kentucky Osteopathic Medical Association Physician of the Year.

After being named AOA president, Dr. Strosnider said, ''I hope to raise students' awareness and remind osteopathic physicians of the history and philosophy of osteopathic medicine. The osteopathic medical profession was built on a primary care philosophy, and we need to get back to those basics so that our patients in these areas have access to the distinctive health care promised by osteopathic medicine.''

When Dr. Strosnider was diagnosed with pancreatic cancer earlier this year, he gathered his students and faculty together to inform them of his illness. He told the assembly he wanted to be open with them and remain optimistic. Shortly after his passing, Pikeville College President Hal Smith wrote a letter to colleagues and friends. In it, he wrote, ''John's vision and work will continue to impact the lives of thousands of individuals he never knew.''

I got to know Dr. Strosnider several years ago. Every year, he would bring a group of his students to Washington, DC, and I had the privilege of meeting with him and his students on several occasions. I was always impressed with how Dr. Strosnider encouraged the future doctors to remain close to home and provide critical health care to the underserved people of eastern Kentucky.

Mr. President, I ask you to join me in remembering this outstanding Kentuckian. He is survived by his wife Jo Ann and three children, John Adam, Alisha, and Paul. He will be missed.

DARFUR

Mr. DODD. Mr. President, I rise today to talk about the ongoing genocide in Darfur. As my colleagues know, the United Nations Security Council is currently hammering out the final text of a new resolution related to the expanded United Nations African Union hybrid force to protect civilians who have been victims of genocide in Darfur. This resolution represents the best hope for the international community to finally come together to put an end to the violence in that country.

This new U.N. resolution reportedly calls for a large increase in military and police personnel to be deployed to Darfur. It calls on member states to make commitments to contribute troops to the hybrid force, and for this bolstered hybrid force UNAMID to take command of the region by the end of the year. Importantly, it also calls on the Sudanese Government and all rebel groups to enter into peace negotiations to reach a political settlement which will ultimately end the conflict in Darfur.

If these reports are accurate, then we may be one step closer to ending the violence in Darfur. But in order to actually stop the violence, we must ensure that the hybrid force is large enough to effectively carry out its mission, and deployed quickly to stop the violence immediately. These increased forces are desperately needed to replace the currently under-funded and under- equipped paltry AU force of 7,000 soldiers presently in Darfur.

We simply cannot wait any longer to protect the hundreds of thousands of innocent civilians whose villages have been burned, who have been driven into refugee camps, and who have been raped and murdered.

I welcome the calls of British Prime Minister Gordon Brown and French President Nicholas Sarkozy for the United Nations to quickly adopt this new draft resolution, and I appreciate the leadership they have demonstrated in personally committing to ensure that the peace process moves forward, once the U.N. resolution has passed. Prime Minister Brown recently declared that ''this is one of the great humanitarian disasters of our generation. It is incumbent on the whole world to act.'' I wholeheartedly agree and I urge President Bush to join with Prime Minister Brown and President Sarkozy in personally committing to ending the conflict in Darfur.

Recent reports have also indicated that the text of the resolution relating to implementing multilateral sanctions has been softened due to the objections of some African member states, as well as China.

While I strongly believe that robust targeted sanctions should be implemented against members of rebel groups and the Sudanese Government, that we should curb the Sudanese Government's access to oil revenues, increase penalties on private companies operating in Sudan, and allow for the divestment of funds in Sudan, the sad truth is that what is most needed now from the international community is a legitimate U.N. mandate for a strengthened hybrid peacekeeping force.

But there is no reason why the United States can't move forward to implement unilateral sanctions against Sudan, even if the international community and the Bush administration refuse to do so. As chairman of the Banking Committee I have asked the majority leader to expedite Senate consideration and passage of S.831, The Sudan Divestment Authorization Act of 2007. The majority leader was prepared to do so, but the minority objected. I have also asked that the majority leader to hold H.R. 180, the Darfur Accountability and Divestment Act of 2007, at the desk and attempt to pass this bill prior to the August recess. I am also planning to ask the majority leader to expedite consideration of S. 1563, the Sudan Disclosure and Enforcement Act of 2007. These three bills represent a good step towards applying targeted economic pressure against the Sudanese Government.

The implementation of robust and targeted sanctions is long overdue. In fact, the time to implement the sanctions was 4 years ago, and it should have been among the first components of the administration's Plan A, instead of the last resort of its Plan B—a plan which it has still failed to implement, despite Special Envoy Andrew Natsios's assurances over 7 months ago, back in January of 2007, that action was imminent.

Sudan's U.N. ambassador recently asserted that the text of the new U.N. Security Council resolution is ''hostile'' and full of ''insinuations.'' He further declared that the language is ''ugly'' and ''awful.'' Ugly and awful? Ugly and awful is the murder of 450,000 people in Darfur and the displacement of 2.5 million civilians. Ugly and awful is the Sudanese President, Omar al-Bashir, after his recent visit to Darfur, declaring ''that most of Darfur is now secure and enjoying real peace. People are living normal lives,'' he said. Ugly and awful is the United States and the international community waiting one day longer to protect these innocent civilians.

The time for action is now. We must not allow the Sudanese Government to

engage in anymore prevarication regarding its acceptance of a hybrid peacekeeping force. And we must ensure that this new U.N. Security Council resolution marks the beginning of the end of genocide in Darfur, by mandating the immediate deployment of a robust multinational peacekeeping force.

DOGFIGHTING

Mr. KERRY. Mr. President, on July 26, I introduced critical legislation to stem the rising tide of dogfighting in our country. Dogfighting is one of society's most barbaric and inhumane activities. The dogs are mistreated, starved and conditioned for aggression, and then allowed to literally destroy one another in the ring. As we have read in the recent indictment of Atlanta Falcon's quarterback Michael Vick on dogfighting charges, poor-performing dogs are tortured, maimed, and killed. This illegal and despicable activity has no place in a civilized society.

However, dogfighting has expanded its hold in recent years. The Humane Society of the United States estimates that 40,000 people in the United States are involved in professional dogfighting, and fight purses reach as high as $100,000. As many as 100,000 additional people are involved in ''streetfighting,'' informal dogfighting that often involves young people in gangs.

This legislation would place a Federal ban on all aspects of dogfighting activity from owning to transporting to training dogs for the purpose of fighting, to participating as a spectator at dogfighting ventures. I hope this legislation will end the practice of dogfighting in our country, once and for all.

This Congress's authority to make the lucrative commercial aspects of dogfighting a crime cannot be doubted. Just 2 years ago, the Supreme Court made clear in Gonzales v. Raich that Congress's authority under the commerce clause extends to local activities that are an integral component of interstate criminal activities.

This bill is well within that standard. As demonstrated in the Vick indictment and by the many law enforcement records, animal welfare reports, and economic studies that will be entered into the RECORD on this bill the—dogfighting industry has become nationwide in scope, and Congress is well within its authority to address both the nationwide framework and localized branches that are a critical part of that extensive criminal venture. We are dealing with a criminal industry has developed into a multifaceted, national and international commercial market that depends heavily upon illegal trafficking between States. Dogfighting is an inherently commercial and economic activity that has a substantial effect upon interstate commerce.

Dogfighting is an interconnected, nationwide, lucrative commercial industry. In addition to high-stakes gambling, dogfighters exchange tens if not hundreds of millions of dollars annually on the purchase and sale of fighting dogs. Dog fighters also make top dollar by breeding or selling ''stud'' privileges for fighting dogs, and can make top dollar by breeding dogs that have proven themselves in the ring by killing multiple other dogs.

This extensive commercial venture also requires trafficking in the specialized equipment necessary to train and house fighting dogs. There are even underground transport services to courier these dogs from one match to the next—assuming they survive. Dog fighters also make a living handling and training fighting dogs for well-funded sponsors—as we saw in the Vick indictment.

It could not be clearer that the overwhelming majority of dog fights—if not every single dog fight—are truly economic endeavors that involve some element of interstate commerce, such as animals, equipment, breeders, or spectators having traveled across State lines. Many dog fights are conducted for the purposes of illegal gambling, and some gambling on the sidelines is almost always present at these fights. Dogfighting also burdens interstate commerce by increasing the risk of injury or disease to both animals and humans, including dog bites, rabies, and heartworms.

What's more, small, localized dogfighting ventures, when viewed in the aggregate, have a substantial impact upon interstate commerce. As the allegations I mentioned earlier against Michael Vick and his codefendants demonstrate, large amounts of money are at stake in dogfighting matches, and winners often take home all or some portion of entry fees paid by other participants. The individual dogs used in fighting can have a commercial value of between hundreds of dollars and tens of thousands of dollars per animal. All of the activities associated with dogfighting, including gambling and other illegal activities, equipment outlays, breeding expenses, and promotion costs are not only inherently commercial in nature but transcend State boundaries.

By way of example, there are dozens of Federal criminal prohibitions on the local creation, possession, and sale of narcotics and narcotic-making equipment. Congress recognized that the illicit drug industry had become nationwide in scope, and chose to exercise its constitutional power to address the localized branches of that extensive criminal venture. Likewise, this bill responds to the proliferation of dog fighting into a nationwide criminal network of local ventures, which Congress is similarly authorized to address. Just look at the Endangered Species Act, which broadly restricts the killing, taking, or breeding of certain wild animals, in order to effectuate Congress's goal of preventing the extinction of imperiled species. The ESA has been upheld as a valid exercise of Congress's authority by every federal appeals court to address the issue, and the Supreme Court has repeatedly declined to upset those judgments.

The effects of dogfighting on interstate commerce are neither indirect, remote, nor attenuated. Regulation of dogfighting is necessary to prevent and eliminate burdens upon interstate commerce. In addition, the regulation of dogfighting is an essential part of a larger regulatory scheme, the Animal Welfare Act, which mandates the humane treatment of animals in our society.

PRESTICIDE REGISTRATION IMPROVEMENT RENEWAL ACT

Mr. HARKIN. Mr. President, I ask unanimous consent that the following chart be printed in the RECORD. It is a chart related to the Pesticide Registration Improvement Renewal Act, a bill that Senator CHAMBLISS and I plan to introduce shortly.

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

EPA No.	New No.	Action	Decision time (months), PRIA II:			Registration Service Fee ($)
			FY #1	FY #2	FY #3	
TABLE 1.—REGISTRATION DIVISION—NEW ACTIVE INGREDIENTS						
R1	1	Food use (1)	24	24	24	516,300
R2	2	Food use; reduced risk (1)	18	18	18	516,300
R3	3	Food use; Experimental Use Permit application submitted simultaneously with application for registration; decision time for Experimental Use Permit and temporary tolerance same as #R4 (1).	24	24	24	570,700
R4	4	Food use; Experimental Use Permit application; establish temporary tolerance; submitted before application for registration; credit $326,025 toward new active ingredient application that follows.	18	18	18	380,500
R5	5	Food use; application submitted after Experimental Use Permit application; decision time begins after Experimental Use Permit and temporary tolerance are granted (1).	14	14	14	190,300
R6	6	Non-food use; outdoor (1)	21	21	21	358,700
R7	7	Non-food use; outdoor; reduced risk (1)	16	16	16	358,700
R8	8	Non-food use; outdoor; Experimental Use Permit application submitted simultaneously with application for registration; decision time for Experimental Use Permit same as #R9 (1).	21	21	21	396,800

EPA No.	New No.	Action	Decision time (months), PRIA II: FY #1	FY #2	FY #3	Registration Service Fee ($)
R9	9	Non-food use; outdoor; Experimental Use Permit application submitted before application for registration; credit $228,225 toward new active ingredient application that follows.	16	16	16	266,300
R10	10	Non-food use; outdoor; submitted after Experimental Use Permit application; decision time begins after Experimental Use Permit is granted (1)	12	12	12	130,500
R11	11	Non-food use; indoor (1)	20	20	20	199,500
R12	12	Non-food use; indoor; reduced risk (1)	14	14	14	199,500
new	13	Non-food use; indoor; Experimental Use Permit application submitted before application for registration; credit $100,000 toward new active ingredient application that follows.	18	18	18	150,000
R36	14	Enriched isomer(s) of registered mixed-isomer active ingredient (1)	18	18	18	260,900
new	15	Seed treatment only; includes non-food and food uses; limited uptake into Raw Agricultural Commodities (1)	18	18	18	388,200
new	16	Conditional Ruling on Preapplication Study Waivers; applicant-initiated	6	6	6	2,080
TABLE 2.—REGISTRATION DIVISION—NEW USES						
R13	17	First food use; indoor; food/food handling (1)	21	21	21	157,500
R14	18	Additional food use; indoor; food/food handling	15	15	15	36,750
R15	19	First food use (1)	21	21	21	217,400
R16	20	First food use; reduced risk (1)	16	16	16	217,400
R17	21	Additional food use	15	15	15	54,400
R18	22	Additional food use; reduced risk	10	10	10	54,400
R19	23	Additional food uses; 6 or more submitted in one application	15	15	15	326,400
R20	24	Additional food uses; 6 or more submitted in one application; reduced risk	10	10	10	326,400
R21	25	Additional food use; Experimental Use Permit application; establish temporary tolerance; no credit toward new use registration	12	12	12	40,300
R22	26	Additional food use; Experimental Use Permit application; crop destruct basis; no credit toward new use registration	6	6	6	16,320
R23	27	Additional use; non-food; outdoor	15	15	15	21,740
R24	28	Additional use; non-food; outdoor; reduced risk	10	10	10	21,740
R25	29	Additional use; non-food; outdoor; Experimental Use Permit application; no credit toward new use registration	6	6	6	16,320
R26	30	New use; non-food; indoor	12	12	12	10,500
R27	31	New use; non-food; indoor; reduced risk	9	9	9	10,500
new	32	New use; non-food; indoor; Experimental Use Permit application; no credit toward new use registration	6	6	6	8,000
new	33	Review of Study Protocol; applicant-initiated; excludes DART, pre-registration conferences, Rapid Response review, DNT protocol review, protocols needing HSRB review.	3	3	3	2,080
new	34	Additional use; seed treatment; limited uptake into Raw Agricultural Commodities; includes crops with established tolerances (e.g., for soil or foliar application); includes food or non-food uses.	12	12	12	41,500
new	35	Additional uses; seed treatment only; 6 or more submitted in one application; limited uptake into Raw Agricultural Commodities; includes crops with established tolerances (e.g., for soil or foliar application); includes food and/or non-food uses.	12	12	12	249,000
TABLE 3.—REGISTRATION DIVISION—IMPORT AND OTHER TOLERANCES						
R28	36	Establish import tolerance; new active ingredient or first food use [1]	21	21	21	262,500
R29	37	Establish import tolerance; additional food use	15	15	15	52,500
new	38	Establish import tolerances; additional food uses; 6 or more crops submitted in one petition	15	15	15	315,000
new	39	Amend an established tolerance (e.g., decrease or increase); domestic or import; applicant-initiated	10	10	10	37,300
new	40	Establish tolerance(s) for inadvertent residues in one crop; applicant-initiated	12	12	12	44,000
new	41	Establish tolerances for inadvertent residues; 6 or more crops submitted in one application; applicant-initiated	12	12	12	264,000
new	42	Establish tolerance(s) for residues in one rotational crop in response to a specific rotational crop application; applicant-initiated	15	15	15	54,400
new	43	Establish tolerances for residues in rotational crops in response to a specific rotational crop petition; 6 or more crops submitted in one application; applicant-initiated.	15	15	15	326,400
TABLE 4.—REGISTRATION DIVISION—NEW PRODUCTS						
R30	44	New product; identical or substantially similar in composition and use to a registered product; no data review or only product chemistry data; cite-all data citation, or selective data citation where applicant owns all required data, or applicant submits specific authorization letter from data owner. Category also includes 100% re-package of registered end-use or manufacturing-use product that requires no data submission nor data matrix..	3	3	3	1,300
new	45	New product; identical or substantially similar in composition and use to a registered product; registered source of active ingredient; selective data citation only for data on product chemistry and/or acute toxicity and/or public health pest efficacy, where applicant does not own all required data and does not have a specific authorization letter from data owner..	4	4	4	1,560
R31	46	New end-use or manufacturing-use product; requires review of data package within RD; includes reviews and/or waivers of data for only: product chemistry and/or acute toxicity and/or public health pest efficacy	6	6	6	4,360
R32	47	New product; new physical form; requires data review in science divisions	12	12	.....	10,880
R33	48	New manufacturing-use product; registered active ingredient; selective data citation	12	12	12	16,320
new	49	New product; requires approval of new food-use inert; applicant-initiated; excludes approval of safeners	12	12	12	15,540
new	50	New product; requires approval of new non-food-use inert; applicant-initiated	6	6	6	8,300
new	51	New product; requires amendment to existing inert tolerance exemption (e.g., adding post-harvest use); applicant-initiated	10	10	10	11,420
new	52	New product; repack of identical registered end-use product as a manufacturing-use product; same registered uses only	3	3	3	2,080
new	53	New manufacturing-use product; registered active ingredient; unregistered source of active ingredient; submission of completely new generic data package; registered uses only.	24	24	24	233,000
TABLE 5.—REGISTRATION DIVISION—AMENDMENTS TO REGISTRATION						
R34	54	Amendment requiring data review within RD (e.g., changes to precautionary label statements, or source changes to an unregistered source of active ingredient) [2].	4	4	4	3,280
R35	55	Amendment requiring data review in science divisions (e.g., changes to REI, or PPE, or PHI, or use rate, or number of applications; or add aerial application; or modify GW/SW advisory statement) [2].	8	8	8	10,880
R37	56	Cancer reassessment; applicant-initiated	18	18	18	163,100
new	57	Amendment to Experimental Use Permit; requires data review/risk assessment	6	6	6	8,300
new	58	Refined ecological and/or endangered species assessment; applicant-initiated	18	18	12	155,300
TABLE 6.—ANTIMICROBIALS DIVISION—NEW ACTIVE INGREDIENTS						
A38	59	Food use; establish tolerance exemption [1]	24	24	24	94,500
A39	60	Food use; establish tolerance [1]	24	24	24	157,500
A40	61	§ 2(mm) uses [1]	18	18	18	78,750
A41	62	Non-food use; outdoor; uses other than FIFRA § 2(mm) [1]	21	21	21	157,500
A42	63	Non-food use; indoor; FIFRA § 2(mm) uses (1)	18	18	18	52,500
A43	64	Non-food use; indoor; uses other than FIFRA § 2(mm) (1)	20	20	20	78,750
new	65	Non-food use; indoor; low-risk and low-toxicity foodgrade active ingredient(s); efficacy testing for public health claims required under GLP and following DIS/TSS or AD-approved study protocol.	12	12	12	55,000
TABLE 7.—ANTIMICROBIALS DIVISION—NEW USES						
A44	66	First food use; establish tolerance exemption [1]	21	21	21	26,250
A45	67	First food use; establish tolerance [1]	21	21	21	78,750
A46	68	Additional food use; establish tolerance exemption	15	15	15	10,500
A47	69	Additional food use; establish tolerance	15	15	15	26,250
A48	70	Additional use; non-food; outdoor; FIFRA § 2(mm) uses	9	9	9	15,750
A49	71	Additional use; non-food; outdoor; uses other than FIFRA § 2(mm)	15	15	15	26,250
A50	72	Additional use; non-food; indoor; FIFRA § 2(mm) uses	9	9	9	10,500
A51	73	Additional use; non-food; indoor; uses other than FIFRA § 2(mm)	12	12	12	10,500
A52	74	Experimental Use Permit application	9	9	9	5,250
new	75	Review of public health efficacy study protocol within AD; per AD Internal Guidance for the Efficacy Protocol Review Process; applicant-initiated; Tier 1	6	4	3	2,000
new	76	Review of public health efficacy study protocol outside AD by members of AD Efficacy Protocol Review Expert Panel; applicant-initiated; Tier 2	18	15	12	10,000
TABLE 8.—ANTIMICROBIALS DIVISION—NEW PRODUCTS & AMENDMENTS						
A53	77	New product; identical or substantially similar in composition and use to a registered product; no data review or only product chemistry data; cite-all data citation, or selective data citation where applicant owns all required data, or applicant submits specific authorization letter from data owner. Category also includes 100% re-package of registered end-use or manufacturing-use product that requires no data submission nor data matrix..	3	3	3	1,050
new	78	New product; identical or substantially similar in composition and use to a registered product; registered source of active ingredient; selective data citation only for data on product chemistry and/or acute toxicity and/or public health pest efficacy, where applicant does not own all required data and does not have a specific authorization letter from data owner..	4	4	4	1,500
A54	79	New end use product; FIFRA § 2(mm) uses only	4	4	4	4,200

EPA No.	New No.	Action	Decision time (months), PRIA II: FY #1	FY #2	FY #3	Registration Service Fee ($)
A55	80	New end-use product; uses other than FIFRA § 2(mm); non-FQPA product	6	6	6	4,200
A56	81	New manufacturing-use product; registered active ingredient; selective data citation	12	12	12	15,750
A57	82	Label amendment requiring data submission (2)	4	4	4	3,150
New	83	Cancer reassessment; applicant-initiated	18	18	18	78,750
New	84	Refined ecological risk and/or endangered species assessment; applicant-initiated	18	18	12	75,000
New	85	New product; identical or substantially similar in composition and use to a registered product; registered active ingredient; unregistered source of active ingredient; cite-all data citation except for product chemistry; product chemistry data submitted.	4	4	4	4,200
TABLE 9.—BIOPESTICIDE & POLLUTION PREVENTION DIVISION—MICROBIAL & BIOCHEMICAL PESTICIDES; NEW PRODUCTIONS & AMENDMENTS						
B58	86	New active ingredient; food use; establish tolerance [1]	18	18	18	42,000
B59	87	New active ingredient; food use; establish tolerance exemption [1]	16	16	16	26,250
B60	88	New active ingredient; non-food use [1]	12	12	12	15,750
B61	89	Food use; Experimental Use Permit application; establish temporary tolerance exemption	9	9	9	10,500
B62	90	Non-food use; Experimental Use Permit application	6	6	6	5,250
new	91	Extend or amend Experimental Use Permit	6	6	6	4,200
B63	92	First food use; establish tolerance exemption	12	12	12	10,500
new	93	Amend established tolerance exemption	9	9	9	10,500
B64	94	First food use; establish tolerance [1]	18	18	18	15,750
new	95	Amend established tolerance (e.g., decrease or increase)	12	12	12	10,500
B65	96	New use; non-food	6	6	6	5,250
B66	97	New product; identical or substantially similar in composition and use to a registered product; no data review or only product chemistry data; cite-all data citation, or selective data citation where applicant owns all required data, or applicant submits specific authorization letter from data owner. Category also includes 100% re-package of registered end-use or manufacturing-use product that requires no data submission nor data matrix.	3	3	3	1,050
B67	98	New product; registered source of active ingredient; all Tier I data for product chemistry, toxicology, non-target organisms, and product performance must be addressed with product specific data or with request for data waivers supported by scientific rationales.	6	6	6	4,200
new	99	New product; food use; unregistered source of active ingredient; requires amendment of established tolerance or tolerance exemption; all Tier I data requirements for product chemistry, toxicology, nontarget organisms, and product performance must be addressed with product-specific data or with request for data waivers supported by scientific rationales.	16	16	16	10,500
new	100	New product; non-food use or food use having established tolerance or tolerance exemption; unregistered source of active ingredient; no data compensation issues; all Tier I data requirements for product chemistry, toxicology, non-target organisms, and product performance must be addressed with product-specific data or with request for data waivers supported by scientific rationales.	12	12	12	7,500
B68	101	Label amendment requiring data submission [2]	4	4	4	4,200
new	102	Label amendment; unregistered source of active ingredient; supporting data require scientific review	6	6	6	5,000
new	103	Protocol review; applicant-initiated; excludes time for HSRB review (pre application)	3	3	3	2,000
TABLE 10.—BIOPESTICIDE & POLLUTION PREVENTION DIVISION—STRAIGHT CHAIN LEPIDOPTERAN PHEROMONES (SCLPs)						
B69	104	New active ingredient; food or non-food use [1]	6	6	6	2,100
B70	105	Experimental Use Permit application; new active ingredient or new use	6	6	6	1,050
new	106	Extend or amend Experimental Use Permit	3	3	3	1,050
B71	107	New product; identical or substantially similar in composition and use to a registered product; no data review or only product chemistry data; cite-all data citation, or selective data citation where applicant owns all required data, or applicant submits specific authorization letter from data owner. Category also includes 100% re-package of registered end-use or manufacturing-use product that requires no data submission nor data matrix..	3	3	3	1,050
B72	108	New product; registered source of active ingredient; all Tier I data for product chemistry, toxicology, non-target organisms, and product performance must be addressed with product specific data or with request for data waivers supported by scientific rationales.	4	4	4	1,050
new	109	New product; unregistered source of active ingredient	6	6	6	2,200
new	110	New use and/or amendment to tolerance or tolerance exemption	6	6	6	2,200
B73	111	Label amendment requiring data submission [2]	4	4	4	1,050
TABLE 11.—BIOPESTICIDE & POLLUTION PREVENTION DIVISION—PLANT INCORPORATED PROTECTANTS (PIPs)						
B74	112	Experimental Use Permit application; registered active ingredient; non-food/feed or crop destruct basis; no SAP review required [3]	6	6	6	78,750
B75	113	Experimental Use Permit application; registered active ingredient; establish temporary tolerance or tolerance exemption; no SAP review required [3]	9	9	9	105,000
B76	114	Experimental Use Permit application; new active ingredient; non-food/feed or crop destruct basis; SAP review required; credit $78,750 toward new active ingredient application that follows.	12	12	12	131,250
new	115	Experimental Use Permit application; new active ingredient; non-food/feed or crop destruct; no SAP review required; credit $78,750 toward new active ingredient application that follows.	7	7	7	78,750
B77	116	Experimental Use Permit application; new active ingredient; establish temporary tolerance or tolerance exemption; SAP review required; credit $105,000 toward new active ingredient application that follows.	15	15	15	157,500
new	117	Experimental Use Permit application; new active ingredient; establish temporary tolerance or tolerance exemption; no SAP review required; credit $105,000 toward new active ingredient application that follows.	10	10	10	105,000
new	118	Amend or extend Experimental Use Permit; minor changes to experimental design; established temporary tolerance or tolerance exemption is unaffected	3	3	3	10,500
new	119	Amend or extend existing Experimental Use Permit; minor changes to experimental design; extend established temporary tolerance or tolerance exemption	5	5	5	26,250
B86	120	Amend Experimental Use Permit; first food use or major revision of experimental design	6	6	6	10,500
B78	121	New active ingredient; non-food/feed; no SAP review required [4]	12	12	12	131,250
B79	122	New active ingredient; Non-food/feed; SAP review required [4]	18	18	18	183,750
B80	123	New active ingredient; establish permanent tolerance or tolerance exemption based on temporary tolerance or tolerance exemption; no SAP review required [4].	12	12	12	210,000
B81	124	New active ingredient; establish permanent tolerance or tolerance exemption based on temporary tolerance or tolerance exemption; SAP review required [4]	18	18	18	262,500
B82	125	New active ingredient; establish tolerance or tolerance exemption; no SAP review required [4]	15	15	15	262,500
B84	126	New active ingredient; establish tolerance or tolerance exemption; SAP review required [4]	21	21	21	315,000
B83	127	New active ingredient; Experimental Use Permit application submitted simultaneously; establish tolerance or tolerance exemption; no SAP review required [4].	15	15	15	315,000
B85	128	New active ingredient; Experimental Use Permit requested simultaneously; establish tolerance or tolerance exemption; SAP review required [4]	21	21	21	367,500
new	129	New active ingredient; different genetic event of a previously approved active ingredient; same crop; no tolerance action required; no SAP review required	9	9	9	105,000
new	130	New active ingredient; different genetic event of a previously approved active ingredient; same crop; no tolerance action required; SAP review required	9	9	9	157,500
B87	131	New use [3]	9	9	9	31,500
B88	132	New product; no SAP review required [5]	9	9	9	26,250
new	133	New product; SAP review required [5]	15	15	15	278,250
B89	134	Amendment; seed production to commercial registration; no SAP review required	9	9	9	52,500
new	135	Amendment; seed production to commercial registration; SAP review required	15	15	15	105,000
B90	136	Amendment (except #B89); No SAP review required; (e.g., new IRM requirements that are applicant initiated; or amending a conditional registration to extend the registration expiration date with additional data submitted) (2).	6	6	6	10,500
new	137	Amendment (except #B89); SAP review required (2)	12	12	12	63,000
new	138	PIP Protocol review	3	3	3	5,250
new	139	Inert ingredient tolerance exemption; e.g., a marker such as NPT II; reviewed in BPPD	6	6	6	52,500
new	140	Import tolerance or tolerance exemption; processed commodities/food only	9	9	9	105,000

[1] All uses (food and/or non-food) included in any original application or petition for a new active ingredient or a first food use that otherwise satisfy the conditions for the category are covered by the base fee for that application.
[2] EPA-initiated amendments shall not be charged fees. Fast-track amendments handled by the Antimicrobials Division are to be completed within the FIFRA stated timelines listed in Section 3(h) and are not subject to PRIA fees. Label amendments submitted by notification under PR Notices, such as PR Notice 95–2 and PR Notice 98–10, continue under PR Notice timelines and are not subject to PRIA fees.
[3] Example: Transfer existing PIP trait by traditional breeding, such as from field corn to sweet corn.
[4] May be either a registration for seed increase or a full commercial registration. If a seed increase registration is granted first, full commercial registration is obtained using B89 or New 134.
[5] Example: Stacking PIP traits within a crop using traditional breeding techniques.

ADDITIONAL STATEMENTS

HONORING THE 100TH ANNIVERSARY OF THE MARIN HUMANE SOCIETY

• Mrs. BOXER. Mr. President, I ask my colleagues to join me today in honoring the 100th anniversary of a wonderful organization in my home State of California, the Marin Humane Society.

The Marin County Humane Society was founded on December 14, 1907, by Ethel H. Tompkins and a group of concerned citizens who wanted to find a solution to the plight of lost and abused animals. From its first animal shelter in the San Rafael stables in 1912, the organization has expanded its facilities to a four-building complex on a 7-acre campus. Today, the Marin Humane Society, which shortened its name in 1980, serves the community with 95 staff members and 800 volunteers.

Through the dedicated work of the Marin Humane Society, 8,000 animals each year find refuge, rehabilitation, and loving homes. This has included efforts to rescue animals lost and injured in disasters, such as the Oakland firestorm of 1991.

It is particularly noteworthy that in 2005, the organization brought over 2,500 Hurricane Katrina animal victims to bay area shelters and out of harm's way through its rescue effort, ''Orphans of the Storm.'' In partnership with commercial airlines, these pet airlifts were a first for the Nation and protected the lives of thousands of animals. Funded solely from private benefactors and coordinated by the Marin Humane Society, nine flights of lost animals arrived in the bay area in the 2 months following the disaster. Additional flights carried animals to southern California, Oregon, and Washington, where other animal shelters and rescue groups agreed to offer refuge.

The Marin Humane Society's admirable milestones continued in 2006, when it adopted its 250,000th animal to a loving home.

When in 1997 the Marin Humane Society staff felt they had made significant progress on controlling the pet overpopulation problem in Marin County, they decided to expand their services to neighboring counties through their Pet Partnership program. Volunteers brought thousands of dogs and cats from congested shelters in other communities to Marin to give them a second chance.

I am so pleased to acknowledge the Marin Humane Society's long and distinguished record of community service. Over the past century, the organization has educated children and adults on the importance of humane treatment of animals; provided comprehensive veterinary care and rehabilitation for neglected and abused animals; provided pet adoption services and dog training programs; and advocated for animal welfare policy on the local, State and Federal level.

I commend the Marin Humane Society staff and volunteers for their compassion and commitment to protecting and caring for our society's lost, neglected, and abused animals. They do a tremendous service to the greater community and are deserving of the highest recognition for their large hearts and generous ways. Please join me in celebrating the 100th Anniversary of the Marin Humane Society.●

HONORING DR. W. RON DeHAVEN

● Mr. HARKIN. Mr. President, today I would like to take a moment to honor Dr. W. Ron DeHaven, Administrator of the Department of Agriculture's Animal and Plant Health Inspection Service, APHIS, and to congratulate him on his retirement from public service. Dr. DeHaven has served the agency for 28 years during which he has contributed greatly to the agency's mission of promoting and protecting U.S. agriculture.

Dr. DeHaven began his APHIS career working in a field office for the veterinary services program in 1979. He later joined the agency's animal care program, rising to the top position in 1996. From 2001 to 2002 he served as the APHIS acting associate administrator, and in 2002, became head of the agency's veterinary services program.

As the Nation's chief veterinarian, he played a leading role as the agency faced the first U.S. detection of bovine spongiform encephalopathy, BSE, in 2003. His handling of this situation—as well as other animal health emergencies—showcased his trademark straightforward leadership style and calm demeanor. These challenges prepared him well for the role of APHIS Administrator, which he assumed in 2004.

As Administrator, he has skillfully guided his agency and communicated with the public, Congress, and USDA's many stakeholders. He worked conscientiously to position APHIS to prevent and respond to such threats as highly pathogenic avian influenza, exotic Newcastle disease, sudden oak death, Asian longhorned beetle and citrus diseases.

Dr. DeHaven's dedication, work ethic, and personal commitment to excellence have served U.S. agriculture well and ensured a healthy and abundant food supply for U.S consumers.●

TRIBUTE TO MICHAEL J. DONOGHUE

● Mr. KENNEDY. Mr. President, I welcome this opportunity to extend my warmest congratulations to Michael J. Donoghue on his retirement from the Worcester Regional Retirement System. I commend him for his impressive service to the people of Worcester for the past 30 years, and I know he will be deeply missed by all those he helped and supported.

Mike's impressive career extends well beyond his time at Worcester Regional Retirement System. He served two terms on the Worcester City Council before being elected Worcester County treasurer in 1978, and his outstanding experience and knowledge of the issues made him a valuable member of many charitable organizations in our city.

Mike also has served on the board of directors of the Worcester Regional Chamber of Commerce and the Massachusetts Biomedical Initiatives, and he had an invaluable role over the years in establishing Worcester as a center for medical research.

All of us in our State owe Mike our gratitude for his skillful efforts on behalf of the less fortunate. Over the years, he has given his skills and impressive leadership to the board of directors for the Visiting Nurses Association Network Foundation, the Worcester Area Mental Health Association, the Worcester Area United Way, and Special Olympics of Massachusetts.

It has been an honor to call Mike a friend, and I am especially grateful for his decades of kindness to the Kennedy family. I have relied often on Mike over the years for his advice and wise counsel, and I commend him for his service and dedication. It is a special privilege to join his wife Maureen, their children and grandchildren in congratulating him for all he has achieved in his many years of outstanding service to our Commonwealth, and I wish him well in the years ahead.●

ANNIVERSARY OF THE TURKISH INVASION OF CYPRUS

● Mr. REED. Mr. President, today, on behalf of the Greek Cypriot population of Rhode Island and Greek Cypriots around the world, I recognize the 33rd anniversary of the Turkish invasion of Cyprus.

At 5:30 a.m. 33 years ago today, heavily armed Turkish troops landed on a narrow northern beachhead in Cyprus 5 days after Greek Cypriot nationalists ousted then-President Archbishop Makarios. The invasion and subsequent occupation was described by Turkey as a ''peace operation'' to protect the minority Turkish population living in Cyprus from being victimized in the aftermath of the coup.

However, during the next 2 months, over 200,000 Greek Cypriots fled south or were expelled by Turkish forces. The Turkish Cypriots took over 37 percent of the island and then called a ceasefire, leaving the Greek Cypriots, 82 percent of the population, with under two-thirds of Cyprus. In 1983, the Turkish Republic of Northern Cyprus declared itself a country. Currently, Turkey is the only nation that recognizes this self-declaration of statehood.

Despite international efforts over the last 30 years to reunify the island, Cyprus has remained divided with more than 40,000 Turkish troops occupying its northern third. The United Nations Security Council and General Assembly have worked to determine an equally agreeable solution, but talks between the Greek Cypriot south and the Turkish Cypriot north consistently end in a stalemate.

A survey completed in February 2007 by the United Nations Peacekeeping Force in Cyprus found that a majority of both Greek and Turkish Cypriot communities view the United Nations' presence on the island as a positive. Both see any withdrawal scenario involving the U.N. departing before restoration of normal conditions and a settlement being reached as a negative. We must applaud the continued efforts of the United Nations and the focus of Cypriot leaders to reunite a divided Cyprus and remain, ourselves, committed to ushering the settlement process forward. Cypriot, Mediterranean, and United States interests will benefit from a settlement that addresses all legitimate concerns of both sides and promotes the stability of a hostile region.

Sirens wailed across the southern half of Cyprus today, in memory of the day known as ''black anniversary'' among the Greek Cypriots. Cypriot leaders, on both sides of the divide, must take forward steps to wash away the darkness of this day and replace it with peace and tolerance.●

REMEMBERING GENERAL WAYNE A. DOWNING

● Mr. REED. Mr. President, today, with a heavy heart, I recognize an American patriot and public servant who passed away on July 17, 2007: GEN Wayne A. Downing, U.S. Army, Retired.

Born on May 10, 1940, in Peoria, IL, General Downing graduated from the Spalding Institute in 1958 and was then appointed to the U.S. Military Academy. Following his graduation from West Point in 1962, General Downing served two combat tours in Vietnam as a junior infantry officer.

General Downing served his country for 34 years in a variety of command assignments in infantry, armored, special operations, and joint units, culminating in his appointment as the commander-in-chief of the U.S. Special Operations Command. As a general officer, he commanded the special operations of all services during the 1989 invasion of Panama and commanded a joint special operations task force operating deep behind the Iraqi lines during Operation Desert Storm.

General Downing's reputation was that of a smart, decisive, forceful, and caring leader, known in particular for his unwavering determination to accomplish any mission assigned and provide his soldiers the best possible support. His personal courage and leadership by example inspired fierce loyalty from all the soldiers who worked for him.

Following his retirement from the U.S. Army in 1996, General Downing had repeatedly answered the call of public service. After the terrorist attack on the U.S. base at Khobar Towers in Saudi Arabia, he was appointed by President Clinton to assess the attack and to make recommendations on how to protect Americans and U.S. facilities worldwide from future attacks.

From 1999–2000, General Downing was a member of the congressionally mandated National Commission on Terrorism charged with examining the terrorist threat to the U.S., evaluating America's laws, policies, and practices for preventing and punishing terrorism directed at U.S. citizens, and recommending corrective actions.

In the wake of 9/11, General Downing served for almost a year in the White House as national director and deputy national security advisor for combating terrorism. As the President's principal adviser on matters related to combating terrorism, he was responsible for coordinating the military, diplomatic, intelligence, law enforcement, information, and financial operations of our war on terror, and for developing and executing a strategy that integrated all elements of national power.

Following his assignment at the White House, General Downing returned to the U.S. Military Academy at West Point when he assumed the position of ''Distinguished Chair'' of the Combating Terrorism Center, CTC. Under his leadership, the center sought to better understand foreign and domestic terrorism threats, to educate future leaders, and to provide political analysis and advice to counter future terrorist activities.

In addition to his duties at the CTC, General Downing was a visiting faculty member at the University of Michigan Business School conducting seminars on leadership and transformation management and was military and terrorism analyst for NBC News.

General Downing's career has epitomized the phrase ''lifetime of service to the Nation'' and exemplified ideals inherent in duty, honor, and country. He was a true warrior who always spoke the truth, insisted on complete honesty from all he worked with, and was the epitome of honorable behavior. As a combat leader, educator, global strategist, and national security expert, General Downing's contributions to our national defense and security are immeasurable.

Our thoughts and prayers are with his wife Kathryn, his daughters Laura and Elizabeth, and the entire Downing family in this time of sorrow. He will be missed dearly by his many friends, colleagues, and an extremely grateful Nation.●

TRIBUTE TO JULIE SITTASON

● Mr. SHELBY. Mr. President, today I pay tribute to Julie Sittason, who has dedicated over 20 years of her life to caring for others. On August 16, 2007, when Julie steps down as the executive director of Hospice of West Alabama, she will leave behind a legacy of service to others.

Julie and I have been friends for many years. She graduated from my alma mater, the University of Alabama, with an undergraduate degree in sociology and a master's degree in counseling and guidance from the University of Alabama. Soon after, Julie decided to pursue a rewarding career of serving and caring for others.

For 7 years, Julie worked as a counselor at the Alabama State Department of Industrial Relations, providing guidance to the blind, the hearing impaired and recipients of Aid to Families with Dependent Children. Later, Julie returned to the University of Alabama to work as the program administrator for the West Alabama Comprehensive Services program.

In 1986, Julie was named executive director of Hospice of West Alabama. When she was hired, the Agency only employed three full-time staffers, operating on an annual budget of $86,000. Today, the budget has grown to $5 million a year and Hospice of West Alabama has 70 employees, serving 600 patients a year in Tuscaloosa, Greene, Hale, Bibb and Pickens Counties.

Over the past two decades, Julie has overseen many changes at Hospice of West Alabama. It was under her direction in 1997 when the Agency became the first community-based hospice in the State of Alabama to be officially recognized by the Joint Commission on Accreditation of Healthcare Organizations. In 2004, it was Julie's vision that led to the construction of the $5 million facility that includes the State's first community-based inpatient hospice facility.

While many people think that the service Julie contributes each day through her work at Hospice of West Alabama is enough, she thinks otherwise. As an avid volunteer, Julie continues to serve with organizations such as the March of Dimes, the MS Walkathon and Soup Bowl. She has served as an adviser for Alpha Omicron Pi Sorority, is on the administrative board for First United Methodist Church, and the board of directors for United Cerebral Palsy, Castle Hill Clinic and the Maude Whatley Clinic. Julie has also held several leadership positions in the Alabama Hospice Organization.

Julie is married to Chuck Sittason. She has two daughters, Katherine Cramer, who served with distinction as my first Senate page in 1995, and Meredith Cramer.

As Julie embarks on another phase in her life, she will remain an inspiration to many and will be remembered for her dedication and many contributions to Hospice of West Alabama. I wish her much luck in her future endeavors, and I ask this entire Senate to join me in recognizing and honoring the life and career of my good friend Julie Sittason.●

RECOGNIZING THE 114TH FIGHTER WING

● Mr. THUNE. Mr. President, today I recognize the 114th Fighter Wing of the South Dakota Air National Guard for being awarded the 2007 Outstanding Air National Guard Flying Unit Award.

Since 1956, the 114th Fighter Wing has been an outstanding unit and has played an important role in the South Dakota National Guard. The unit has a proud history of accomplishment and this award is in keeping with that tradition. Over the years, the 114th has received numerous unit citations such as the Air Force Outstanding Unit Award and the Armed Forces Expeditionary Streamer for combat duty as a part of Operation Just Cause in Panama. The 114th Fighter Wing has trained with the Navy, Marines, and the Air Force during Operation Provide Comfort II in Turkey, Commando Sling in Singapore, Operation Southern Watch in Al Jaber, Kuwait, and numerous others. Today, the unit is continuing to uphold its

standard of excellence by providing significant contributions in support of Operation Iraqi Freedom and the War on Terror. Their courageous efforts in protecting America should make both South Dakota and the Nation proud.

It gives me great pleasure to represent the men and women who make up the 114th Fighter Wing and congratulate them on their award.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 4:53 p.m., a message from the House of Representatives, delivered by Ms. Brandon, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 31. An act to amend the Reclamation Wastewater and Groundwater Study and Facilities Act to authorize the Secretary of the Interior to participate in the Elsinore Valley Municipal Water District Wildomar Service Area Recycled Water Distribution Facilities and Alberhill Wastewater Treatment and Reclamation Facility Projects.

H.R. 673. An act to direct the Secretary of the Interior to take lands in Yuma County, Arizona, into trust as part of the reservation of the Cocopah Tribe of Arizona, and for other purposes.

H.R. 735. An act to designate the Federal building under construction at 799 First Avenue in New York, New York, as the ''Ronald H. Brown United States Mission to the United Nations Building''.

H.R. 1315. An act to amend title 38, United States Code, to make certain improvements in the benefits provided to veterans under laws administered by the Secretary of Veterans Affairs, and for other purposes.

H.R. 1384. An act to designate the facility of the United States Postal Service located at 118 Minner Street in Bakersfield, California, as the ''Buck Owens Post Office''.

H.R. 1696. An act to amend the Ysleta del Sur Pueblo and Alabama and Coushatta Indian Tribes of Texas Restoration Act to allow the Ysleta del Sur Pueblo tribe to determine blood quantum requirement for membership in that Tribe.

H.R. 2107. An act to create the Office of Chief Financial Officer of the Government of the Virgin Islands, and for other purposes.

H.R. 2120. An act to direct the Secretary of the Interior to proclaim as reservation for the benefit of the Sault Ste. Marie Tribe of Chippewa Indians a parcel of land now held in trust by the United States for that Indian tribe.

H.R. 2309. An act to designate the facility of the United States Postal Service located at 3916 Milgen Road in Columbus, Georgia, as the ''Frank G. Lumpkin, Jr. Post Office Building''.

H.R. 2623. An act to amend title 38, United States Code, to prohibit the collection of copayments for all hospice care furnished by the Department of Veterans Affairs.

H.R. 2688. An act to designate the facility of the United States Postal Service located at 103 South Getty Street in Uvalde, Texas, as the ''Dolph S. Briscoe, Jr. Post Office Building''.

H.R. 2707. An act to reauthorize the Underground Railroad Educational and Cultural Program.

H.R. 2750. An act to require the Secretary of the Treasury to mint coins in commemoration of the 50th anniversary of the establishment of the National Aeronautics and Space Administration.

H.R. 2765. An act to designate the facility of the United States Postal Service located at 44 North Main Street in Hughesville, Pennsylvania, as the ''Master Sergeant Sean Michael Thomas Post Office''.

H.R. 2863. An act to authorize the Coquille Indian Tribe of the State of Oregon to convey land and interests in land owned by the Tribe.

H.R. 2874. An act to amend title 38, United States Code, to make certain improvements in the provision of health care to veterans, and for other purposes.

H.R. 2952. An act to authorize the Saginaw Chippewa Tribe of Indians of the State of Michigan to convey land and interests in land owned by the Tribe.

H.R. 2963. An act to transfer certain land in Riverside County, California, and San Diego County, California, from the Bureau of Land Management to the United States to be held in trust for the Pechanga Band of Luiseno Mission Indians, and for other purposes.

H.R. 3006. An act to improve the use of a grant of a parcel of land to the State of Idaho for use as an agricultural college, and for other purposes.

H.R. 3034. An act to designate the facility of the United States Postal Service located at 127 South Elm Street in Gardner, Kansas, as the ''Private First Class Shane R. Austin Post Office''.

H.R. 3067. An act to amend the United States Housing Act of 1937 to exempt small public housing agencies from the requirement of preparing an annual public housing agency plan.

H.R. 3123. An act to extend the designation of Liberia under section 244 of the Immigration and Nationality Act so that Liberians can continue to be eligible for temporary protected status under that section.

H.R. 3184. An act to authorize the Secretary of Agriculture to carry out a competitive grant program for the Puget Sound area to provide comprehensive conservation planning to address water quality.

H.R. 3206. An act to provide for an additional temporary extension of programs under the Small Business Act and the Small Business Investment Act of 1958 through December 15, 2007, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolutions, in which it requests the concurrence of the Senate:

H. Con. Res. 49. Concurrent resolution recognizing the 75th anniversary of the Military Order of the Purple Heart and commending recipients of the Purple Heart for their courage and sacrifice on behalf of the United States.

H. Con. Res. 136. Concurrent resolution expressing the sense of Congress regarding high level visits to the United States by democratically-elected officials of Taiwan.

H. Con. Res. 143. Concurrent resolution honoring National Historic Landmarks.

H. Con. Res. 188. Concurrent resolution condemning the attack on the AMIA Jewish Community Center in Buenos Aires, Argentina, in July 1994, and for other purposes.

The message further announced that the House passed the following acts, without amendment:

S. 375. An act to waive application of the Indian Self-Determination and Education Assistance Act to a specific parcel of real property transferred by the United States to 2 Indian tribes in the State of Oregon, and for other purposes.

S. 975. An act granting the consent and approval of Congress to an interstate forest fire protection compact.

S. 1099. An act to amend chapter 89 of title 5, United States Code, to make individuals employed by the Roosevelt Campobello International Park Commission eligible to obtain Federal health insurance.

S. 1716. An act to amend the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act, 2007, to strike a requirement relating to forage producers.

The message also announced that the House passed the act (S. 1) to provide greater transparency in the legislative process; with an amendment, in which it requests the concurrence of the Senate.

The message further announced that the House agreed to the concurrent resolution (S. Con. Res. 27) supporting the goals and ideals of 'National Purple Heart Recognition Day'; with an amendment, in which it requests the concurrence of the Senate.

The message also announced that the House disagrees to the amendment of the Senate to the bill (H.R. 2272) to invest in innovation through research and development, and to improve the competitiveness of the United States; it agrees to the conference asked by the Senate on the disagreeing votes of the two Houses thereon, and appoints the following as managers of the conference on the part of the House:

From the Committee on Science and Technology, for consideration of the House bill and the Senate amendment, and modifications committed to conference: Messrs. GORDON, LIPINSKI, BAIRD, WU, LAMPSON, UDALL of Colorado, Ms. GIFFORDS, Messrs. MCNERNEY, HALL of Texas, SENSENBRENNER, EHLERS, Mrs. BIGGERT, Messrs. FEENEY, and GINGREY.

From the Committee on Education and Labor, for consideration of Division C of the Senate amendment, and modifications committed to conference: Messrs. GEORGE MILLER of California, HOLT, and MCKEON.

ENROLLED BILL PRESENTED

The Secretary of the Senate reported that on today, July 31, 2007, she had presented to the President of the United States the following enrolled bill:

S. 1868. An act to temporarily extend the programs under the Higher Education Act of 1965, and for other purposes.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2713. A communication from the Under Secretary of Defense (Comptroller), transmitting, pursuant to law, a report relative to the funding of the support costs associated with the MH–60R helicopter mission avionics multi-year procurement program by the Future Years Defense Program; to the Committee on Armed Services.

EC–2714. A communication from the Director of Defense and Research Engineering, Department of Defense, transmitting, pursuant to law, a report relative to the Department's intent to fund three additional Foreign Comparative Testing Program projects during fiscal year 2007; to the Committee on Armed Services.

EC–2715. A communication from the Secretary of Agriculture and the Secretary of Energy, transmitting, pursuant to law, a report entitled, ''Annual Report to Congress on the Biomass Research and Development Initiative for Fiscal Year 2006''; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2716. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Gypsy Moth Generally Infested Areas; Addition of Counties in Ohio and West Virginia'' (Docket No. APHIS–2006–0116) received on July 26, 2007; to the Committee on Agriculture, Nutrition, and Forestry.

EC–2717. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' (72 FR 37115) received on July 27, 2007; to the Committee on Banking, Housing, and Urban Affairs.

EC–2718. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Final Flood Elevation Determinations'' (72 FR 35938) received on July 27, 2007; to the Committee on Banking, Housing, and Urban Affairs.

EC–2719. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Flood Elevation Determinations'' (72 FR 35937) received on July 27, 2007; to the Committee on Banking, Housing, and Urban Affairs.

EC–2720. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Flood Elevation Determinations'' (72 FR 35932) received on July 27, 2007; to the Committee on Banking, Housing, and Urban Affairs.

EC–2721. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Changes in Flood Elevation Determinations'' (72 FR 35934) received on July 27, 2007; to the Committee on Banking, Housing, and Urban Affairs.

EC–2722. A communication from the General Counsel, Department of Housing and Urban Development, transmitting, pursuant to law, the report of a vacancy in the position of Assistant Secretary for Community Planning and Development, received on July 27, 2007; to the Committee on Banking, Housing, and Urban Affairs.

EC–2723. A communication from the Deputy Secretary, Division of Corporation Finance, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled ''Shareholder Choice Regarding Proxy Materials'' (RIN3235–AJ79) received on July 26, 2007; to the Committee on Banking, Housing, and Urban Affairs.

EC–2724. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Final Rule to Limit the Daily Harvest of Halibut in the Guided Sport Charter Vessel Fishery for Halibut in Regulatory Area 2C'' (RIN0648–AV47) received on July 27, 2007; to the Committee on Commerce, Science, and Transportation.

EC–2725. A communication from the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''2007 Summer Flounder, Scup, and Black Sea Bass Recreational Fishery Management Measures'' (RIN0648–AU60) received on July 27, 2007; to the Committee on Commerce, Science, and Transportation.

EC–2726. A communication from the Director, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Economic Exclusive Zone Off Alaska; Deep-Water Species Fishery by Catcher Processor Rockfish Cooperatives in the Gulf of Alaska'' (RIN0648–XB12) received on July 27, 2007; to the Committee on Commerce, Science, and Transportation.

EC–2727. A communication from the Director, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Nantucket Lightship Scallop Access Area Closure for General Category Scallop Vessels'' (RIN0648–AU47) received on July 27, 2007; to the Committee on Commerce, Science, and Transportation.

EC–2728. A communication from the Director, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Fisheries of the Exclusive Economic Zone Off Alaska; Pacific Ocean Perch in the Eastern Aleutian District of the Bering Sea and Aleutian Islands Management Area'' (RIN0648–XB33) received on July 27, 2007; to the Committee on Commerce, Science, and Transportation.

EC–2729. A communication from the Acting Director, Office of Sustainable Fisheries, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Inseason Adjustments to Groundfish Management Measures'' (RIN0648–AV69) received on July 27, 2007; to the Committee on Commerce, Science, and Transportation.

EC–2730. A communication from the Director, National Oceanic and Atmospheric Administration, Department of Commerce, transmitting, pursuant to law, a report relative to the development of a training course for newly appointed Regional Fishery Management Council members; to the Committee on Commerce, Science, and Transportation.

EC–2731. A communication from the Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce , transmitting, pursuant to law, the report of a rule entitled ''Export Licensing Jurisdiction for Microelectronic Circuits'' (RIN0694–AE02) received on July 26, 2007; to the Committee on Commerce, Science, and Transportation.

EC–2732. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Pennsylvania; Attainment Determination, Redesignation of the Franklin County Ozone Nonattainment Area to Attainment and Approval of the Area's Maintenance Plan and 2002 Base Year Inventory'' (FRL No. 8445–6) received on July 27, 2007; to the Committee on Environment and Public Works.

EC–2733. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; State of Iowa'' (FRL No. 8448–5) received on July 27, 2007; to the Committee on Environment and Public Works.

EC–2734. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Bromoxynil, Diclofop-methyl, Dicofol, Diquat, Etridiazole, et al.; Tolerance Actions'' (FRL No. 8139–5) received on July 27, 2007; to the Committee on Environment and Public Works.

EC–2735. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Quillaja Saponaria Extract; Exemption from the Requirement of a Tolerance'' (FRL No. 8136–6) received on July 27, 2007; to the Committee on Environment and Public Works.

EC–2736. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Indiana'' (FRL No. 8442–9) received on July 27, 2007; to the Committee on Environment and Public Works.

EC–2737. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Pennsylvania; Redesignation of the Altoona's 8-Hour Ozone Nonattainment Area to Attainment and Approval of the Area's Maintenance Plan and 2002 Base Year Inventory'' (FRL No. 8446–9) received on July 26, 2007; to the Committee on Environment and Public Works.

EC–2738. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Pennsylvania; Redesignation of the Johnstown Ozone Nonattainment Area to Attainment and Approval of the Area's Maintenance Plan and 2002 Base Year Inventory'' (FRL No. 8442–7) received on July 26, 2007; to the Committee on Environment and Public Works.

EC–2739. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; Texas; Clean Air Interstate Rule Nitrogen Oxides Annual Trading Program'' (FRL No. 8446–3) received on July 26, 2007; to the Committee on Environment and Public Works.

EC–2740. A communication from the Principal Deputy Associate Administrator, Office

of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Chlorthalonil; Pesticide Tolerance'' (FRL No. 8127–9) received on July 26, 2007; to the Committee on Environment and Public Works.

EC–2741. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Revisions to the California State Implementation Plan, Sacramento Metropolitan Air Quality Management District and San Joaquin Valley Air Pollution Control District'' (FRL No . 8442–4) received on July 26, 2007; to the Committee on Environment and Public Works.

EC–2742. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Rimsulfuron; Pesticide Tolerance'' (FRL No. 8139–1) received on July 26, 2007; to the Committee on Environment and Public Works.

EC–2743. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; Implementation Plan Revision; State of New Jersey'' (FRL No. 8444–9) received on July 25, 2007; to the Committee on Environment and Public Works.

EC–2744. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Air Quality Implementation Plans; Maryland; Clarification of Visible Emissions Exceptions'' (FRL No. 8447–6) received on July 25, 2007; to the Committee on Environment and Public Works.

EC–2745. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval and Promulgation of Implementation Plans; States of Arizona and Nevada; Interstate Transport of Pollution'' (FRL No. 8443–5) received on July 25, 2007; to the Committee on Environment and Public Works.

EC–2746. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Partial Withdrawal of Direct Final Rule Revising the California State Implementation Plan, San Joaquin Valley Air Pollution Control District'' (FRL No. 8444–3) received on July 25, 2007; to the Committee on Environment and Public Works.

EC–2747. A communication from the Principal Deputy Associate Administrator, Office of Policy, Economics and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled ''Approval of New Jersey's Title V Operating Permit Program Revision'' (FRL No. 8446–4) received on July 25, 2007; to the Committee on Environment and Public Works.

EC–2748. A communication from the Regulations Coordinator, Center for Medicare and Medicaid Services, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Amendment to the Interim Final Regulation for Mental Health Parity'' (RIN0938–AO83) received on July 27, 2007; to the Committee on Finance.

EC–2749. A communication from the Regulations Coordinator, Center for Medicare and Medicaid Services, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''High Risk Pools'' (RIN0938–AO46) received on July 27, 2007; to the Committee on Finance.

EC–2750. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Weighted Average Interest Rate Update'' (Notice 2007–61) received on July 27, 2007; to the Committee on Finance.

EC–2751. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, a report relative to restrictions on assistance to the central government of Serbia; to the Committee on Foreign Relations.

EC–2752. A communication from the Director, Division for Strategic Human Resources Policy, Office of Personnel Management, transmitting, pursuant to law, the report of a rule entitled ''Veterans' Preference'' (RIN3206–AL33) received on July 26, 2007; to the Committee on Homeland Security and Governmental Affairs.

EC–2753. A communication from the Deputy White House Liaison, Bureau of Alcohol, Tobacco, Firearms, and Explosives, Department of Justice, transmitting, pursuant to law, (31) reports relative to vacancy announcements within the Department, received on July 27, 2007; to the Committee on the Judiciary.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–173. A resolution adopted by the City Council of the City of Miami Gardens, Florida, urging Congress to appropriate the funds necessary to bring the Herbert Hoover Dike into compliance with current levee protection safety standards; to the Committee on Appropriations.

POM–174. A concurrent resolution adopted by the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to create a federal catastrophe fund; to the Committee on Banking, Housing, and Urban Affairs.

HOUSE CONCURRENT RESOLUTION NO. 17

Whereas, the hurricane seasons of 2004 and 2005 were startling reminders of both the human and economic devastation that hurricanes, flooding, and other natural disasters can cause; and

Whereas, creation of a federal catastrophe fund is a comprehensive, integrated approach to help better prepare and protect the Nation from natural catastrophes, such as hurricanes, tornadoes, wildfires, snowstorms, and earthquakes; and

Whereas, the current system of response to catastrophes leaves many people and businesses at risk of being unable to replace what they lost, wastes tax dollars, raises insurance premiums, and leads to shortages of insurance needed to sustain our economy; and

Whereas, creation of a federal catastrophe fund would help stabilize insurance markets following a catastrophe and help steady insurance costs for consumers while making it possible for private insurers to offer more insurance in catastrophe-prone areas; and

Whereas, a portion of the premiums collected by insurance companies could be deposited into such a fund which could be administered by the United States Treasury and grow tax free; and

Whereas, a portion of the interest earnings of the fund could be dedicated to emergency responder efforts and public education and mitigation programs; and

Whereas, the federal catastrophe fund would operate as a ''backstop'' and could only be accessed when private insurers and state catastrophe funds have paid losses in excess of a defined threshold; and

Whereas, utilizing the capacity of the Federal Government would help smooth out fluctuations consumers currently experience in insurance prices and availability because of exposure to large catastrophic losses and would provide better protection at a lower price; and

Whereas, when there is a gap between the insurance protection consumers buy and the damage caused by a major catastrophe, taxpayers across the country pay much of the difference, as congressional appropriations of billions of dollars for after-the-fact disaster relief in the aftermath of Hurricane Katrina demonstrated; and

Whereas, there are a number of legislative instruments pending in the current One Hundred Tenth Congress which address the need for a federal catastrophe fund, including the Homeowners Protection Act of 2007 (H.R. 91) and the Commission on Catastrophic Disaster Risk an Insurance Act of 2007 (H.R. 537 and S. 292). Therefore, be it

Resolved, that the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to create a federal catastrophe fund. Be it further

Resolved, that a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–175. A concurrent resolution adopted by the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to either extend the Terrorism Risk Insurance Act to include insurance coverage for natural disasters such as earthquakes and hurricanes or, alternatively, to establish a tax incentive program for insurance companies that provide insurance coverage for such disasters; to the Committee on Banking, Housing, and Urban Affairs.

HOUSE CONCURRENT RESOLUTION NO. 50

Whereas, as a result of the devastation caused by Hurricane Katrina and Hurricane Rita to personal residential property, commercial residential property, and commercial property, Louisiana insureds, especially those located in the greater New Orleans area, are at risk with regard to the availability and affordability of personal residential property, commercial residential property, and commercial property insurance; and

Whereas, Hurricane Katrina and Hurricane Rita have created a real threat to the public health, safety, and welfare of the citizens of Louisiana, as well as to the rebuilding efforts of Louisiana citizens in the post-Katrina and Rita era; and

Whereas, Louisiana, as a state located on the coast of the Gulf of Mexico, will continue to be at risk from the threat of hurricanes, further jeopardizing the availability and affordability of personal residential property, commercial residential property, and commercial property insurance. Therefore, be it

Resolved, that the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to either extend the Terrorism Risk Insurance Act (TRIA) to include insurance coverage for natural disasters such as

earthquakes and hurricanes or, alternatively, to establish a tax incentive program for insurance companies that provide insurance coverage for natural disasters such as earthquakes and hurricanes. Be it further

Resolved, that a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–176. A concurrent resolution adopted by the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to revise the National Flood Insurance Program to extend coverage for other natural disasters; to the Committee on Banking, Housing, and Urban Affairs.

HOUSE CONCURRENT RESOLUTION NO. 212

Whereas, the National Flood Insurance Act of 1968 established the National Flood Insurance Program as a means of mitigating flood damages by making flood insurance available in communities that adopt and enforce measures to reduce flood losses; and

Whereas, the National Flood Insurance Program is a federal program that allows property owners to purchase insurance protection against losses due to flooding; and

Whereas, Louisiana as well as other states have significant vulnerability to natural disasters, and when coupled with the lack of appropriate insurance coverage, this may result in a catastrophic impact on the economic, human, and physical environment of the United States; and

Whereas, Hurricanes Katrina and Rita caused unprecedented property damage, loss of life, and the upheaval of societal norms in the state of Louisiana; and

Whereas, the availability and affordability of property insurance has become an issue of paramount importance in a post-Katrina environment that has seen a significant drop in property coverages offered in the private market, unprecedented rate increases, and total risk avoidance in hurricane-prone areas; and

Whereas, revising the National Flood Insurance Program to extend multi-peril insurance coverage for damage resulting from earthquakes, volcanos, tsunamis, and hurricanes would reduce the economic consequences of future natural disasters; and

Whereas, the accessibility of multi-peril insurance coverage through a federally offered program may increase participation in the National Flood Insurance Program, thereby reducing rates due to the aggregate risk pooling of natural disasters; and

Whereas, this goal may be accomplished by generating sufficient premium income to provide insurance protection against disasters and to reduce the government's expenditures for future disaster relief; and

Whereas, the incorporation of a multi-peril mitigation program within the National Flood Insurance Program would afford consumers the protection of a residential insurance program with multi-peril protection. Therefore, be it

Resolved, that the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to allow the National Flood Insurance Program to extend coverage for other natural disasters. Be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–177. A concurrent resolution adopted by the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to ensure that all all-terrain vehicles sold in the United States meet mechanical equipment standards of the Consumer, Product Safety Commission and that safety information and training are being provided to all purchasers of all-terrain vehicles; to the Committee on Banking, Housing, and Urban Affairs.

HOUSE CONCURRENT RESOLUTION NO. 274

Whereas, the United States Consumer Product Safety Commission (CPSC) is charged with protecting the public from unreasonable risks of serious injury or death from more than fifteen thousand types of consumer products under the agency's jurisdiction, and the commission is committed to protecting consumers and families from products that pose a fire, electrical, chemical, or mechanical hazard or can injure children; and

Whereas, despite success in general, injuries and deaths resulting from the use of all-terrain vehicles (ATVs), particularly involving children, are on the rise; and

Whereas, a CPSC staff report from 2005 includes the following ATV-related injury and death data:

In 2003, there were an estimated seven hundred forty deaths associated with ATVs.

In 2001, the most recent year for which death data collection is complete, twenty-six percent of the reported deaths were of children under sixteen years old.

The estimated risk of death was 1.1 deaths per ten thousand four-wheeled ATVs in use in 2003.

The estimated number of A TV-related emergency-room-treated injuries for all ages in 2004 was one hundred thirty-six thousand one hundred, an increase of ten thousand six hundred from 2003. This increase was statistically significant.

Children under sixteen years of age accounted for forty-four thousand seven hundred, or thirty-three percent, of the total estimated number of injuries in 2004.

There were about one hundred eighty-eight emergency-room-treated injuries per ten thousand four-wheeled ATVs in use in 2004; and

Whereas, currently ATVs are subject only to voluntary standards and Letters of Undertaking entered into by the CPSC and the major manufacturers; and

Whereas, there are gaps in the current, voluntary system of regulating the industry; primary among them is the fact that the regulations do not apply to ''new entrants'', that is, those manufacturers who have not agreed to participate in the standards; and

Whereas, despite a recommendation from its own staff that equipment standards and safety measures should be applied to all manufacturers and distributors, the CPSC has failed to adopt final mandatory regulations applicable to ATVs; and

Whereas, in the interest of saving lives and preventing injury, it is appropriate that Congress get involved in this issue: Therefore be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to do all of the following:

(1) Require the Consumer Product Safety Commission to promulgate a consumer product safety standard for all-terrain vehicles. The standard shall be the same as the American National Standard for Four Wheel All-Terrain Vehicles-Equipment, Configuration, and Performance Requirements ANSI/SVIA–1–2001 or its successor standard.

(2) Require each manufacturer or importer of an all-terrain vehicle to which the ATV standard applies to submit an action plan to the commission for its approval. Such plan shall include the offer of free rider training, dissemination of safety information, age recommendations, the monitoring of such sales, and other safety-related measures.

(3) Prohibit a manufacturer or importer of all-terrain vehicles from distributing an all-terrain vehicle in commerce unless the manufacturer or importer has complied with its obligations under its action plan that has been approved by the commission.

(4) Require each all-terrain vehicle to which the ATV standard applies to bear a permanent label certifying that the all-terrain vehicle complies with the consumer product safety standard and is subject to an action plan accepted by the commission; identifies the manufacturer or importer issuing the certification; and contains sufficient information to enable the commission to identify the particular action plan that applies to that all-terrain vehicle; and be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–178. A resolution adopted by the General Assembly of the State of New Jersey urging Congress to reinstate its offshore water quality testing program along the New Jersey coastline; to the Committee on Environment and Public Works.

ASSEMBLY RESOLUTION NO. 270

Whereas, The United States Environmental Protection Agency has conducted a seasonal offshore monitoring program by helicopter for the last 30 years along the New Jersey coastline that searched for and tested the presence of dissolved oxygen and enterococci (i.e., fecal) bacteria in ocean waters; and

Whereas, The existence of certain levels of dissolved oxygen and enterococci bacteria are precursors or indicators of potential fish kills and harmful algal blooms or ''brown tide''; and

Whereas, The United States Environmental Protection Agency has announced that it is terminating this offshore water testing program in favor of alternative methods of testing for these environmental indicators; and

Whereas, A massive algal bloom appeared in Raritan and Sandy Hook Bays in late May 2007, turning coastal ocean waters brown from Sandy Hook to Manasquan, thereby reemphasizing the need for the continuation of the federal ocean water testing program; and

Whereas, The State, counties and municipalities affected by the termination of the federal ocean water testing program do not have the logistical or financial capability to continue or replace this program in time for the 2007 summer shore season; and

Whereas, New Jersey has a coastline of beautiful beaches which is not only one of the State's greatest natural resources but also is vital to the State's economy through the billions of dollars generated from shore-related tourism; and

Whereas, The United States Environmental Protection Agency is continuing the use of its coastal monitoring helicopter to conduct surveillance of floatable objects in the ocean off the coast of New Jersey and therefore could reinstate the ocean water testing program in an expeditious manner without undue financial or logistical hardships; Now, therefore, be it

Resolved, by the General Assembly of the State of New Jersey:

(1) This House opposes the decision by the United States Environmental Protection Agency to terminate the offshore ocean

water quality testing program along the coast of New Jersey and urges that it be reinstated immediately.

(2) Duly authenticated copies of this resolution, signed by the Speaker of the Assembly and attested by the Clerk thereof, shall be transmitted to the President and Vice-President of the United States, the Administrator of the United States Environmental Protection Agency, the Region II Administrator of that agency, the Speaker of the United States House of Representatives, the majority and minority leaders of the United States Senate and the United States House of Representatives, each member of the Congress of the United States elected from this State, and the Commissioner of the New Jersey Department of Environmental protection.

POM–179. A concurrent resolution adopted by the Senate of the State of Louisiana urging Congress to vote in favor of H.R. 1229, the Non-Market Economy Trade Remedy Act of 2007; to the Committee on Finance.

SENATE CONCURRENT RESOLUTION NO. 115

Whereas, H.R. 1229, the ''Non-Market Economy Trade Remedy Act of 2007,'' will ensure that the United States countervailing duty law applies to imports from non-market economies; and

Whereas, the purpose of the countervailing duty law is to offset any unfair competitive advantage that foreign manufacturers or exporters have as a result of subsidies; and

Whereas, manufacturing is a vital part of the American economy; and

Whereas, each American manufacturing job results in the creation of approximately four additional jobs; and

Whereas, since 1997, Louisiana has lost over thirty-nine thousand manufacturing jobs due to unfair trade practices; and

Whereas, Louisiana's coastal area is home to some of the Nation's premiere commercial fisheries, accounting for 30 percent of the commercial fisheries production of the lower 48 States; and

Whereas, the Louisiana seafood industry provides an annual economic impact of approximately two billion eight hundred million dollars and over thirty-one thousand jobs; and

Whereas, the Louisiana seafood industry has lost over eleven thousand jobs and millions of dollars due to illegally subsidized seafood imports and dumping from foreign nations; and

Whereas, industries that once were the pride of their communities and employed generations of the same family have been shut down resulting from jobs being shifted to foreign nations where labor is cheap and environmental standards are not enforced; and

Whereas, billions of dollars in wages and millions of jobs are expected to move from the United States to low-cost nations by 2015; and

Whereas, H.R. 1229, the ''Non-Market Economy Trade Remedy Act of 2007,'' is being considered in Congress to correct the long-standing inequity of trade law, and requires the Department of Commerce to take action in countervailing duty cases in support of American businesses: Now, therefore, be it

Resolved, That the Legislature of Louisiana memorializes the Congress of the United States to vote in favor of H.R. 1229, the ''Non-Market Economy Trade Remedy Act of 2007''; and be it further

Resolved, That a copy of this Resolution shall be transmitted to the secretary of the United States Senate and the clerk of the United States House of Representatives and to each member of the Louisiana delegation to the United States Congress.

POM–180. A resolution adopted by the Senate of the State of Wisconsin urging Congress to create a system that ensures that trade agreements are developed and implemented using a democratic, inclusive mechanism that enshrines the principles of federalism and state sovereignty; to the Committee on Finance.

SENATE RESOLUTION NO. 8

Whereas, democratic, accountable governance in the States, generally, and the authority granted by the Wisconsin constitution to the legislative branch, specifically, are being undermined by international commercial and trade rules enforced by the World Trade Organization (WTO) and established by the North American Free Trade Agreement (NAFTA) and are further threatened by similar provisions in an array of pending trade agreements; and

Whereas, today's ''trade'' agreements have impacts that extend significantly beyond the bounds of traditional trade matters, such as tariffs and quotas, and instead grant foreign investors and service providers certain rights and privileges regarding acquisition of land and facilities and regarding operations within a State's territory, subject State laws to challenge as ''nontariff barriers to trade'' in the binding dispute resolution bodies that accompany the pacts, and place limits on the future policy options of State legislatures; and

Whereas, NAFTA and other U.S. free trade agreements grant foreign firms new rights and privileges for operating within a State that exceed those rights and privileges granted to U.S. businesses under State and Federal law; and

Whereas, NAFTA already has generated ''regulatory takings'' cases against State and local land-use decisions, State environmental and public health policies, adverse State court rulings, and State and local contracts that would not have been possible in U.S. courts; and

Whereas, when States are bound to comply with government procurement provisions contained in trade agreements, common economic development and environmental policies, such as buy-local laws, prevailing wage laws, and policies to prevent offshoring of State jobs, as well as recycled content laws, could be subject to challenge as violating the obligations in the trade agreements; and

Whereas, recent trade agreements curtail State regulatory authority by placing constraints on future policy options; and

Whereas, the WTO general agreement on trade in services (GATS) could undermine State efforts to expand health care coverage and rein in health care costs and places constraints on State and local land-use planning and gambling policy; and

Whereas, new GATS negotiations could impose additional constraints on State regulation of energy, higher education, professional licensing, and other areas; and

Whereas, despite the indisputable fact that international trade agreements have a far-reaching impact on State and local laws, Federal Government trade negotiators have failed to respect States' rights to prior informed consent before binding States to conform State law and authority to trade agreement requirements and have refused even to inform State legislatures of key correspondence; and

Whereas, the current encroachment on State regulatory authority by international commercial and trade agreements has occurred in no small part because U.S. trade policy is being formulated and implemented under the Fast Track Trade Authority procedure; and

Whereas, Fast Track eliminates vital checks and balances established in the U.S. Constitution by broadly delegating to the executive branch Congress's exclusive constitutional authority to set the terms of trade, such that the executive branch is empowered to negotiate broad-ranging trade agreements and to sign them prior to Congress voting on the agreements; and

Whereas, the ability of the executive branch to sign trade agreements prior to Congress's vote of approval means that executive branch negotiators can ignore congressional negotiating objectives or States' demands, and neither Congress nor the States have any means to enforce any decision regarding what provisions must be contained in every U.S. trade agreement or what provisions may not be included in any U.S. trade agreement; and

Whereas, Federal trade negotiators have ignored and disrespected States' demands regarding whether States agree to be bound to certain nontariff trade agreement provisions; and

Whereas, Fast Track also circumvents normal congressional review and amendment committee procedures, limits debate to 20 hours, and forbids any floor amendments to the implementing legislation that is presented to Congress to conform hundreds of U.S. laws to trade agreement obligations and to incorporate the actual trade agreement itself into U.S. Federal law that preempts State law; and

Whereas, Fast Track is not necessary for negotiating trade agreements as demonstrated by the existence of scores of trade agreements, including major pacts, implemented in the past 30 years without use of Fast Track; and

Whereas, Fast Track, which was established in 1974 by President Richard Nixon when trade agreements were limited to traditional matters, such as tariffs and quotas, is now woefully outdated and inappropriate given the diverse range of nontrade issues now included in ''trade'' agreements that broadly affect State and Federal nontrade regulatory authority; and

Whereas, the current grant of Fast Track expires in June 2007: Now, therefore, be it

Resolved, by the Senate, That:

(1) The U.S. Congress be urged to create a replacement for the outdated Fast Track system so that U.S. trade agreements are developed and implemented using a more democratic, inclusive mechanism that enshrines the principles of federalism and State sovereignty.

(2) This new process for developing and implementing trade agreements include an explicit mechanism for ensuring the prior informed consent of State legislatures before States are bound to the nontariff terms of any trade agreement that affects State regulatory authority to ensure that the United States trade representative respects the decisions made by States.

(3) Copies of this resolution be sent to President George W. Bush, Ambassador Susan Schwab, U.S. Trade Representative, the President of the U.S. Senate, the Speaker of the House of Representatives, and the Wisconsin Congressional Delegation.

POM–181. A concurrent resolution adopted by the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to examine the provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to provide prenatal care to immigrants; to the Committee on Finance.

HOUSE CONCURRENT RESOLUTION NO. 258

Whereas, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104–193, (PRWORA) significantly changed the eligibility of noncitizens for federal means-tested public benefits, including

Medicaid and the State Children's Health Insurance Program; and

Whereas, as a general rule, only ''qualified aliens'' as defined in §431 of PRWORA maybe eligible for coverage; and

Whereas, some immigrants cannot be eligible for coverage for five years from the date they enter the country as a qualified alien; and

Whereas, the five-year bar only applies to qualified aliens who entered the United States on or after August 22, 1996, unless they meet one of the exceptions in PRWORA; and

Whereas, the five-year bar never applies to immigrants who are applying for treatment of an emergency medical condition only; and

Whereas, under PRWORA all immigrants, both qualified and non-qualified aliens as well as those who are residing in the country in an undocumented status, may be eligible for treatment of an emergency medical condition only, provided that they otherwise meet the eligibility criteria for the state's Medicaid program; and

Whereas, if prenatal care was provided for immigrants who are currently not eligible, there would likely be a great return on the money because once the baby is born in the United States, it becomes a citizen and may possibly receive Medicaid benefits; and

Whereas, it would be beneficial to our citizens if the Federal Government would study the costs of providing prenatal care versus the costs for caring for a preterm baby; and

Whereas, changes in the PRWORA may save the lives of many preterm babies born to immigrants in this country; and

Whereas, this Resolution is executed in memory of baby Jui: Now, therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to examine the provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to provide prenatal care to immigrants; and be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–182. A communication from the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to provide the same tax breaks and federal financial assistance to Louisiana residents affected by Hurricane Rita as those afforded to Louisiana residents affected by Hurricane Katrina; to the Committee on Finance.

HOUSE CONCURRENT RESOLUTION NO. 223.

Whereas, in August and September 2005, Louisiana was decimated by multiple hurricanes striking the state, resulting in a combination of natural disasters of unprecedented proportions in American history; and

Whereas, these disasters caused a burden no state has ever had to bear, including the loss of life, livelihoods, and homes, destruction and damage to public buildings and public works, and damage to its coastal wetlands and coastline; and

Whereas, the citizens, businesses, communities, schools, and state and local governments of Louisiana have suffered tremendous loss; and

Whereas, the ramifications of these events continue to affect every citizen of the state as we continue to struggle to rebuild our lives, homes, businesses, and communities; and

Whereas, because of the mass devastation and loss of life suffered by the citizens of New Orleans and southeast Louisiana as a result of Hurricane Katrina, congress acted quickly in granting victims and survivors of Hurricane Katrina various tax breaks and federal financial assistance aimed at long-term recovery; and

Whereas, although the devastation realized as a result of Hurricane Rita was not as large-scale as the devastation of Hurricane Katrina, the victims and survivors of Hurricane Rita who lost their homes, businesses, livelihoods, and entire communities are suffering every bit as much as the citizens affected by Hurricane Katrina; and

Whereas, the citizens of southwest Louisiana are in need for congress to act quickly in granting them the same tax breaks and federal financial assistance as was granted to the victims and survivors of Hurricane Katrina in order to sustain long-term recovery: Now, therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to provide the same tax breaks and federal financial assistance to Louisiana residents affected by Hurricane Rita as those afforded to Louisiana residents affected by Hurricane Katrina; and be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–183. A resolution adopted by the House of Representatives of the State of Illinois establishing May 2007 as Amyotrophic Lateral Sclerosis Awareness Month; to the Committee on Health, Education, Labor, and Pensions.

HOUSE JOINT RESOLUTION NO. 58

Whereas, Amyotrophic lateral sclerosis or ALS is better known as Lou Gehrig's disease; and

Whereas, ALS is a fatal neurodegenerative disease characterized by degeneration of cell bodies of the lower motor neurons in the gray matter of the anterior horns of the spinal cord; and

Whereas, The initial symptom of ALS is weakness of the skeletal muscles, especially those of the extremities; and

Whereas, As ALS progresses the patient experiences difficulty in swallowing, talking, and breathing; and

Whereas, ALS eventually causes muscles to atrophy and the patient becomes a functional quadriplegic; and

Whereas, ALS does not affect a patient's mental capacity, so that the patient remains alert and aware of his or her loss of motor functions and the inevitable outcome of continued deterioration and death; and

Whereas, On average, patients diagnosed with ALS only survive two to five years from the time of diagnosis; and

Whereas, research indicates that military veterans are at a 50% or greater risk of developing ALS than those who have not served in the military; and

Whereas, ALS has no known cause, means of prevention, or cure; and

Whereas, Amyotrophic Lateral Sclerosis Awareness Month increases the public's awareness of ALS patients' circumstances and acknowledges the terrible impact this disease has not only on the patient but on his or her family and the community and recognizes the research being done to eradicate this horrible disease; Now, therefore, be it

Resolved, by the House of Representatives of the Ninety-Fifth General Assembly of the State of Illinois, The Senate concurring herein, that we proclaim the month of May 2007 as Amyotrophic Lateral Sclerosis Awareness Month in the State of Illinois; and be it further

Resolved, That we memorialize the President and Congress of the United States to enact legislation to provide additional funding for research in order to find a treatment and eventually a cure for amyotrophic lateral sclerosis; and be it further

Resolved, That suitable copies of this resolution be presented to the President of the United States and each member of the Illinois congressional delegation.

POM–184. A resolution adopted by the House of Representatives of the State of Illinois urging Congress to address certain concerns relative to the reauthorization of the No Child Left Behind Act; to the Committee on Health, Education, Labor, and Pensions.

HOUSE RESOLUTION NO. 396

Whereas, The federal No Child Left Behind Act of 2001 (NCLB) requires reauthorization in 2007; Now therefore, be it

Resolved, by the House of Representatives of the Ninety-Fifth General Assembly of the State of Illinois, That we urge the United States Congress to address the following concerns when considering the reauthorization of NCLB:

(1) allow states the flexibility to use growth model assessment models to enhance existing measures of student progress;

(2) provide flexibility in program implementation with respect to varying student and teacher needs related to diversity of geography, wealth, and background;

(3) revise assessment guidelines for special needs students so that such students are more fairly assessed considering their specific individualized education programs and, therefore, better served;

(4) resolve other contradictions between NCLB and the Individuals with Disabilities Education Act (IDEA);

(5) address issues arising from students who are counted in multiple groups when determining adequate yearly progress;

(6) allow schools to offer, and provide full funding for, important supplemental education services before schools are forced to offer choice;

(7) provide greater flexibility when determining the sizes of groups regarding assessment subgroups;

(8) school improvement grants must be funded so that the sanctions placed on schools will result in improved student achievement and the reversal of negative trends;

(9) seek greater consistency in state certification criteria and the federal ''highly qualified'' designation;

(10) the highly qualified teacher provisions of NCLB require clarification, greater flexibility regarding alignment with state certification, and appropriate, specific, technical assistance in order to ensure compliance; and

(11) resident school districts of special needs students attending private schools must pay for IDEA services delivered at a private school; and be it further

Resolved, That suitable copies of this resolution be delivered to President of the United States George W. Bush, United States Secretary of Education Margaret Spellings, and each member of the Illinois congressional delegation.

POM–185. A resolution adopted by the Senate of the State of Michigan urging Congress to enact the Education Begins at Home Act; to the Committee on Health, Education, Labor, and Pensions.

SENATE RESOLUTION NO. 61

Whereas, each year, an estimated 2.7 million children in America are abused or neglected, including 900,000 cases that are actually investigated and verified by overburdened state child protection systems. Nationally, more than 1,400 children die from abuse or neglect each year. Over half of them were previously unknown to child protective services. In Michigan during 2005, 147,628 families were investigated for suspected child maltreatment. In those families investigated, 28,154 children were confirmed to be victims of child abuse and neglect. Of all confirmed cases of abuse and neglect, more than a third involved children three years old or younger. Another 19,265 children were in out-of-home placement as the result of child abuse and neglect and delinquency; and

Whereas, children who survive abuse or neglect likely carry the emotional scars for life, while studies also show that being abused or neglected multiplies the risk that a child will grow up to be violent. The best available research indicates that, based on confirmed cases of child abuse and neglect in just one year, of these children, there will be an additional 35,000 adult violent criminals and more than 250 murderers who would never have become violent criminals if not for the abuse or neglect they endured as children. Fortunately, evidence-based in-home parent coaching programs can prevent child abuse and neglect and reduce later crime and violence. In general, these programs provide voluntary coaching to parents of children up to five years old in home settings for some period of time; and

Whereas, a number of programs exist to help parents. The Nurse Family Partnership randomly assigned interested at-risk pregnant women to receive in-home visits by nurses starting before the birth of the first child and continuing until the child was two years old. The program cut abuse and neglect among at-risk children in half according to research published in a leading medical journal. In addition, children of mothers who received this coaching had 59 percent fewer arrests by age 15 than the children of mothers who were not coached. Yet this program reaches only a tiny fraction of eligible parents. Other major home-visiting programs include Parents as Teachers, Healthy Families America, Early Head Start, Home Instruction for Parents of Preschool Youngsters, and the Parent-Child Home Program. However, hundreds of thousands of at-risk mothers across the country receive no in-home parent coaching. The impacts of child abuse and neglect cost Americans $94 billion a year. In 2005, the direct cost of child abuse and neglect in Michigan was an estimated $531,744,598. Prevention efforts such as Michigan's 0–3 Secondary Prevention Initiative, which reflects the use of a variety of program models, saved an estimated $41,268,095 in direct costs associated with child abuse and neglect; and

Whereas, in the 109th Congress, Senator Bond and Representatives Davis and Platts, together with many of their colleagues, cosponsored the bipartisan Education Begins at Home Act in the Senate and House (S. 503/H.R. 3628) to provide grants to help states establish or expand voluntary in-home parent-coaching programs for families with young children. The Education Begins at Home Act would have authorized $400 million over three years in grants from the United States Department of Health and Human Services for voluntary in-home parent-coaching programs. The Education Begins at Home Act would also have authorized $100 million over three years in grants for voluntary in-home parent-coaching programs for English language learners and military families. These programs would strengthen Early Head Start, which includes center-based and in-home parent coaching components. Each of the major home-visiting programs operates in Michigan, and the Education Begins at Home Act would allow program flexibility so that states would not be tied to one particular model. These voluntary programs would help new parents learn skills to promote healthy child development and be better parents; Now: therefore, be it

Resolved by the Senate, That we memorialize the United States Congress to reintroduce an expanded Education Begins at Home Act. We encourage sponsors of the new bill to include separate funding authorization levels for each of the next five years, to target funding first toward jurisdictions with the greatest need, and to ensure that funding priority be given to evidence-based approaches that deliver effective results in improving outcomes for children and families; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United Stales Senate, the Speaker of the United States House of Representatives, and the members of the Michigan congressional delegation.

POM–186. A concurrent resolution adopted by the Senate of the State of Louisiana urging Congress to take a proactive role in assisting the communities of New Orleans East in protecting their health and safety and in promoting economic development; to the Committee on Health, Education, Labor, and Pensions.

SENATE CONCURRENT RESOLUTION NO. 134

Whereas, the health, safety, welfare, and economic recovery of the residents and businesses of New Orleans East are dependent upon the continued assistance and encouragement from our federal partners; and

Whereas, the Legislature of Louisiana created the New Orleans Regional Business Park as a special municipal district for the primary purpose of engaging industrial, manufacturing, processing, assembling, distribution, and wholesale businesses; and

Whereas, as of early May 2006, approximately forty companies out of one hundred four pre-Katrina were back in business and the future of the others is largely uncertain; and

Whereas, New Orleans East has become the illegal burial grounds for homes and businesses washed out by hurricanes Katrina and Rita; and

Whereas, illegal dumping makes it extremely hard to attract businesses to New Orleans East and to the business park; and

Whereas, in the business park alone there are twenty-three known illegal dumping sites and thirteen illegal automobile dumping sites; and

Whereas, the U.S. Environmental Protection Agency awarded the business park $400,000 in grants to catalogue contamination, but none of the federal funds will be used for cleanup; and

Whereas, the Louisiana Department of Environmental Quality Enforcement Division, Surveillance Division and Criminal Investigations Section of the Legal Affairs Division have inspected over one hundred seventy-five sites and found potential environmental violations on one hundred fifty of these sites in the Almonaster/Gentilly area alone; and

Whereas, on one of these sites, sixty-five thousand cubic yards of debris or approximately an eleven foot tall mound of debris was found to have been illegally dumped on this one site in New Orleans East; and

Whereas, the illegal piles of debris do not have protective barriers to keep whatever poisons are in the piles contained and from leaking out into the wetlands surrounding this area; and

Whereas, numerous federal agencies have roles and responsibilities in the health, safety, and economic development after hurricanes Katrina and Rita which range from debris removal, oversight of regulations, and recovery funding; and

Whereas, the removal of all dump sites within the New Orleans Regional Business Park will improve the health, safety, and economic development: Now Therefore, be it

Resolved, That the Legislature of Louisiana memorializes the Congress of the United States to urge and request the respective executive branch departments to take a proactive role in assisting the communities of New Orleans East in protecting their health and safety and in promoting economic development: and be it further

Resolved, That the Legislature of Louisiana does hereby request the Congress ofthe United States and the appropriate federal agencies, in coordination with appropriate Louisiana state agencies, to immediately take the following actions: (a) cease funding any waste disposal activities within the New Orleans Regional Business Park, except for the city of New Orleans' landfill known as the Gentilly Landfill which is legally permitted and should continue working with all state and federal agencies; (b) develop and implement procedures for expeditious environmental sampling, analysis, and reporting; (c) resolve the blurring of debris management responsibilities between the Federal Emergency Management Agency and Environmental Protection Agency, and state environmental and public health agencies; (d) review and enhance the Environmental Protection Agency's oversight role of illegal and improper debris disposal; and (e) provide guidance and mechanisms for the development of public/private partnerships in restoring and redeveloping the New Orleans Regional Business Park and the New Orleans East community; and be it further

Resolved, That a copy of this Resolution shall be transmitted to the secretary of the United States Senate and the clerk of the United States House of Representatives and to each member of the Louisiana delegation to the United States Congress.

POM–187. A concurrent resolution adopted by the Senate of the State of New Hampshire urging Congress to fully fund the federal government's share of special education services under the Individuals with Disabilities Education Act; to the Committee on Health, Education, Labor, and Pensions.

Whereas, since its enactment in 1975, the Individuals with Disabilities Education Act (IDEA) has helped millions of children with special needs to receive a quality education and to develop to their full capacities; and

Whereas, IDEA has moved children with disabilities out of institutions and into public school classrooms with their peers; and

Whereas, IDEA has helped break down stereotypes and ignorance about people with disabilities, improving the quality of life and economic opportunity for millions of Americans; and

Whereas, when the federal government enacted IDEA, it promised to fund up to 40 percent of the average per pupil expenditure in public elementary and secondary schools in the United States; and

Whereas, the federal government currently funds, on average, less than 17 percent of the average per pupil expenditure in public elementary and secondary schools in the United States; and

Whereas, local school districts and state government end up bearing the largest share of the cost of special education services; and

Whereas, the federal government's failure to adequately fulfill its responsibility to special needs children undermines public support for special education and creates hardship for disabled children and their families; and

Whereas, the general court is currently challenged with the responsibility of defining and funding an adequate education for all children in this state; and

Whereas, these legislative efforts are significantly burdened and constrained by the costs incurred by the federal government's failure to meet its full financial promise under IDEA: Now, therefore, be it

Resolved by the Senate, the House of Representatives concurring, That the New Hampshire general court urges the President and the Congress, prior to spending any surplus in the federal budget, to fund 40 percent of the average per pupil expenditure in public elementary and secondary schools in the United States as promised under IDEA to ensure that all children, regardless of disability, receive a quality education and are treated with the dignity and respect they deserve; and be it further

Resolved, That copies of this resolution be forwarded by the senate clerk to the President of the United States, the Speaker of the United States House of Representatives, the President of the United States Senate, and the members of the New Hampshire congressional delegation.

POM–188. A concurrent resolution adopted by the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to forgive student loans of college graduates who move to Louisiana to support activities to rebuild and revitalize communities damaged by Hurricane Katrina or Rita; to the Committee on Health, Education, Labor, and Pensions.

HOUSE CONCURRENT RESOLUTION NO. 15

Whereas, there are currently student loan forgiveness programs administered by the United States Department of Education for Stafford Loan recipients who serve as teachers serving low-income students and some childcare providers serving in low-income areas; and

Whereas, there are currently student loan forgiveness programs administered by the United States Department of Education for Perkins Loan recipients who serve as teachers serving low-income students, Head Start staff, special education teachers or providers, members of the armed forces in an area of hostilities, Vista or Peace Corps volunteers, full-time law enforcement and corrections officers, full-time teachers in shortage areas, full-time nurses and medical technicians, and service providers to high-risk children and families in low-income communities; and

Whereas, the United States Military and federal agencies may pay all or a portion of an individual's student loans based on years of service; and

Whereas, these loan forgiveness and repayment programs, by decreasing the financial demands on recent college graduates, provide incentive for individuals to work in professions and for pay that would otherwise not be economically feasible; and

Whereas, the needs and demands for assistance in the areas damaged by Hurricanes Katrina and Rita to children and families exceed the services provided by education to low-income schools, the federal government, Vista, law enforcement, or the medical community: Now, therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to expand the student loan forgiveness programs currently provided by the United States Department of Education to provide for loan forgiveness of Stafford Loan and Perkins Loan recipients for college graduates who relocate to Louisiana to support efforts to rebuild and revitalize communities damaged by Hurricane Katrina or Rita; and be it further

Resolved, That such efforts shall include but not be limited to partial or total forgiveness of loans for individuals employed by public and nonprofit agencies and providing services to communities damaged by Hurricane Katrina or Rita; and be it futher

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–189. A resolution adopted by the House of Representatives of the State of Louisiana urging Congress to fulfill the commitment to the citizens of Louisiana to fully fund recovery from damages resulting from Hurricanes Katrina and Rita; to the Committee on Homeland Security and Governmental Affairs.

HOUSE RESOLUTION NO. 68

Whereas, in August and September 2005, the state of Louisiana experienced two of the most damaging natural disasters to occur in the United States with Hurricanes Katrina and Rita; and

Whereas, as a result of these devastating events, the President's Office of Gulf Coast Rebuilding estimated that over one hundred twenty-seven thousand owner-occupied homes received major or severe damage based on the criteria used by the Federal Emergency Management Agency; and

Whereas, in the aftermath of Hurricane Katrina, President George W. Bush made a commitment to the people of Louisiana, in a nationally covered statement, that the federal government would do what was necessary to provide for the recovery of the state and its citizens; and

Whereas, the state of Louisiana has always proposed that The Road Home Program pay for owner-occupied uninsured or underinsured wind damage as well as flood damage within the parameters of the program; and

Whereas, in Action Plan Amendment No.1 proposed by the Louisiana Recovery Authority, captioned Action Plan Amendment for Disaster Recovery Funds for The Road Home Housing Program, which, according to news releases, was approved by the United States Department of Housing and Urban Affairs in May 2006, it was clearly stated in the program proposed to provide ''the full proposed assistance to all of the Louisiana homeowners who suffered major or severe damage'' and stated, ''It is the State's policy that participants in the Homeowner Assistance Program deserve a fair and independent estimate or projection of damages from the storm, regardless of the cause of the damage''; and

Whereas, according to federal sources, 43,298 homeowners experienced no major flooding but major or severe wind damage; and

Whereas, since the adoption of the Action Plan Amendment No.1, the state has experienced increased costs in the program, resulting in a current three billion dollar shortfall, duly from a combination of factors, including an increase in the number of eligible claimants from the original estimates by approximately eleven thousand, more homes severely damaged than originally estimated, increased costs per eligible claimant than originally estimated, lower than anticipated homeowner property insurance claim benefits received from private insurers, and higher than estimated costs of repair and construction: Therefore, be it

Resolved, That the House of Representatives of the Legislature of Louisiana memorializes the Congress of the United States and urges and requests the federal administration to fulfill the commitment to the citizens of Louisiana to fully fund recovery from damages resulting from Hurricanes Katrina and Rita; and be it further

Resolved, That a copy of this Resolution be transmitted to the secretary of the United States Senate and the clerk of the United States House of Representatives, to each member of the Louisiana delegation to the United States Congress, and to the president of the United States.

POM–190. A concurrent resolution adopted by the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to grant an extension to Louisiana with regard to the deadlines for implementing the provisions of the Adam Walsh Child Protection and Safety Act of 2006; to the Committee on the Judiciary.

HOUSE CONCURRENT RESOLUTION NO. 251

Whereas, the United States Congress enacted the Adam Walsh Child Protection and Safety Act of 2006 to provide for a comprehensive national system for the registration of sex offenders and child predators; and

Whereas, the Act provides for a set of minimum standards governing the sex offender registration and notification programs in each state to provide for a more effective method of tracking offenders nationwide; and

Whereas, the federal legislation made significant changes in the manner in which sex offenders and child predators register with law enforcement agencies, including but not limited to requiring offenders to provide additional information to law enforcement at the time of registration, increasing the length of time in which an offender must maintain registration, and requiring offenders to register in the jurisdiction of residence, employment, or enrollment; and

Whereas, Section 126 of the Adam Walsh Child Protection and Safety Act of 2006 authorizes bonus payments for states or other jurisdictions that substantially implement the federal provisions not later than two years after the enactment date; and

Whereas, although the federal legislation created incentive grant programs for those states who implement the new requirements within the first two years after the enactment of the Adam Walsh Act, the United States Department of Justice only recently issued the proposed National Guidelines for Sex Offender Registration and Notification, which were intended to provide further guidance to states in implementing the provisions of the Adam Walsh Act; and

Whereas, the proposed National Guidelines for Sex Offender Registration and Notification were issued in May of this year, over a month after the 2007 Regular Session of the Louisiana Legislature began; and

Whereas, these guidelines, although issued in May, will not become finalized prior to the end of the 2007 Regular Session and are subject to change until that time; and

Whereas, legislation was introduced in the Louisiana Legislature by Representative Cazayoux (House Bill No. 970) to amend Louisiana's sex offender registration and notification provisions to comply with the provisions of the federal Adam Walsh Child Protection and Safety Act of 2007; and

Whereas, once the National Guidelines for Sex Offender Registration and Notification are finalized, it will be necessary to review and analyze Louisiana's laws on sex offender

registration and notification to determine if additional changes are necessary: Therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to grant an extension to Louisiana with regard to the deadlines for implementing the provisions of the Adam Walsh Child Protection and Safety Act of 2006, and federal guidelines adopted pursuant thereto, regarding Louisiana's eligibility to receive incentive grants created by the Adam Walsh Act; and be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–191. A concurrent resolution adopted by the House of Representatives of the State of Louisiana urging Congress to take such actions as are necessary to ensure the passage of the Online Pharmacy Consumer Protection Act of 2007; to the Committee on the Judiciary.

HOUSE CONCURRENT RESOLUTION NO. 106

Whereas, a great number of rogue online pharmacy web sites offer controlled substances for sale based simply on the results of a cursory online questionnaire and without the need for a valid prescription; and

Whereas, Senators Dianne Feinstein of California and Jeff Sessions of Alabama have introduced Senate Bill No. 980 in the first session of the One Hundred Tenth Congress, the Online Pharmacy Consumer Protection Act of 2007, to combat abuse by rogue online pharmacy web sites; and

Whereas, the Act requires a valid prescription and physician-patient relationship in order for a controlled substance to be dispensed through an online pharmacy; and

Whereas, the Act requires an online pharmacy to file a registration statement with the attorney general as well as report controlled substances dispensed under such registration; and

Whereas, the Act mandates that an online pharmacy comply with state law licensure requirements for both the state from which it delivers a controlled substance and the state to which it delivers a controlled substance; and

Whereas, the Act requires that the web site of an online pharmacy prominently display identifying information about the business, a list of states in which the pharmacy is licensed, all applicable licenses and certifications, and identifying information about the practitioners who provide medical consultations through the web site; and

Whereas, the Act provides criminal penalties for any individual or entity who unlawfully dispenses controlled substances online, gives state attorneys general the right to file a civil action against an individual or entity who violates the Act if the violation has affected residents of the state, and allows the federal government to seize any tangible or intangible property which has been used illegally by an online pharmacy. Therefore, be it

Resolved, That the Legislature of Louisiana does hereby memorialize the United States Congress to take such actions as are necessary to ensure the passage of the Online Pharmacy Consumer Protection Act of 2007. Be it further

Resolved, That a copy of this Resolution be transmitted to the presiding officers of the Senate and the House of Representatives of the Congress of the United States of America and to each member of the Louisiana congressional delegation.

POM–192. A resolution adopted by the Senate of the State of Texas urging Congress to support legislation for veterans' health care budget reform to allow assured funding; to the Committee on Veterans' Affairs.

SENATE RESOLUTION NO. 594

Whereas, Military veterans who have served their country honorably and who were promised and have earned health care and benefits from the federal government through the Department of Veterans Affairs are now in need of these benefits; and

Whereas, Federal discretionary funding is controlled by the executive branch and the United States Congress through the budget and appropriations process; and

Whereas, Direct funding provides the Department of Veterans Affairs with a reliable, predictable, and consistent source of funding to provide timely, efficient, and high-quality health care for our veterans; and

Whereas, Currently almost 90 percent of federal health care spending is direct rather than discretionary, and only the funding for health care for active duty military, Native Americans, and veterans is subject to the discretion of the United States Congress; and

Whereas, Discretionary funding for health care lags behind both medical inflation and the increased demand for services; for example, the enrollment for veterans' health care increased 134 percent between fiscal years 1996 and 2004 yet funding increased only 34 percent during the same period when adjusted to 1996 dollars; and

Whereas, The Department of Veterans Affairs is the largest integrated health care system in the United States and has four critical health care missions: to provide health care to veterans, to educate and train health care personnel, to conduct medical research, and to serve as a backup to the United States Department of Defense and support communities in times of crisis; and

Whereas, The Department of Veterans Affairs operates 157 hospitals, with at least one in each of the contiguous states, Puerto Rico, and the District of Columbia; and

Whereas, The Department of Veterans Affairs operates more than 850 ambulatory care and community-based outpatient clinics, 132 nursing homes, 42 residential rehabilitation treatment programs, and 88 home care programs; and

Whereas, The Department of Veterans Affairs provides a wide range of specialized services to meet the unique needs of veterans, including spinal cord injury and dysfunction care and rehabilitation, blind rehabilitation, traumatic brain injury care, posttraumatic stress disorder treatment, amputee care and prosthetics programs, mental health and substance abuse programs, and long-term care programs; and

Whereas, The Department of Veterans Affairs health care system is severely underfunded, and had funding for the department's medical programs been allowed to grow proportionately as the system sought to admit newly eligible veterans following the eligibility reform legislation in 1996, the current veterans' health care budget would be approximately $10 billion more; and

Whereas, In a spirit of bipartisan accommodation, members of the United States Congress should collectively resolve the problem of discretionary funding and jointly fashion an acceptable formula for funding the medical programs of the Department of Veterans Affairs; now, therefore, be it

Resolved, That the Senate of the State of Texas, 80th Legislature, hereby express its profound gratitude the for sacrifices made by veterans, including those who suffer from medical or mental health problems resulting from injuries that occurred while serving in the United States Armed Forces at home or abroad; and, be it further

Resolved, That the Senate hereby respectfully urge the Congress of the United States to support legislation for veterans' health care budget reform to allow assured funding; and, be it further

Resolved, That the Secretary of the Senate forward official copies of this Resolution to the Secretary of Veterans Affairs, to the President of the United States, to the Speaker of the House of Representatives and the President of the Senate of the United States Congress, and to all the members of the Texas delegation to the Congress with the request that this Resolution be officially entered in the Congressional Record as a memorial to the Congress of the United States of America.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. INOUYE, from the Committee on Commerce, Science, and Transportation, with amendments:

S. 675. A bill to provide competitive grants for training court reporters and closed captioners to meet requirements for realtime writers under the Telecommunications Act of 1996, and for other purposes (Rept. No. 110–138).

By Mr. BIDEN, from the Committee on Foreign Relations, without amendment:

S. 1565. A bill to provide for the transfer of naval vessels to certain foreign recipients (Rept. No. 110–139).

By Mr. BAUCUS, from the Committee on Finance, with an amendment in the nature of a substitute:

S. 1607. A bill to provide for identification of misaligned currency, require action to correct the misalignment, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. LEVIN for the Committee on Armed Services.

Air Force nomination of Maj. Gen. Daniel J. Darnell, 0600, to be Lieutenant General.

Air Force nomination of Col. Lyn D. Sherlock, 8452, to be Brigadier General.

Air Force nomination of Maj. Gen. Donald C. Wurster, 1815, to be Lieutenant General.

Air Force nomination of Gen. Duncan J. McNabb, 2295, to be General.

Air Force nomination of Lt. Gen. Arthur J. Lichte, 5483, to be General.

Air Force nomination of Gen. John D. W. Corley, 9553, to be General.

Air Force nomination of Lt. Gen. Frank G. Klotz, 6089, to be Lieutenant General.

Air Force nominations beginning with Brigadier General Robert R. Allardice and ending with Brigadier General Robert M. Worley II, which nominations were received by the Senate and appeared in the Congressional Record on July 17, 2007.

Army nomination of Col. Bradly S. MacNealy, 4551, to be Brigadier General.

Army nomination of Col. Michael J. Trombetta, 2104, to be Brigadier General.

Army nominations beginning with Brigadier General Charles A. Anderson and ending with Brigadier General Dennis L. Via, which nominations were received by the Senate and appeared in the Congressional Record on July 11, 2007.

Navy nomination of Rear Adm. (lh) Victor G. Guillory, 1980, to be Rear Admiral.

Navy nomination of Capt. David J. Mercer, 7160, to be Rear Admiral (lower half).

Navy nomination of Rear Adm. David Architzel, 0741, to be Vice Admiral.

Navy nomination of Vice Adm. John D. Stufflebeem, 4012, to be Vice Admiral.

Navy nomination of Rear Adm. (Selectee) Adam M. Robinson, Jr., 9660, to be Vice Admiral.

Mr. LEVIN. Mr. President, for the Committee on Armed Services I report favorably the following nomination lists which were printed in the RECORDS on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Air Force nominations beginning with Maria M. Alsina and ending with Le Thi Zimmerman, which nominations were received by the Senate and appeared in the Congressional Record on March 19, 2007.

Air Force nomination of Jonathan L. Huggins, 8049, to be Lieutenant Colonel.

Air Force nomination of Nelson L. Reynolds, 6465, to be Lieutenant Colonel.

Air Force nomination of Bryan M. Boyles, 7840, to be Lieutenant Colonel.

Air Force nomination of Michael S. Agabegi, 3057, to be Major.

Air Force nomination of Freddie M. Goldwire, 9686, to be Major.

Air Force nominations beginning with Val C. Hagans and ending with Rujing Han, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Air Force nominations beginning with Kent S. Thompson and ending with Javier Santiago, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Air Force nominations beginning with Thomas S. Butler and ending with Adam W. Schnicker, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Army nominations beginning with James E. Caraway, Jr. and ending with William S. Weichl, which nominations were received by the Senate and appeared in the Congressional Record on June 4, 2007.

Army nomination of Stephen T. Sauter, 3267, to be Colonel.

Army nomination of Terry D. Bonner, 7657, to be Colonel.

Army nomination of Mark Trawinski, 3185, to be Lieutenant Colonel.

Army nomination of Francisco C. Dominicci, 5062, to be Major.

Army nomination of Joseph E. Jones, 2493, to be Major.

Army nomination of Colin S. McKenzie, 0759, to be Major.

Army nominations beginning with Lozay Foots and ending with Joseph L. Karhan, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Army nominations beginning with Louis R. Kubala and ending with Thomas K. Spears, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Army nominations beginning with William A. McNaughton and ending with Michael B. Vitt, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Army nominations beginning with James E. Cole and ending with Michael F. Traver, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Army nominations beginning with Daniel L. Duecker and ending with Douglas L. Weeks, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Army nominations beginning with Joseph A. Bernierrodriguez and ending with Edward M. Wise, Jr., which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Army nominations beginning with Mazen Abbas and ending with Tamatha F. Zemzars, which nominations were received by the Senate and appeared in the Congressional Record on July 17, 2007.

Navy nominations beginning with Nicholas J. Alaga, Jr. and ending with Mark H. Zuhone, which nominations were received by the Senate and appeared in the Congressional Record on May 15, 2007.

Navy nomination of Peter J. Oldmixon, 3125, to be Lieutenant Commander.

Navy nominations beginning with Dan L. Ammons and ending with Robert D. Woods, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Gilbert Ayan and ending with Colin D. Xander, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Simonia R. Blassingame and ending with Jason L. Webb, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Jeffrey A. Bayless and ending with Warren Yu, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Chris D. Agar and ending with Tyrone L. Ward, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Paul B. Anderson and ending with Darren S. Williams, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Christina S. Hagen and ending with Ron A. Steiner, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Christopher J. Arends and ending with Keith E. Williams, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Sarah A. Dachos and ending with Clay G. Williams, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Benito E. Baylosis and ending with Jon E. Withee, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Douglas S. Belvin and ending with Kyle T. Turco, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Fitzgerald Britton and ending with John F. Zrembski, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with William L. Abbott and ending with Allen W. Wooten, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nominations beginning with Kevin T. Aanestad and ending with William A. Ziegler, which nominations were received by the Senate and appeared in the Congressional Record on June 28, 2007.

Navy nomination of Bruce S. Lavin, 5081, to be Captain.

Navy nominations beginning with Christopher R. Davis and ending with Alan J. Ferguson, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Navy nominations beginning with Robert D. Clery and ending with Garfield M. Sicard, which nominations were received by the Senate and appeared in the Congressional Record on July 12, 2007.

Navy nominations beginning with Michael J. Allanson and ending with Janine Y. Wood, which nominations were received by the Senate and appeared in the Congressional Record on July 17, 2007.

Navy nominations beginning with Maria L. Aguayo and ending with Steven T. Zimmerman, which nominations were received by the Senate and appeared in the Congressional Record on July 17, 2007.

Navy nominations beginning with Antony Berchmanz and ending with Glen Wood, which nominations were received by the Senate and appeared in the Congressional Record on July 17, 2007.

Navy nominations beginning with Eric J. Bach and ending with William B. Zabicki, Jr., which nominations were received by the Senate and appeared in the Congressional Record on July 17, 2007.

Navy nominations beginning with Elizabeth M. Adriano and ending with Scot A. Youngblood, which nominations were received by the Senate and appeared in the Congressional Record on July 17, 2007.

By Mrs. BOXER for the Committee on Energy and Natural Resources.

*R. Lyle Laverty, of Colorado, to be Assistant Secretary for Fish and Wildlife.

*Robert Boldrey, of Michigan, to be a Member of the Board of Trustees of the Morris K. Udall Scholarship and Excellence in National Environmental Policy Foundation for a term expiring May 26, 2013.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. REED (for himself, Mr. LEAHY, Mr. WHITEHOUSE, and Ms. KLOBUCHAR):

S. 1903. A bill to extend the temporary protected status designation of Liberia under section 244 of the Immigration and Nationality Act so that Liberians can continue to be eligible for such status through September 30, 2008; to the Committee on the Judiciary.

By Mr. SALAZAR (for himself and Mr. NELSON of Nebraska):

S. 1904. A bill to amend the Farm Security and Rural Investment Act of 2002 to ensure that only producers receive commodity program payments; to the Committee on Agriculture, Nutrition, and Forestry.

By Ms. KLOBUCHAR (for herself, Mr. ALEXANDER, and Mr. LIEBERMAN):

S. 1905. A bill to provide for a rotating schedule for regional selection of delegates to a national Presidential nominating convention, and for other purposes; to the Committee on Rules and Administration.

By Mr. BAUCUS (for himself and Mr. COLEMAN):

S. 1906. A bill to understand and comprehensively address the oral health problems associated with methamphetamine use; to the Committee on Health, Education, Labor, and Pensions.

By Mr. BAUCUS (for himself and Mr. COLEMAN):

S. 1907. A bill to amend title I of the Omnibus Crime Control and Safe Streets Act of 1968 to understand and comprehensively address the inmate oral health problems associated with methamphetamine use, and for other purposes; to the Committee on the Judiciary.

By Mr. VITTER:

S. 1908. A bill to amend the procedures regarding military recruiter access to secondary school student recruiting information; to the Committee on Health, Education, Labor, and Pensions.

By Mr. ISAKSON:

S. 1909. A bill to amend title XVIII of the Social Security Act to provide for coverage, as supplies associated with the injection of insulin, of home needle removal, decontamination, and disposal devices and the disposal of needles and syringes through a sharps-by-mail or similar program under part D of the Medicare program; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Ms. MURKOWSKI (for herself, Mr. JOHNSON, Mr. COLEMAN, Mr. SPECTER, Mr. STEVENS, Mr. DURBIN, Mr. DODD, Mrs. MURRAY, and Mr. HATCH):

S. Res. 285. A resolution designating September 9, 2007, as ''National Fetal Alcohol Spectrum Disorders Awareness Day''; considered and agreed to.

By Mr. HATCH (for himself, Mr. ENSIGN, Mr. DOMENICI, Mr. WYDEN, Mr. KYL, Mr. BARRASSO, Mr. SALAZAR, Mr. CRAIG, Ms. CANTWELL, Mr. BENNETT, Mr. STEVENS, Mr. TESTER, and Mr. REID):

S. Res. 286. A resolution recognizing the heroic efforts of firefighters to contain numerous wildfires throughout the Western United States; considered and agreed to.

By Mr. HARKIN (for himself and Mr. GRASSLEY):

S. Res. 287. A resolution honoring and expressing gratitude to the 1st Battalion of the 133rd Infantry (''Ironman Battalion'') of the Iowa National Guard; considered and agreed to.

ADDITIONAL COSPONSORS

S. 59

At the request of Mr. INOUYE, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 59, a bill to amend title XIX of the Social Security Act to improve access to advanced practice nurses and physician assistants under the Medicaid Program.

S. 60

At the request of Mr. INOUYE, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 60, a bill to amend the Public Health Service Act to provide a means for continued improvement in emergency medical services for children.

S. 65

At the request of Mr. INHOFE, the names of the Senator from California (Mrs. FEINSTEIN) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 65, a bill to modify the age-60 standard for certain pilots, and for other purposes.

S. 459

At the request of Ms. SNOWE, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 459, a bill to require that health plans provide coverage for a minimum hospital stay for mastectomies, lumpectomies, and lymph node dissection for the treatment of breast cancer and coverage for secondary consultations.

S. 548

At the request of Mr. LEAHY, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 548, a bill to amend the Internal Revenue Code of 1986 to provide that a deduction equal to fair market value shall be allowed for charitable contributions of literary, musical, artistic, or scholarly compositions created by the donor.

S. 558

At the request of Mr. KENNEDY, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 558, a bill to provide parity between health insurance coverage of mental health benefits and benefits for medical and surgical services.

S. 582

At the request of Mr. SMITH, the names of the Senator from Delaware (Mr. BIDEN), the Senator from Maine (Ms. COLLINS) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 582, a bill to amend the Internal Revenue Code of 1986 to classify automatic fire sprinkler systems as 5-year property for purposes of depreciation.

S. 588

At the request of Mr. NELSON of Florida, the name of the Senator from North Dakota (Mr. CONRAD) was added as a cosponsor of S. 588, a bill to amend title XVIII of the Social Security Act to increase the Medicare caps on graduate medical education positions for States with a shortage of residents.

S. 626

At the request of Mr. GRASSLEY, his name was added as a cosponsor of S. 626, a bill to amend the Public Health Service Act to provide for arthritis research and public health, and for other purposes.

S. 651

At the request of Mr. HARKIN, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 651, a bill to help promote the national recommendation of physical activity to kids, families, and communities across the United States.

S. 656

At the request of Mr. REED, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 656, a bill to provide for the adjustment of status of certain nationals of Liberia to that of lawful permanent residence.

S. 771

At the request of Mr. HARKIN, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 771, a bill to amend the Child Nutrition Act of 1966 to improve the nutrition and health of schoolchildren by updating the definition of ''food of minimal nutritional value'' to conform to current nutrition science and to protect the Federal investment in the national school lunch and breakfast programs.

S. 819

At the request of Mr. DORGAN, the name of the Senator from Colorado (Mr. SALAZAR) was added as a cosponsor of S. 819, a bill to amend the Internal Revenue Code of 1986 to expand tax-free distributions from individual retirement accounts for charitable purposes.

S. 961

At the request of Mr. NELSON of Nebraska, the names of the Senator from Rhode Island (Mr. WHITEHOUSE) and the Senator from Texas (Mr. CORNYN) were added as cosponsors of S. 961, a bill to amend title 46, United States Code, to provide benefits to certain individuals who served in the United States merchant marine (including the Army Transport Service and the Naval Transport Service) during World War II, and for other purposes.

S. 1010

At the request of Mr. CONRAD, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1010, a bill to amend the Internal Revenue Code of 1986 to encourage guaranteed lifetime income payments from annuities and similar payments of life insurance proceeds at dates later than death by excluding from income a portion of such payments.

S. 1070

At the request of Mrs. LINCOLN, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of S. 1070, a bill to amend the Social Security Act to enhance the social security of the Nation by ensuring adequate public-private infrastructure and to resolve to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation, and for other purposes.

S. 1143

At the request of Mr. MARTINEZ, his name was added as a cosponsor of S. 1143, a bill to designate the Jupiter Inlet Lighthouse and the surrounding Federal land in the State of Florida as

an Outstanding Natural Area and as a unit of the National Landscape System, and for other purposes.

S. 1161

At the request of Mr. LEAHY, his name was added as a cosponsor of S. 1161, a bill to amend title XVIII of the Social Security Act to authorize the expansion of medicare coverage of medical nutrition therapy services.

S. 1287

At the request of Mr. SMITH, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. 1287, a bill to amend the Internal Revenue Code of 1986 to allow an offset against income tax refunds to pay for State judicial debts that are past-due.

S. 1386

At the request of Mr. REED, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1386, a bill to amend the Housing and Urban Development Act of 1968, to provide better assistance to low- and moderate-income families, and for other purposes.

S. 1460

At the request of Mr. HARKIN, the name of the Senator from Missouri (Mrs. MCCASKILL) was added as a cosponsor of S. 1460, a bill to amend the Farm Security and Rural Development Act of 2002 to support beginning farmers and ranchers, and for other purposes.

S. 1556

At the request of Mr. SMITH, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 1556, a bill to amend the Internal Revenue Code of 1986 to extend the exclusion from gross income for employer-provided health coverage to designated plan beneficiaries of employees, and for other purposes.

S. 1577

At the request of Mr. KOHL, the name of the Senator from Minnesota (Mr. COLEMAN) was added as a cosponsor of S. 1577, a bill to amend titles XVIII and XIX of the Social Security Act to require screening, including national criminal history background checks, of direct patient access employees of skilled nursing facilities, nursing facilities, and other long-term care facilities and providers, and to provide for nationwide expansion of the pilot program for national and State background checks on direct patient access employees of long-term care facilities or providers.

S. 1677

At the request of Mr. DODD, the names of the Senator from New Jersey (Mr. MENENDEZ) and the Senator from Florida (Mr. MARTINEZ) were added as cosponsors of S. 1677, a bill to amend the Exchange Rates and International Economic Coordination Act of 1988 and for other purposes.

S. 1678

At the request of Ms. COLLINS, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1678, a bill to amend title XVIII of the Social Security Act to ensure more timely access to home health services for Medicare beneficiaries under the Medicare program.

S. 1730

At the request of Mr. SMITH, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1730, a bill to amend part A of title IV of the Social Security Act, to reward States for engaging individuals with disabilities in work activities, and for other purposes.

S. 1755

At the request of Mr. CASEY, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1755, a bill to amend the Richard B. Russell National School Lunch Act to make permanent the summer food service pilot project for rural areas of Pennsylvania and apply the program to rural areas of every State.

S. 1793

At the request of Mrs. CLINTON, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1793, a bill to amend the Internal Revenue Code of 1986 to provide a tax credit for property owners who remove lead-based paint hazards.

S. 1817

At the request of Mr. OBAMA, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1817, a bill to ensure proper administration of the discharge of members of the Armed Forces for personality disorder, and for other purposes.

S. 1825

At the request of Mr. WEBB, the names of the Senator from New York (Mrs. CLINTON) and the Senator from West Virginia (Mr. BYRD) were added as cosponsors of S. 1825, a bill to provide for the study and investigation of wartime contracts and contracting processes in Operation Iraqi Freedom and Operation Enduring Freedom, and for other purposes.

S. 1885

At the request of Mr. OBAMA, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Ohio (Mr. BROWN) were added as cosponsors of S. 1885, a bill to provide certain employment protections for family members who are caring for members of the Armed Forces recovering from illnesses and injuries incurred on active duty.

S. 1894

At the request of Mr. DODD, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1894, a bill to amend the Family and Medical Leave Act of 1993 to provide family and medical leave to primary caregivers of servicemembers with combat-related injuries.

S. RES. 104

At the request of Mrs. HUTCHISON, the name of the Senator from Kentucky (Mr. BUNNING) was added as a cosponsor of S. Res. 104, a resolution commending the national explosives detection canine team program for 35 years of service to the safety and security of the transportation systems within the United States.

S. RES. 252

At the request of Mr. BOND, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. Res. 252, a resolution recognizing the increasingly mutually beneficial relationship between the United States of America and the Republic of Indonesia.

S. RES. 276

At the request of Mr. BIDEN, the names of the Senator from Nebraska (Mr. HAGEL) and the Senator from Utah (Mr. HATCH) were added as cosponsors of S. Res. 276, a resolution calling for the urgent deployment of a robust and effective multinational peacekeeping mission with sufficient size, resources, leadership, and mandate to protect civilians in Darfur, Sudan, and for efforts to strengthen the renewal of a just and inclusive peace process.

At the request of Ms. CANTWELL, her name was added as a cosponsor of S. Res. 276, supra.

At the request of Mr. NELSON of Florida, his name was added as a cosponsor of S. Res. 276, supra.

S. RES. 278

At the request of Mr. CASEY, the name of the Senator from Georgia (Mr. CHAMBLISS) was added as a cosponsor of S. Res. 278, a resolution expressing the sense of the Senate regarding the announcement of the Russian Federation of its suspension of implementation of the Conventional Armed Forces in Europe Treaty.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. KLOBUCHAR (for herself, Mr. ALEXANDER, and Mr. LIEBERMAN):

S. 1905. A bill to provide for a rotating schedule for regional selection of delegates to a national Presidential nominating convention, and for other purposes; to the Committee on Rules and Administration.

Mr. ALEXANDER. Mr. President, today I joined Senators KLOBUCHAR and LIEBERMAN in introducing the Regional Presidential Primary and Caucus Act. Our legislation would establish a rotating schedule of regional presidential primaries and caucuses.

We introduced this legislation because we agree that the Presidential nomination system is broken. The American dream that ''any boy or girl can grow up to be President'' has become a nightmare.

Crowded schedules and government restraints on contributions close primaries to worthy competitors. States racing to schedule early contests have made the nomination process too long and expensive. As a result, media and money make decisions voters should make.

The National Football League schedules 16 contests over 5 months to determine its champions. The Presidential nominating process uses the equivalent of two preseason contests in Iowa and New Hampshire to narrow the field to two or three and sometimes pick the winner.

If professional football were Presidential politics, SportsCenter would pick the Super Bowl teams after two preseason games.

The problem is not Iowa and New Hampshire. The problem is what comes after Iowa and New Hampshire. At least 18 States will choose delegates in a 1-day traffic jam on February 5 next year.

The legislation we introduced today requires States to spread out the primaries and caucuses into a series of regional contests over four months. Beginning in 2012, States could only schedule primaries and caucuses during the first weeks of March, April, May, and June of Presidential years.

The traditional warm up contests in Iowa and New Hampshire would still come first, but they would return to their proper role as ''off-Broadway'' opportunities for lesser known candidates to become well-enough known to compete on the 4-month-long big stage.

In addition, at the appropriate time I will offer an amendment to this legislation that would allow Presidential candidates to raise up to $20 million in individual contribution amounts of up to $10,000, indexed for inflation. The current limit of $2,300 makes it too hard for many worthy but unknown candidates to raise enough early money to be taken seriously—leaving the field to the rich—who constitutionally can spend their own funds—and famous.

Together, these two reforms—spreading out the primaries and allowing a ''start-up'' fund for candidates—will increase the pool of good candidates willing to run for the White House and give more Americans the opportunity to hear their ideas and to cast a meaningful vote.

Mr. President, I ask unanimous consent to have the following documents printed in the CONGRESSIONAL RECORD: a David Broder column, ''No Way to Choose a President,'' that ran in the May 10, 2007 issue of The Washington Post; Remarks that I delivered on the floor of the Senate on February 2, 2004 titled ''Two Super Bowls''; and a lecture I delivered at the Heritage Foundation on May 23, 1996 titled ''Off With the Limits: What I Learned About Money and Politics When I Ran for President.''

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

[From washingtonpost.com, May 10, 2007]

NO WAY TO CHOOSE A PRESIDENT

(By David S. Broder)

The true insanity of the altered presidential primary schedule does not become apparent until you actually lay out the proposed dates on a 2008 calendar.

The mad rush of states to advance their nominating contests in hopes of gaining more influence has produced something so contrary to the national interest that it cries out for action.

The process is not over. Just last week, Florida jumped the line by moving its primary up to Jan. 29, a week ahead of the Feb. 5 date when—unbelievably—22 states may hold delegate selection contests, either primaries or caucuses.

Florida's move crowds the traditional leadoff primary in New Hampshire, which had been set for Jan. 22. And New Hampshire is unhappy about the competition from two caucuses planned even earlier in January, in Iowa and Nevada. So its secretary of state, William M. Gardner, who has unilateral authority to set the New Hampshire voting date, is threatening to jump the rivals, even if it means voting before New Year's Day.

This way lies madness.

Instead of there being a steady progression of contests, challenging and whittling the field of contenders in the wide-open races to select a successor to George W. Bush, it is going to be a herky-jerky, feast-or-famine exercise that looks more like Russian roulette than anything that tests who can best fill the most powerful secular office on Earth.

As things stand, the earliest contests in Iowa, Nevada, New Hampshire, South Carolina and Florida will be followed by that indigestible glut of races on Feb. 5.

On that day, voters in the mega-states of California, Illinois, Michigan, New Jersey, New York, Pennsylvania and Texas will all be called upon to judge the fields of contenders. And so will voters of 17 smaller states, ranging from Alabama to Oregon and from Delaware to Utah.

Most of those voters will never have had an opportunity to get even a glance at the candidates. All they will know is what the ads tell them—and what the media can supply, when reporters are exhausting themselves dashing after the race from state to state.

Assuming everyone is not burned out, the survivors of this ordeal will find things slowing to a crawl—and then screeching to a halt.

Maryland and Virginia hold primaries on Feb. 12, and Wisconsin a week later. Then there's a two-week gap, with only the Hawaii and Idaho caucuses, until Massachusetts, Minnesota, Ohio and Vermont vote on March 4.

At that point, presidential politics effectively stops for more than two months. Between March 4 and the May 6 contests in Indiana and North Carolina, the only scheduled events are a primary in Mississippi and the Maine Republican caucuses.

This crazy calendar sets up one of two scenarios—both scary. If one candidate in each party wraps up the nomination by gaining momentum in the January contests and amassing delegates on Feb. 5, we will be looking at the longest, most-dragged-out general election ever. The conventions are late in 2008; the Democrats' the last week in August, the Republicans' the first week in September. The time from February to Labor Day will be boring beyond belief.

But if nothing is decided by the night of Feb. 5, the chance of a quirky result from the oddity of the political geography of the remaining states will be greatly increased. Democrats will have to compete in Indiana and North Carolina, where they rarely win in November. Republicans will be judged in Massachusetts and Vermont, where their party membership is minuscule.

None of this helps the country get the best-qualified candidates, and none of it helps either party put forward its best candidate.

The situation screams for repair. In my view, the parties would be well advised to make the necessary fixes themselves, rather than wait for Congress to devise remedial legislation.

The mandate for the next pair of national party chairmen should be to agree on a sensible national agenda for the primaries—either a rotating regional system that gives all states a turn at being early or a plan that allows a random mix of states to vote, but only on dates fixed in advance by the parties, and separated at intervals that allow voters to consider seriously their choices.

It would be close to criminal to allow a repeat of this coming year's folly in 2012.

TWO SUPER BOWLS

MR. ALEXANDER. Mr. President, I rise to propose that we turn the Presidential nominating process over to the National Football League, except for Super Bowl half-time shows. Then maybe we can have a second Super Bowl, where anything is possible and everyone can participate.

Take the example of our colleague Senator Kerry's team—I am sure the Senator from Vermont will be quick to point out it is the team of many Senators from New England—the New England Patriots. Last night, they became the Super Bowl champions.

On September 12, in the season's first game, the Buffalo Bills trounced the Patriots 31 to 0. If this had been the first-in-the-Nation Presidential nominating caucus, the Patriots would have been toast. You know the pundits' rule: Only three tickets out of Iowa. The Patriots certainly didn't look like one of the three best professional football teams. Then, the Washington Redskins defeated the Patriots, as unlikely as it would have been for Dennis Kucinich to upend Senator Kerry in New Hampshire. But in the National Football League, upsets don't end the season. The Patriots played 14 more games. They won them all. Yesterday, they beat the Carolina Panthers in the Super Bowl for their 15th consecutive win.

The National Football League schedules 20 weeks of contests over 5 months to determine its champion. The Presidential nominating process, on the other hand, uses the equivalent of two preseason games in Iowa and New Hampshire to narrow the field to two or three—and sometimes they effectively I pick the winner.

The NFL wasn't always so wise. In the 1930s, league owners rearranged schedules after the first few games so that teams that were doing well could play one another. This was good for the Chicago Bears, for example, but not for the league. Fans in other cities quit going to the games—just as voters in most States have quit voting in Presidential primaries.

Bears owner George Halas and others created today's competitive system in which almost any one of 32 teams can hope to make the playoffs. Green Bay can make it because the league makes sure that even smalltown teams have enough revenue. Prime-time television opportunities are rotated. Each Monday, senior officials in the league's New York office grade every call and no call to second-guess even the instant replays.

Professional football has become America's game because it symbolizes the most important aspect of the American character: If you work hard and play by the rules, anything is possible. As a result, 8 of 10 of the most watched network television shows have been Super Bowls; 98 of the 100 best watched cable television games have been NFL games.

Every September, the NFL fields 32 teams, almost all with a shot at the playoffs. Every 4 years, the Presidential nominating process does well to attract a half dozen credible candidates for the biggest job in the world.

All but half are effectively eliminated after two contests. If professional football were Presidential politics, Sportscenter would pick the Super Bowl teams after 3 or 4 preseason games.

These two steps would fix the Presidential nominating process:

No. 1, spread out the primaries. Twenty-eight primaries are crammed into 5 weeks after New Hampshire. Congress should assume the role of Paul Tagliabue. Create a window between February and May during which primaries may be held every 2 weeks. Iowa and New Hampshire could still come first, but they would become off-Broadway warmups and not the whole show.

The second step that would fix the process would be to allow more money—to raise their first $10 million, let candidates collect individual ''start-up contributions'' of up to $10,000. Today's $2,000 limit makes it impossible for most potential candidates to imagine how to raise, say, $40 million. During 1995, when I was a candidate and the individual limit on contributions was $1,000, I fattened 250 fundraisers in that 1 year to collect $10 million. The combination of the new $2,000 limit, the increased coverage of new cable channels, and the growth of the Internet have made it easier to raise money.

Still all but Senator Kerry was short of cash after New Hampshire. Put it this way: The Packers would never make it to the playoffs under the revenue rules of Presidential primaries.

Mr. President, 45,000 Iowans voted for John Kerry in the first caucus. About 83,000 New Hampshirites voted for him in the first primary. More Americans actually attended last night's Super Bowl game in Houston, TX, than voted in either Iowa or New Hampshire. Ninety million others watched the Super Bowl game on television.

Perhaps we should learn something from America's game about how to pick a President. I thank the Chair.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. SMITH). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. ALEXANDER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

[Heritage Lecture #568, May 23, 1996.]

OFF WITH THE LIMITS: WHAT I LEARNED ABOUT MONEY AND POLITICS WHEN I RAN FOR PRESIDENT

(By Lamar Alexander)

On March 3, one day after the disastrous—for me—South Carolina primary and three days before I withdrew from the presidential race, I attended Sunday services at the Peachtree Presbyterian Church in Atlanta. The Rev. Frank Harrington preached about how Joshua, after a great victory at the Battle of Jericho, had been surprised and humiliated in the battle of A'i—so humiliated that Joshua renamed A'i the ''Valley of Calamity.'' He wanted his warriors always to remember the lessons of what had happened there.

Walking out after the service, I asked Rev. Harrington, ''Was the point that I should rename South Carolina the 'Valley of Calamity?'''

''No,'' he said, ''the point is, you must learn lessons from your defeat—and then pick yourself up and go on.''

The voters, in their wisdom, have given me a defeat, and now several weeks to reflect upon its lessons. The Heritage Foundation has invited me today to talk about one of those lessons: the influence of money on the race for the presidency. While my wounds are fresh, here is my view: The so-called campaign reformers are selling the American people a real bill of goods on this one. They are saying that limits on what individuals can give to presidential campaigns and on what candidates can spend will reduce the influence of money and create a better democracy.

In fact, such limits do precisely the reverse. We now have 22 years of experience with them. Limits have increased the influence of money and are dangerous to democracy. It is the law of unintended consequences operating in all of its glory. Instead of adding more limits, we should take the limits off and rely on full disclosure to discourage corruption.

The limits on giving and spending for a presidential campaign were well-intentioned, placed into federal law after Watergate. Corporations can't give at all; political action committees may give up to $5,000; and individuals may give up to $1,000 during the primaries (the government pays for the general election). In addition, there are limits on what a candidate may spend in each state primary and a ceiling on spending for the entire primary. The Federal Election Commission enforces all of this.

The limits were designed to make things better for you, the average voter, so let's look at what they have done. As a result of these limits:

You are more likely to see a comet than meet a presidential candidate, unless you have $1,000—or live in Iowa or New Hampshire;

You have fewer choices of candidates;

The primary campaigns start before you care and end before you have a chance to vote;

You are less likely to hear the candidates' messages;

Your nominee is more likely to be someone already holding office, rather than an insurgent;

More of your choices are among candidates who are rich enough to spend their own money; and

Washington, DC., has more to say about who the nominee is and you have less. In short, the federal limits on giving and spending during elections are turning presidential races into playgrounds for the rich, the already famous, and the Washington-based, and are helping to deprive most Americans of the opportunity to cast a meaningful vote.

When we create a system for picking Presidents, I believe our objectives should be these:

We should want the largest number of good candidates.

We should want a good opportunity to hear what they have to say.

All of us, if possible, want the opportunity to cast a meaningful vote. If this is also your set of objectives, then here is my remedy: Off with the limits. Off with the limits on individual contributions. Off with the spending limits. Require maximum disclosure. Open up the system. Let the candidates speak. Let us vote.

Three Disclaimers—Before you think it, let me say it:

First, I am not here to wallow in gloom. In fact, I come away from the campaign more optimistic, not less. I would do it again in a minute. I believe even more that there is very little wrong with our country that more jobs, better schools, and stronger families won't fix.

Second, I believe I can make these remarks in the spirit of a gracious loser. That is made easier because our process produced a nominee whom I respect, who is my friend, and who I will be proud to call my President. Under any process, Bob Dole was our party's most likely nominee this year. (I will confess that my determination to be a gracious loser is tested about once a week when I remember what another defeated Tennessean, Davy Crockett, once said. Congressman Crockett strode to the courthouse steps, faced the voters who had just turned him out of office, and said what every defeated candidate has always wanted to say to such voters: ''I'm going to Texas and you can go to hell'')

Finally, I am not here to complain because Steve Forbes spent $33 million of his own wealth on his presidential campaign. I believe the First Amendment to our Constitution gives Mr. Forbes the right to spend his money to advance his views. The Rockefellers and Perots and Forbeses and du Ponts all have made valuable contributions to our public life. I hope they continue to do so. What I object to, as I will discuss, is letting them spend all they want and then putting limits on the rest of us. What I am arguing—that it is wrong to put limits on giving and spending—runs smack in the face of what we have been hearing ever since Watergate. So let me take my points one by one. What I have to contribute is a view from the inside. I will stick to my impressions and stories from the road and let scholars here at Heritage and elsewhere compile the statistics and perform the analysis.

Because of the limits, you're more likely to see a comet than meet a presidential candidate, unless you have $1,000—or live in Iowa and New Hampshire.

Of course, not everybody wants to meet a presidential candidate. Walking across New Hampshire, I met a woman taking a work break outside a shoe factory in Manchester. I stuck out my hand and said, ''I'm Lamar Alexander. I'd like to be your next President.'' She looked at me, and at my red and black shirt, and said with disgust, ''That's all we need. Another President!'' Congressman Mo Udall used to tell about walking into a barber shop. ''I'm Mo Udall, running for President,'' he said. ''Yeah, I know,'' the barber replied. ''We were just laughing about that yesterday.''

But if you are one of those persons who would actually like to meet and size up someone who might be your President, get your wallet ready because the $1,000 limit on giving forces candidates to spend most of their time with people who can give $1,000. As with many federal laws, these limits have done just exactly the opposite of what they were intended to do. Limits have increased the influence of money on the candidates.

For example, to raise $10 million in 1995 for the Alexander for President campaign, I traveled to 250 fund-raising events. Now, think about this. This is about one event per campaign day. This took 70 percent of all my time. As a result, I became unusually well acquainted with a great many good Americans capable of giving $1,000 (who probably represent a cross section of about one percent of all the people in the country). Wouldn't I have been a better candidate, and the country better off had I been elected, if I had spent more time traveling around America and visiting allies abroad? (I actually did this during 1994, driving 8,800 miles across America and spending two months overseas. This was when I was not spending most of my time meeting nice people who could give me $1,000.)

Because of the limits, you have fewer choices for President.

This is because, in the real world, a $1,000 limit on gifts makes fund-raising so difficult that it discourages most candidates. I will now wave my own red flag: It is important not to get carried away with this argument. The difficulty of raising money is sometimes just an excuse. There are other more compelling reasons not to run for President.

For example, I recall in November of 1995, when Colin Powell was on the cover of the news magazines and his approval rating in the polls was, literally, higher than the Pope's—and I was struggling to secure a paragraph in the Keokuk, Iowa, daily—I was driving to the airport after a New York fundraiser with a former associate of General Powell's. The unavoidable question arose, ''Will Colin run?'' The former associate answered, ''I don't know. But I can tell you two things about General Powell. One is, he makes rational decisions. Two is, he doesn't like uncertainty.'' I knew from that moment that, if that were true, there was no chance whatsoever Colin would be a candidate. Running for President is not a rational decision. It is instinctive. It is a passion with a purpose. And it is most surely a symphony in uncertainty. That is why I am so surprised that so many have such a hard time taking Colin Powell at his word, that he simply doesn't want to do it. Most people don't. They don't want the job, or they are afraid they can't win, or more and more they are unwilling to expose themselves and their families to the scrutiny that comes with the candidacy.

Having said all of that, it is still true that the prospect of trying to raise $20 million from contributions of $1,000 or less makes the race much less attractive and often impossible for many good candidates. In 1995, Bill Bennett told me he didn't know how to raise that kind of money. Jack Kemp said he knew how but didn't want to. Dan Quayle and Dick Cheney discovered it would have been very hard even for a former Vice President and a former Defense Secretary; they both decided not to become candidates.

You might have wondered this year, where have all the governors gone? I don't think I have ever met a governor who didn't think he or she would make an excellent President. Seventeen of our Presidents have been governors. There are today 32 Republican governors. One might argue (and I will confess that I tried out this argument a few hundred times during 1995) that the natural presidential partner for our strong Republican congressional leaders would have been the best of our Republican governors.

But at the end of 1995, not one sitting Republican governor was in the race. Carroll Campbell, Tommy Thompson, and Bill Weld, perhaps others, had considered it and drawn back, privately saying, ''I can't raise the money.'' Even the governor of California, Pete Wilson, who by my calculation is governor of 5 percent of all the money in the world, could not raise enough money. So, for Republicans, 1995 turned out to be the year of the ''money primary.''

This is how it worked. There were, in the end, only four of us who could find a way to raise enough money to run for President. We all had certain advantages. For example, a contribution to Bob Dole was also a contribution to the respected Senate majority leader. Phil Gramm had worked relentlessly for six years as chairman of the Senate Republican Campaign Committee to build a list of 83,000 names and a $5 million campaign kitty, which he then transferred to his presidential account—a perfectly legal loophole, but one which was unavailable to the governors or others not holding office. Pat Buchanan was able to depend on direct mail for smaller contributions because it was his second race, he had been on network television for 15 years, and he took, shall we say, especially noisy positions.

The Alexander campaign had some advantages, too: exceptional national leadership and strong support at home. Six of the last seven Republican national finance chairs chaired our fund-raising. We began with a $2 million dinner in Nashville on March 6, 1995, and raised $5.2 million in 21 events during the next six weeks. At the end of 1995, the three zip codes in America which had contributed the most to presidential campaigns were all in Nashville. By the time I withdrew, we had raised nearly $13 million from 26,000 contributors, 8,800 of whom had given $1,000. (We received another $4 million from federal matching funds.)

But after the initial $5.2 million spurt, it became much harder for us. I was traveling to 20 events per month to raise $500,000. This created logistical adventures of Desert Storm proportions. On one day, I flew from Nashville to Colorado Springs to Denver for fundraisers and then on to Phoenix to be ready for an early morning breakfast. To collect $20,000 during the crucial week before the Iowa caucus, I ''dropped by'' Knoxville, Tennessee, on the way from New Hampshire to Iowa. To raise another $30,000, I flew from Sioux City, Iowa, to San Juan, Puerto Rico, one Sunday in December. By the last four days of the New Hampshire primary, we were running on empty except for the money set aside for debts, audit, and winding down.

Then, when I placed a strong third in the Iowa caucus on February 12, the money dam broke. Beginning three days after Iowa, five days before the New Hampshire primary, contributions started rolling in to our Nashville headquarters at the rate of $1,000,000 a day without events. This continued for every day except Sunday, until I withdrew on March 6. Our once-a-week telephone conference calls sometimes included more than 200 volunteer fund-raisers. But it came too late, for New Hampshire ads had to be purchased the Friday before the primary on Tuesday. I failed (by 7,000 votes) to overtake Senator Dole. The Republican nomination was decided in the first primary.

Partly because of the limits, the campaign starts before you care and ends before you have a chance to vote.

Not only did the campaign end early; it started ridiculously early because, it seemed at the time, starting early was the only way to raise the necessary amount of money. In early 1995, Senator Gramm of Texas, flush with his 83,000 names and $5 million kitty, declared that it would take $20 million to run for President, that he could raise it and that he doubted many others could, and then sponsored a $4 million kick-off dinner in Dallas and announced, ''Ready cash is a candidate's best friend.''

None of the rest of us were about to be left behind. I held my $2 million dinner in Nashville. Senator Dole jumped in, as did others. Off we went, pounding the streets in 1995 trying to raise money for a race in 1996. It was like trying to stir up a conversation about football in the middle of the NBA playoffs. For me, by mid-summer 1995, it was going something like this interview:

From Washington, D.C., ''Inside Politics,'' Wolf Blitzer (already bored with the long ''money primary''): ''Governor Alexander, why do the polls show Senator Dole ahead of you 54 to 4 in Iowa?''

From Vermont, in my red and black shirt, Me (already tired of being asked the same question for the 50th time): ''Wolf, that's the dumbest question I've ever heard. The reason Senator Dole is ahead of me is that everyone knows him and nobody knows me.''

Now, add to the cost of creating such a long campaign the usual costs of fund-raising. A rule of thumb is that it costs 30 cents to raise a dollar. That meant that of the $10 million we raised in 1995, about $3.5 million went for fund-raising. Then there is the cost of complying with federal regulations. Another $1 million of the $10 million we raised during 1995 went for that. We set aside still another $500,000 for the campaign audit, which usually takes years. I think you can see where I am heading.

Add the costs of the long campaign to the usual costs of fund-raising and complying with federal rules and, by the time the 1995 money primary was over and the real primary in 1996 was here, the handful of us still standing (except for Mr. Forbes) were running out of money. The Alexander campaign spent $10 million during 1995, everything we raised, which left us about $3 million in the bank (counting federal matching funds) at the beginning of 1996. And, by comparison, we were running a bare-bones effort. Senator Gramm had spent $28 million when he dropped out just before the first primary in midFebruary. Senator Dole had spent more than $30 million by March 1 and, with 39 primaries yet to go, was coming uncomfortably close to the federally imposed primary spending ceiling. Steve Forbes spent $33 million before he dropped out. I'm not sure whether my friend Pat has dropped out yet or not!

The reason why the Republican nomination was decided in the first primary is not only because limits on giving and spending forced the campaigns to start early. It is also because so many states moved their primaries to an earlier date in an attempt to give their citizens the same privilege Iowa and New Hampshire citizens have: the opportunity to cast a meaningful vote to pick the first President of the new century. This bunching of primaries created a wild roller coaster ride through 38 states in the 25 days after New Hampshire. Ironically, this made New Hampshire even more important. Here was the law of unintended consequences mischievously at work once again. The money primary became so long and expensive that we all arrived financially exhausted at the real starting line: New Hampshire, which turned out to be the finish line as well. About the time the voters had returned from the refrigerator to settle in and watch the presidential campaign unfold and perhaps even to vote in it the campaign had ended.

Because of the limits, you are less likely to hear the candidates' message.

This is because limits on giving and spending prevent most candidates from raising enough money to get across their messages, especially if the candidate is relatively unknown at the beginning. Let me offer an example. Yesterday's Newsweek contains a column by Meg Greenfield which says this: ''The doomed Presidential campaign of Lamar Alexander should tell the Republicans something. It was the quintessential antigovernment pitch—complete with an implicit—and often explicit—denial and disavowal of Alexander's career as a government guy. He bombed.''

Well, now, this is the stuff of a pretty good debate. Of course, I disagree with Ms. Greenfield. I think my campaign nearly succeeded because I understand that the next President must lead us to expect less from Washington and ask more of ourselves, including our local governmental institutions. Ms. Greenfield's and President Clinton's solution is more from Washington. So let the debate begin.

Ms. Greenfield has her page in Newsweek. She is also editorial director for the Washington Post. President Clinton has the best forum of all. Their ''more from Washington'' side of the argument will get plenty of exposure. But what about my ''more from us'' argument? I made my case in Iowa during 80 visits and walked 100 miles across New Hampshire. I found that in those small meetings I could be persuasive. I also found that nothing much happened in the public opinion polls until I was on television. ''Free TV''—the network news—was not of much help (although some local stations were very aggressive). To begin with, the national networks didn't arrive until mid-January when the campaign was nearly over.

The Center for Media and Public Affairs watched all the network newscasts in January and February, ten-and-one-half hours of campaign coverage. The Center found that we nine Republican candidates were allotted 79 minutes total. We were allowed to present our views in seven-second sound bites. The journalists covering us received five times as many minutes of coverage on those same newscasts. What the journalists said about us and our campaigns was more negative than what we candidates said about each other. And more than half the journalists' comments were about the horse race, not the issues. The Freedom Forum, in a remarkable survey of the journalists covering the presidential campaign, found that in 1992, 89 percent had voted for Bill Clinton. A candidate cannot rely on ''Free TV'' to get his message across. That is why, in our media-drenched society, where things are not important unless they are on TV, a candidate must have money for television to get a message across, and the limits on giving and spending make it difficult for candidates to do that.

This is not just one candidate's lament. Limits on giving and spending are an affront to the First Amendment to the U.S. Constitution. The whole idea of the framers of the Bill of Rights was to keep the government from attempting to limit political debate and criticism: ''Congress shall make no law abridging the freedom of speech.'' In Buckley v. Valeo, the Supreme Court acknowledged this and struck down most congressional limits of this sort, but left standing the current provisions because of its worry about ''corruption.'' I believe the better antidote to corruption is disclosure. To correct something bad, we have created something worse.

Because of limits, your nominee is more likely to be an incumbent than an insurgent.

In the real world, insurgents not only need more money than incumbents; they need it early. The New York Times reported that two-thirds of voters in New Hampshire made their minds up during the last week before the primary, after the Iowa caucuses. Among those voters, I won with 31 percent. Among the one-third who voted before Iowa, I received six percent. More money, earlier, might have helped get my message across to those early deciders.

Candidates for President who already hold public office have government-paid staffs of policy advisers, PR people, and political administrators. They have name recognition and franking privileges. They have a fundraising advantage because of their positions of power. If they are in Washington, they have a huge media advantage because that is where the media are. So putting a limit on what all candidates can raise and spend turns out to be a protection policy for some candidates: the ones who already enjoy the perquisites of public office.

This is not just true in federal races. My home state, Tennessee, has just limited contributions to governors' races to $500. This is an enormous advantage for our incumbent Republican governor, Don Sundquist. And it virtually guarantees that the only effective candidate against Governor Sundquist when he runs for re-election will be someone who is so rich that he can spend his or her own money—which brings us to the most important point.

Because of the limits, more of your choices are likely to be rich candidates willing to spend their own money.

This brings us to the major problem with limits on campaign giving and spending: The limits apply to some candidates but not to others. This is because the U.S. Supreme Court has said that the First Amendment to the U.S. Constitution prohibits Congress from preventing anyone from spending his or her own money on our own campaigns. So the limits apply only to people who aren't rich enough to spend money on their own campaign.

This creates an absurd advantage for wealthy candidates and a distorted contest for the voter. The first advantage is the obvious: The wealthy candidate has more money to spend. For example, Mr. Forbes spent $33 million of (mostly) his own money; I spent, with matching funds, about $16 million of other peoples' money.

There are two other less obvious advantages. The candidate with his own money spends no time raising it. On the other hand, the candidate raising it is careening from event to event, repeating speeches, meeting nice people who can give $1,000, wearing himself ragged, and using up 70 percent of his time. By the time you reach the finals the week between Iowa and New Hampshire, you are a candidate for a fitness center, not the presidency.

Finally, there are the state-by-state spending limits, which also help the rich. The federal government has decreed, for example, that a campaign may not spend more than $1 million in Iowa and $618,000 in New Hampshire during the presidential primaries. Mr. Forbes, unaffected by these limits, spent $5 million in Iowa on television. The Alexander campaign spent $930,000. The AP reported that on the third week before the New Hampshire primary, Mr. Forbes bought 700 ads on one Boston television station (which covers southern New Hampshire). That week, Senator Dole bought 200 ads on that station. The Alexander campaign: none. Mr. Forbes must have spent $5 million in Arizona, by my estimates. Local newspapers said it was more than any advertiser had ever spent on local television to introduce a new product. (It must be pointed out that having your own money doesn't automatically mean you win. Mr. Perot is not President. Mr. Forbes came in fourth in both Iowa and New Hampshire. I recall my race for governor in 1978 against a candidate who must have spent $8 million. I spent $2 million, enough to win, although I could never have raised $2 million if there had been limits of $500 or $1,000 per contribution.)

What kind of contest is this, having different rules for different contestants? This is like watching the Magic play the Bulls with one team wearing handcuffs. It is certainly not the game the voters paid to see. Think of it this way: Say the fifth grade teacher organizes a contest for class president with water pistols as the weapon of choice; then some kid arrives with a garden hose. Either take away the new kid's garden hose (Bill Bradley suggests a constitutional amendment to limit what individuals can spend on their own campaigns) or give the rest of the fifth graders the freedom to raise and spend enough money to buy their own garden hoses. And if the New Hampshire primary is most of the ball game in presidential primaries, why should state-by-state spending limits keep candidates from defending themselves, even if they use up all their money?

Because of the limits, Washington has more to say about who the nominee is and you have less.

Talking about Washington these days has gotten to be a sticky business. The rest of the country is tired of Washington, and Washington is tired of hearing about Washington. The rest of the country is becoming more offensive about its feelings, and Washington is becoming more defensive. ''Cut their pay and send them home'' still makes sense in Sioux City, but they call it nonsense here. One of Washington's most senior journalists told me sadly last year that ''This town has grown too big for its britches.'' I have been coming and going from Washington off and on for 30 years and I believe that is true as well; but to come from outside Washington and say it, and to really believe it, is asking for trouble.

I believe our President must lead us to expect less from Washington and to ask more of ourselves. That is a message less frequently heard in Washington and more difficult to launch from outside Washington. For one thing, this is a media-drenched society, and the message-launchers—the media—are increasingly concentrated here. That will be more true in 2000 and 2004 than it was in 1996. The party fund-raising apparatus is here. The party leadership is here. The think tanks, if you will excuse me, are here. To receive maximum attention to my speech today, I am here. There are all sorts of good people here in Washington, but we of necessity, when we are here, talk mostly with each other.

REFORMING THE PROCESS

Limits on giving and spending make it less likely that a candidate based outside Washington can succeed. Such candidates, by their experience and skills, may be able to help make Washington more like the rest of America, rather than the rest of America more like Washington. I believe Washington will always be a better place if it is constantly refreshed by the strength of the country outside Washington. The way we pick Presidents today makes that more difficult. Limits are not all that is wrong.

The process should be deregulated. We should sunset the existing regulations and start over. Fewer rules and full disclosure should be the byword.

Spread out the primaries. Let Iowa and New Hampshire go first, in February or March, and then arrange all the other primaries on the second Tuesday of the next three months. This would give winners a chance to capitalize on success, voters a chance to digest new faces, and candidates a chance to actually meet voters.

The candidates should be given the opportunity to speak on television more often for themselves. My even mentioning this runs the same risks Dennis Rodman would take if he suggested some rule changes to a convention of NBA officials. So let me begin with some praise. Some print reporters sat through New Hampshire Lincoln Day dinners in the early stages of the money primary, in 1994 and 1995. C–SPAN and CNN labored valiantly and early. In January and February of 1996, the New York Times began printing some long excerpts of the candidates' speeches, and the networks began showing unedited stump speeches. But most of the coverage came late, or was about the horse race, or about candidates who were never going to run. Seventy-nine minutes of network exposure in seven-second sound bites for nine Republican candidates is pathetically little.

There are dangers to early voting. In a growing number of states, voters may vote a month or two before the election day. According to the Edison exit poll of 1996 New Hampshire primary voters, 40 percent of the voters made their minds up during the last three days before the primary. Those who cast their votes a month earlier were voting in quite a different race.

OTHER OPTIONS FOR REFORM

The first option is suggested by Senator Bill Bradley, whose sporting background must make him especially allergic to contests with one rule for some participants and another rule for others. Senator Bradley would try to create a level playing field by putting limits on everyone, in effect making Mr. Forbes live by the same rules I do.

This takes care of Mr. Forbes and me. But the AFL–CIO will still be able to run $35 million worth of TV ads attacking particular Republican candidates. The National Association of Wholesaler-Distributors will still

be able to run ads slamming President Clinton's product liability veto. The National Restaurant Association will advertise that President Clinton is wrong about the minimum wage. The National Education Association will say I am wrong about school choice. The national political parties will raise tens of millions in ''soft money.'' The President is the one person in America who is able to advocate the best interests of the country as a whole. Why should we limit the speech only of those who seek to speak for the country as a whole?

Senator Bradley should leave the First Amendment alone. The First Amendment is correct. It stands in the way of preventing ill-advised efforts by the government to limit a candidate's right to speak. And if there cannot be limits on most of us, why should there be limits on any of us?

A second option is public financing which we now have with the presidential general elections. But such taxpayer-funded campaigns still leave Mr. Perot and the AFL–CIO and other committees free to spend millions creating an unlevel playing field. Also, public financing leaves the media with more horsepower than the candidates themselves have. And I cannot fathom how public financing would work in a primary situation. Would the government have funded everyone who showed up at the Republican debates this season? If so, such funding would have produced countless more candidates. I am opposed to public financing. It is incestuous. It is an unnecessary use of taxpayers' money. It invites government regulations. It creates an unlevel playing field by favoring incumbents.

Finally, there are various proposals to require the media to give away TV time. (Such proposals would never work in a primary for the same reasons public financing could not work: How would you choose to whom to give it?) The lack of an opportunity for voters to consider the messages of candidates—especially insurgent candidates—is at the heart of the problem with our presidential process. But I am afraid these well-meaning proposals will drown in their own complexity and the law of unintended consequences will somehow rear its head again. Isn't the best solution for the media simply to cover the races and present the serious candidates on network news and in the newspapers more often on appropriate occasions, speaking for themselves?

FIND THE GOOD AND PRAISE IT

I mentioned at the beginning of my remarks that I came away from the campaign with a good feeling, not a bad feeling. My friend Alex Haley used to say, ''Find the good and praise it,'' and I can easily do that about this process, even with its flaws. During the last year, I walked across New Hampshire, meeting several hundred people a day, spent 80 days in Iowa in maybe 200 meetings that ranged from 20 to 300 people, and had at least 50 meetings in Florida with the delegates to the Presidency III straw poll. During most of these meetings I was little known and unencumbered by the news media, so there was no disruption to the flow of the session.

I remember wishing time after time that anybody who had any sense of cynicism about our presidential selection process could be with me, like a fly on the wall, because they could not be cynical after hearing and seeing and feeling what I saw. The groups with whom I met always listened carefully. Most often, they wanted to talk about our jobs, our schools and our neighborhoods, and our families. In meeting after meeting, I came away certain that this is a nation hungry for a vision contest, not one willing to tolerate a trivial presidential election. I believe there is a great market in the American electorate for a full-fledged discussion about what kind of country we can have in the year 2000 and beyond.

As the song says, it is a long, long time from May 'til September when the presidential race really begins. One way to help fill this time usefully would be to review the way we pick Presidents and make certain that next time, in the new century, we have a process that attracts the largest number of good candidates, that gives them an opportunity to say and us to hear their messages, and gives as many of us as possible a chance to cast a meaningful vote.

One lesson I learned when I ran for President is that step one toward those objectives would be these four words: Off with the limits.

Mr. LIEBERMAN. Mr. President, I rise to state my support for the legislation Senators KLOBUCHAR, ALEXANDER, and I are introducing today to create a regional Presidential primary system effective in 2012.

The goal of this legislation is to transform what has become a tired, arbitrary, and exclusive presidential primary system that simply does not give enough voters the opportunity to weigh the ideas of candidates and choose the one they think would best represent their future.

Given the significance of choosing the most powerful officeholder in the world, our Presidential selection process must be a fair and deliberate one that tests the strength of the ideas and character of all the candidates and exposes them to the maximum number of voters.

Instead, what we have now is a confusing process that, with each passing Presidential election season, becomes more and more compressed, forcing States to move their primaries up earlier in the calendar year in order to give their citizens a chance to participate, and granting disproportionate influence to the early States.

Where 50 States once scattered their primaries throughout the first half of the election year—from January through June—this year, we have a system in which 39 caucuses or primaries will be held in January and February alone, up from 19 in 2004, with enough delegates at stake potentially to decide the nominee. Almost half the States of the Union will be excluded from that process.

There is another insidious effect of this increasingly condensed schedule: The more compressed the primary schedule is the more reliant candidates become on large campaign donations and the people who give them. The fundraising primary this year has already eliminated candidates who simply could not raise sufficient funds quickly enough to be competitive in the first 2 months of the Presidential year.

This is no way for the world's greatest democracy to choose its President.

Our legislation offers a commonsense alternative that would transform the primary season into what it should be: a contest between candidates who take their cases to the broadest possible slice of the electorate.

I was honored to cosponsor proposals to bring reason to the Presidential primary system twice in the past—in 1996 and 1999—with former Senator Slade Gorton. What we are introducing today is very similar in that it calls for a regional, rotating primary system that divides the 50 States into four regions that would take turns holding primaries in the months of March, April, May, and June of the Presidential election year.

Specifically, the bill would asign all States to one of four regions—corresponding roughly to the Northeast, South, Midwest, and Western regions of the country. A lottery would determine which region goes first, and the regions would rotate in subsequent election years. Each State within a region must hold its primary or caucus during the period assigned to that region.

New Hampshire and Iowa would be permitted to continue holding the first primary and caucus, respectively, before any of the regional primaries would take place. I personally would have preferred to omit this provision in the bill. If we are going to change to a regional system, there should be no exceptions, and I am concerned that these two States will continue to have a disproportionate impact on the outcome of the nominating process. But Iowa and New Hampshire hold iconic status in the Presidential primary system and so they remain the first caucus and primary States in this bill.

The new system would take effect for the 2012 Presidential election.

By creating a series of regional primaries, we will make it more likely that all areas of the country have input into the nominee selection process, and that the candidates and their treasuries will not be stretched so thin by primaries all over the country on the same day. By spreading out the primaries over a 4-month period, we would provide the electorate with a better opportunity to evaluate the candidates over time. And with our bill, we hope that voters—not just financial contributors—will have the lion's share of influence over who the parties' nominees will be.

The guiding principle of our democracy is that every citizen has the opportunity to choose his or her leaders. But the sad truth is this principle no longer bears a resemblance to the reality of an increasingly squashed and arbitrary primary system.

We need to change our presidential primary system to make it more reasonable, more inclusive, and better structured so that it properly reflects the significance it holds—not only every 4 years but as a founding principle of our great Nation.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 285—DESIGNATING SEPTEMBER 9, 2007, AS ''NATIONAL FETAL ALCOHOL SPECTRUM DISORDERS AWARENESS DAY''

Ms. MURKOWSKI (for herself, Mr. JOHNSON, Mr. COLEMAN, Mr. SPECTER, Mr. STEVENS, Mr. DURBIN, Mr. DODD, Mrs. MURRAY, and Mr. HATCH) submitted the following resolution; which was considered and agreed to:

S. RES. 285

Whereas the term ''fetal alcohol spectrum disorders'' includes a broader range of conditions and therefore has replaced the term ''fetal alcohol syndrome'' as the umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy;

Whereas fetal alcohol spectrum disorders are the leading cause of cognitive disability in western civilization, including the United States, and are 100 percent preventable;

Whereas fetal alcohol spectrum disorders are a major cause of numerous social disorders, including learning disabilities, school failure, juvenile delinquency, homelessness, unemployment, mental illness, and crime;

Whereas the incidence rate of fetal alcohol syndrome is estimated at 1 out of 500 live births and the incidence rate of fetal alcohol spectrum disorders is estimated at 1 out of every 100 live births;

Whereas, although the economic costs of fetal alcohol spectrum disorders are difficult to estimate, the cost of fetal alcohol syndrome alone in the United States was $5,400,000,000 in 2003 and it is estimated that each individual with fetal alcohol syndrome will cost taxpayers of the United States between $1,500,000 and $3,000,000 in his or her lifetime;

Whereas, in February 1999, a small group of parents of children who suffer from fetal alcohol spectrum disorders came together with the hope that in 1 magic moment the world could be made aware of the devastating consequences of alcohol consumption during pregnancy;

Whereas the first International Fetal Alcohol Syndrome Awareness Day was observed on September 9, 1999;

Whereas Bonnie Buxton of Toronto, Canada, the co-founder of the first International Fetal Alcohol Syndrome Awareness Day, asked ''What if . . . a world full of FAS/E [Fetal Alcohol Syndrome/Effect] parents all got together on the ninth hour of the ninth day of the ninth month of the year and asked the world to remember that during the 9 months of pregnancy a woman should not consume alcohol . . . would the rest of the world listen?''; and

Whereas on the ninth day of the ninth month of each year since 1999, communities around the world have observed International Fetal Alcohol Syndrome Awareness Day: Now, therefore, be it

Resolved, That the Senate—

(1) designates September 9, 2007, as ''National Fetal Alcohol Spectrum Disorders Awareness Day''; and

(2) calls upon the people of the United States—

(A) to observe National Fetal Alcohol Spectrum Disorders Awareness Day with appropriate ceremonies—

(i) to promote awareness of the effects of prenatal exposure to alcohol;

(ii) to increase compassion for individuals affected by prenatal exposure to alcohol;

(iii) to minimize further effects of prenatal exposure to alcohol; and

(iv) to ensure healthier communities across the United States; and

(B) to observe a moment of reflection on the ninth hour of September 9, 2007, to remember that during the 9 months of pregnancy a woman should not consume alcohol.

SENATE RESOLUTION 286—RECOGNIZING THE HEROIC EFFORTS OF FIREFIGHTERS TO CONTAIN NUMEROUS WILDFIRES THROUGHOUT THE WESTERN UNITED STATES

Mr. HATCH (for himself, Mr. ENSIGN, Mr. DOMENICI, Mr. WYDEN, Mr. KYL, Mr. BARRASSO, Mr. SALAZAR, Mr. CRAIG, Ms. CANTWELL, Mr. BENNETT, Mr. STEVENS, Mr. TESTER, and Mr. REID) submitted the following resolution; which was considered and agreed to:

S. RES. 286

Whereas the annual peak of the Western wildfire season occurs during July and August;

Whereas the 2007 Western wildfire season has been characterized by continued drought, record-setting temperatures, extreme fuel conditions, and widespread dry lightning storms;

Whereas firefighters have had to contend with extreme fire behavior and rapid rates of fire spread;

Whereas, as of July 23, 2007, more than 55,000 wildfires have burned more than 4,000,000 acres of land, which is more than 8,000 fires and 1,000,000 acres higher than the average reported fire rate over the last 10 years;

Whereas, from July 6 through July 8, 2007, more than 1,200 fires were ignited in the Western United States, most of which were caused by dry lightning storms that swept across California, Nevada, Idaho, and Utah;

Whereas, as of July 23, 2007—

(1) the State of Idaho has reported more than 760 fires that have burned more than 800,000 acres;

(2) the State of Utah has reported more than 670 fires that have burned more than 660,000 acres;

(3) the State of Nevada has reported more than 560 fires that have burned more than 510,000 acres;

(4) the State of Oregon has reported more than 1,200 fires that have burned nearly 212,000 acres;

(5) the State of California has reported more than 4,600 fires that have burned more than 117,000 acres;

(6) the State of Arizona has reported more than 1,600 fires that have burned more than 88,000 acres;

(7) the State of Washington has reported more than 680 fires that have burned more than 64,000 acres;

(8) the State of New Mexico has reported more than 870 fires that have burned nearly 35,000 acres;

(9) the State of Montana has reported more than 960 fires that have burned more than 19,000 acres;

(10) the State of Wyoming has reported more than 200 fires that have burned more than 18,000 acres; and

(11) the State of Colorado has reported more than 740 fires that have burned more than 7,400 acres;

Whereas, at any given time during the Western wildfire season, as many as 14,000 firefighters are assigned to large, uncontained fires throughout the Western United States; and

Whereas, despite tremendously volatile weather and terrain conditions, Federal, State, and local firefighting units have contained between 95 and 98 percent of all wildfires during initial attack: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the heroic efforts of firefighters to contain wildfires and protect lives, homes, and rural economies throughout the Western United States; and

(2) encourages the people and government officials of the United States to express their appreciation to the brave men and women serving in the firefighting services.

SENATE RESOLUTION 287—HONORING AND EXPRESSING GRATITUDE TO THE 1ST BATTALION OF THE 133RD INFANTRY (''IRONMAN BATTALION'') OF THE IOWA NATIONAL GUARD

Mr. HARKIN (for himself and Mr. GRASSLEY) submitted the following resolution; which was considered and agreed to:

S. RES. 287

Whereas 476 members of the 1st Battalion, 133rd Infantry of the Iowa National Guard were mobilized for active duty in September and October of 2005;

Whereas 80 members of the 1st Battalion, 133rd Infantry have been providing essential support to the Battalion from Iowa National Guard installations in Waterloo, Iowa, and Dubuque, Iowa, and at least 490 members of the 1st Battalion, 133rd Infantry were deployed to Iraq in April and May of 2006;

Whereas the members of the 1st Battalion, 133rd Infantry have been serving bravely and honorably since April and May of 2006 in the al-Anbar Province of Iraq, one of the most dangerous parts of Iraq;

Whereas the 1st Battalion, 133rd Infantry deployed as part of the 1st Brigade Combat Team of the 34th Infantry Division, which has completed the longest continuous deployment of any National Guard unit during Operation Iraqi Freedom;

Whereas the 1st Battalion, 133rd Infantry is the longest-serving Iowa Army National Guard unit since World War II;

Whereas the CBS program ''60 Minutes'' devoted an entire hour to telling the story of the 1st Battalion, 133rd Infantry on May 27, 2007;

Whereas the members of the 1st Battalion, 133rd Infantry have completed over 500 missions, providing security for convoys operating in al-Anbar Province;

Whereas the members of the 1st Battalion, 133rd Infantry have logged over 4,000,000 mission miles, and have delivered over ⅓ of the fuel needed to sustain coalition forces in Iraq;

Whereas the members of the 1st Battalion, 133rd Infantry have detained over 60 insurgents;

Whereas the members of the 1st Battalion, 133rd Infantry were scheduled to return home in April 2007, but had their tours of duty extended until July 2007;

Whereas the members of the 1st Battalion, 133rd Infantry left behind civilian jobs, friends, and families in order to serve the United States;

Whereas 1st Battalion, 133rd Infantry members Sergeant 1st Class Scott E. Nisely and Sergeant Kampha B. Sourivong gave the ultimate sacrifice for their country when they were tragically killed during combat operations near Al Asad, Iraq, on September 30, 2006; and

Whereas the United States will be forever indebted to the soldiers and families of the 1st Battalion, 133rd Infantry for their sacrifices and their contributions to the mission

of the United States in Iraq: Now, therefore, be it

Resolved, That the Senate honors and expresses gratitude for the service and sacrifices of the members and families of the 1st Battalion of the 133rd Infantry of the Iowa National Guard upon the return home of the Battalion from its deployment in Iraq.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2529. Mr. KERRY (for himself and Ms. SNOWE) submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table.

SA 2530. Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) proposed an amendment to the bill H.R. 976, supra.

SA 2531. Mr. MARTINEZ submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2532. Mr. MARTINEZ (for himself and Mr. VITTER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2533. Mr. MARTINEZ submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2534. Mr. DORGAN (for himself, Mr. JOHNSON, Ms. MURKOWSKI, Mr. STEVENS, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra.

SA 2535. Mr. ALLARD submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2536. Mr. ALLARD submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra.

SA 2537. Mr. KYL submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2538. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra.

SA 2539. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2540. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2541. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2542. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2543. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2544. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2545. Mr. ENSIGN (for himself and Mr. DEMINT) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2546. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2547. Mr. BUNNING submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra.

SA 2548. Mr. BURR (for himself, Mr. CORKER, Mr. COBURN, Mr. MARTINEZ, and Mrs. DOLE) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2549. Mr. LOTT submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2550. Mr. LOTT submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2551. Mr. BROWN (for himself and Mr. VOINOVICH) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2552. Mr. SMITH (for himself and Mr. KOHL) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2553. Mr. SMITH submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2554. Mrs. DOLE submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2555. Mrs. DOLE submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2556. Mrs. CLINTON (for herself, Mrs. DOLE, Ms. MIKULSKI, Mr. GRAHAM, Mr. BROWN, and Mrs. BOXER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2557. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2558. Mr. GRAHAM submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2559. Mr. GRAHAM submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2560. Mr. DODD submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2561. Mr. SMITH (for himself and Mrs. CLINTON) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2562. Mr. KYL submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2563. Mr. KYL submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2564. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2565. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2566. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2567. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2568. Mr. AKAKA (for himself, Mr. ALEXANDER, Mr. INOUYE, and Mr. CORKER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2569. Mr. MENENDEZ submitted an amendment intended to be proposed to

amendment SA 2547 submitted by Mr. BUNNING to the amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2570. Mr. WYDEN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2571. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2572. Mr. SANDERS submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2573. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2574. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2575. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2576. Mr. DEMINT submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2577. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2578. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2579. Mr. THUNE (for himself, Mr. LOTT, Mr. CORNYN, and Mr. DEMINT) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2580. Mr. BINGAMAN (for himself, Mr. LEVIN, Ms. STABENOW, and Mr. FEINGOLD) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2581. Mr. BINGAMAN (for himself, Mr. KERRY, and Mr. JOHNSON) submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2582. Mr. BINGAMAN (for himself, Mr. KERRY, and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2583. Mr. BINGAMAN (for himself and Mr. KERRY) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2584. Mr. BINGAMAN (for himself, Mr. KERRY, and Mr. FEINGOLD) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2585. Mr. BINGAMAN (for himself, Mr. LEVIN, Mr. KERRY, Mr. FEINGOLD, Mr. DURBIN, and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2586. Mr. BINGAMAN (for himself and Mr. KERRY) submitted an amendment intended to be proposed by him to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2587. Mr. GREGG proposed an amendment to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra.

SA 2588. Mr. OBAMA (for himself, Mrs. MCCASKILL, Mr. HARKIN, Mr. KERRY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, supra; which was ordered to lie on the table.

SA 2589. Mr. REID proposed an amendment to the bill S. 1, to provide greater transparency in the legislative process.

SA 2590. Mr. REID proposed an amendment to amendment SA 2589 proposed by Mr. REID to the bill S. 1, supra.

SA 2591. Mr. TESTER (for Mr. BIDEN) proposed an amendment to the resolution S. Res. 276, calling for the urgent deployment of a robust and effective multinational peacekeeping mission with sufficient size, resources, leadership, and mandate to protect civilians in Darfur, Sudan, and for efforts to strengthen the renewal of a just and inclusive peace process.

SA 2592. Mr. TESTER (for Mr. BIDEN) proposed an amendment to the resolution S. Res. 276, supra.

TEXT OF AMENDMENTS

SA 2529. Mr. KERRY (for himself and Ms. SNOWE) submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. OUTREACH REGARDING HEALTH INSURANCE OPTIONS AVAILABLE TO CHILDREN.

(a) DEFINITIONS.—In this section—

(1) the terms ''Administration'' and ''Administrator'' means the Small Business Administration and the Administrator thereof, respectively;

(2) the term ''certified development company'' means a development company participating in the program under title V of the Small Business Investment Act of 1958 (15 U.S.C. 695 et seq.);

(3) the term ''Medicaid program'' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(4) the term ''Service Corps of Retired Executives'' means the Service Corps of Retired Executives authorized by section 8(b)(1) of the Small Business Act (15 U.S.C. 637(b)(1));

(5) the term ''small business concern'' has the meaning given that term in section 3 of the Small Business Act (15 U.S.C. 632);

(6) the term ''small business development center'' means a small business development center described in section 21 of the Small Business Act (15 U.S.C. 648);

(7) the term ''State'' has the meaning given that term for purposes of title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(8) the term ''State Children's Health Insurance Program'' means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(9) the term ''task force'' means the task force established under subsection (b)(1); and

(10) the term ''women's business center'' means a women's business center described in section 29 of the Small Business Act (15 U.S.C. 656).

(b) ESTABLISHMENT OF TASK FORCE.—

(1) ESTABLISHMENT.—There is established a task force to conduct a nationwide campaign of education and outreach for small business concerns regarding the availability of coverage for children through private insurance options, the Medicaid program, and the State Children's Health Insurance Program.

(2) MEMBERSHIP.—The task force shall consist of the Administrator, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury.

(3) RESPONSIBILITIES.—The campaign conducted under this subsection shall include—

(A) efforts to educate the owners of small business concerns about the value of health coverage for children;

(B) information regarding options available to the owners and employees of small business concerns to make insurance more affordable, including Federal and State tax deductions and credits for health care-related expenses and health insurance expenses and Federal tax exclusion for health insurance options available under employer-sponsored cafeteria plans under section 125 of the Internal Revenue Code of 1986;

(C) efforts to educate the owners of small business concerns about assistance available through public programs; and

(D) efforts to educate the owners and employees of small business concerns regarding the availability of the hotline operated as part of the Insure Kids Now program of the Department of Health and Human Services.

(4) IMPLEMENTATION.—In carrying out this subsection, the task force may—

(A) use any business partner of the Administration, including—

(i) a small business development center;

(ii) a certified development company;

(iii) a women's business center; and

(iv) the Service Corps of Retired Executives;

(B) enter into—

(i) a memorandum of understanding with a chamber of commerce; and

(ii) a partnership with any appropriate small business concern or health advocacy group; and

(C) designate outreach programs at regional offices of the Department of Health and Human Services to work with district offices of the Administration.

(5) WEBSITE.—The Administrator shall ensure that links to information on the eligibility and enrollment requirements for the Medicaid program and State Children's Health Insurance Program of each State are prominently displayed on the website of the Administration.

(6) REPORT.—

(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, and every 2 years thereafter, the Administrator shall submit to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the

House of Representatives a report on the status of the nationwide campaign conducted under paragraph (1).

(B) CONTENTS.—Each report submitted under subparagraph (A) shall include a status update on all efforts made to educate owners and employees of small business concerns on options for providing health insurance for children through public and private alternatives.

SA 2530. Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) proposed an amendment to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Children's Health Insurance Program Reauthorization Act of 2007''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO MEDICAID; CHIP; SECRETARY.—In this Act:

(1) CHIP.—The term ''CHIP'' means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

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

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

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

Sec. 1. Short title; amendments to Social Security Act; references; table of contents.

TITLE I—FINANCING OF CHIP

Sec. 101. Extension of CHIP.
Sec. 102. Allotments for the 50 States and the District of Columbia.
Sec. 103. One-time appropriation.
Sec. 104. Improving funding for the territories under CHIP and Medicaid.
Sec. 105. Incentive bonuses for States.
Sec. 106. Phase-out of coverage for nonpregnant childless adults under CHIP; conditions for coverage of parents.
Sec. 107. State option to cover low-income pregnant women under CHIP through a State plan amendment.
Sec. 108. CHIP Contingency fund.
Sec. 109. Two-year availability of allotments; expenditures counted against oldest allotments.
Sec. 110. Limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line.
Sec. 111. Option for qualifying States to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children.

TITLE II—OUTREACH AND ENROLLMENT

Sec. 201. Grants for outreach and enrollment.
Sec. 202. Increased outreach and enrollment of Indians.
Sec. 203. Demonstration project to permit States to rely on findings by an Express Lane agency to determine components of a child's eligibility for Medicaid or CHIP.
Sec. 204. Authorization of certain information disclosures to simplify health coverage determinations.

TITLE III—REDUCING BARRIERS TO ENROLLMENT

Sec. 301. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.
Sec. 302. Reducing administrative barriers to enrollment.

TITLE IV—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

Sec. 401. Additional State option for providing premium assistance.
Sec. 402. Outreach, education, and enrollment assistance.

Subtitle B—Coordinating Premium Assistance With Private Coverage

Sec. 411. Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage; coordination of coverage.

TITLE V—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES OF CHILDREN

Sec. 501. Child health quality improvement activities for children enrolled in Medicaid or CHIP.
Sec. 502. Improved information regarding access to coverage under CHIP.
Sec. 503. Application of certain managed care quality safeguards to CHIP.

TITLE VI—MISCELLANEOUS

Sec. 601. Technical correction regarding current State authority under Medicaid.
Sec. 602. Payment error rate measurement (''PERM'').
Sec. 603. Elimination of counting medicaid child presumptive eligibility costs against title XXI allotment.
Sec. 604. Improving data collection.
Sec. 605. Deficit Reduction Act technical corrections.
Sec. 606. Elimination of confusing program references.
Sec. 607. Mental health parity in CHIP plans.
Sec. 608. Dental health grants.
Sec. 609. Application of prospective payment system for services provided by Federally-qualified health centers and rural health clinics.

TITLE VII—REVENUE PROVISIONS

Sec. 701. Increase in excise tax rate on tobacco products.
Sec. 702. Administrative improvements.
Sec. 703. Time for payment of corporate estimated taxes.

TITLE VIII—EFFECTIVE DATE

Sec. 801. Effective date.

TITLE I—FINANCING OF CHIP

SEC. 101. EXTENSION OF CHIP.

Section 2104(a) (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (9), by striking ''and'' at the end;

(2) in paragraph (10), by striking the period at the end and inserting a semicolon; and

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

''(11) for fiscal year 2008, $9,125,000,000;

''(12) for fiscal year 2009, $10,675,000,000;

''(13) for fiscal year 2010, $11,850,000,000;

''(14) for fiscal year 2011, $13,750,000,000; and

''(15) for fiscal year 2012, for purposes of making 2 semi-annual allotments—

''(A) $1,750,000,000 for the period beginning on October 1, 2011, and ending on March 31, 2012, and

''(B) $1,750,000,000 for the period beginning on April 1, 2012, and ending on September 30, 2012.''.

SEC. 102. ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA.

(a) IN GENERAL.—Section 2104 (42 U.S.C. 1397dd) is amended by adding at the end the following new subsection:

''(i) DETERMINATION OF ALLOTMENTS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FISCAL YEARS 2008 THROUGH 2012.—

''(1) COMPUTATION OF ALLOTMENT.—

''(A) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the Secretary shall for each of fiscal years 2008 through 2012 allot to each subsection (b) State from the available national allotment an amount equal to 110 percent of—

''(i) in the case of fiscal year 2008, the highest of the amounts determined under paragraph (2);

''(ii) in the case of each of fiscal years 2009 through 2011, the Federal share of the expenditures determined under subparagraph (B) for the fiscal year; and

''(iii) beginning with fiscal year 2012, subject to subparagraph (E), each semi-annual allotment determined under subparagraph (D).

''(B) PROJECTED STATE EXPENDITURES FOR THE FISCAL YEAR.—For purposes of subparagraphs (A)(ii) and (D), the expenditures determined under this subparagraph for a fiscal year are the projected expenditures under the State child health plan for the fiscal year (as certified by the State and submitted to the Secretary by not later than August 31 of the preceding fiscal year).

''(C) AVAILABLE NATIONAL ALLOTMENT.—For purposes of this subsection, the term 'available national allotment' means, with respect to any fiscal year, the amount available for allotment under subsection (a) for the fiscal year, reduced by the amount of the allotments made for the fiscal year under subsection (c). Subject to paragraph (3)(B), the available national allotment with respect to the amount available under subsection (a)(15)(A) for fiscal year 2012 shall be increased by the amount of the appropriation for the period beginning on October 1 and ending on March 31 of such fiscal year under section 103 of the Children's Health Insurance Program Reauthorization Act of 2007.

''(D) SEMI-ANNUAL ALLOTMENTS.—For purposes of subparagraph (A)(iii), the semi-annual allotments determined under this paragraph with respect to a fiscal year are as follows:

''(i) For the period beginning on October 1 and ending on March 31 of the fiscal year, the Federal share of the portion of the expenditures determined under subparagraph (B) for the fiscal year which are allocable to such period.

''(ii) For the period beginning on April 1 and ending on September 30 of the fiscal year, the Federal share of the portion of the expenditures determined under subparagraph (B) for the fiscal year which are allocable to such period.

''(E) AVAILABILITY.—Each semi-annual allotment made under subparagraph (A)(iii) shall remain available for expenditure under this title for periods after the period specified in subparagraph (D) for purposes of determining the allotment in the same manner

as the allotment would have been available for expenditure if made for an entire fiscal year.

''(2) SPECIAL RULE FOR FISCAL YEAR 2008.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A)(i), the amounts determined under this paragraph for fiscal year 2008 are as follows:

''(i) The total Federal payments to the State under this title for fiscal year 2007, multiplied by the annual adjustment determined under subparagraph (B) for fiscal year 2008.

''(ii) The Federal share of the amount allotted to the State for fiscal year 2007 under subsection (b), multiplied by the annual adjustment determined under subparagraph (B) for fiscal year 2008.

''(iii) Only in the case of—

''(I) a State that received a payment, redistribution, or allotment under any of paragraphs (1), (2), or (4) of subsection (h), the amount of the projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary;

''(II) a State whose projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the May 2006 estimates certified by the State to the Secretary, were at least $95,000,000 but not more than $96,000,000 higher than the projected total Federal payments to the State under this title for fiscal year 2007 on the basis of the November 2006 estimates, the amount of the projected total Federal payments to the State under this title for fiscal year 2007 on the basis of the May 2006 estimates; or

''(III) a State whose projected total Federal payments under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary, exceeded all amounts available to the State for expenditure for fiscal year 2007 (including any amounts paid, allotted, or redistributed to the State in prior fiscal years), the amount of the projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary,

multiplied by the annual adjustment determined under subparagraph (B) for fiscal year 2008.

''(iv) The projected total Federal payments to the State under this title for fiscal year 2008, as determined on the basis of the August 2007 projections certified by the State to the Secretary by not later than September 30, 2007.

''(B) ANNUAL ADJUSTMENT FOR HEALTH CARE COST GROWTH AND CHILD POPULATION GROWTH.—The annual adjustment determined under this subparagraph for a fiscal year with respect to a State is equal to the product of the amounts determined under clauses (i) and (ii):

''(i) PER CAPITA HEALTH CARE GROWTH.—1 plus the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year that begins during the fiscal year involved over the preceding calendar year, as most recently published by the Secretary.

''(ii) CHILD POPULATION GROWTH.—1.01 plus the percentage change in the population of children under 19 years of age in the State from July 1 of the fiscal year preceding the fiscal year involved to July 1 of the fiscal year involved, as determined by the Secretary based on the most timely and accurate published estimates of the Bureau of the Census.

''(C) DEFINITION.—For purposes of subparagraph (B), the term 'fiscal year involved' means the fiscal year for which an allotment under this subsection is being determined.

''(D) PRORATION RULE.—If, after the application of this paragraph without regard to this subparagraph, the sum of the State allotments determined under this paragraph for fiscal year 2008 exceeds the available national allotment for fiscal year 2008, the Secretary shall reduce each such allotment on a proportional basis.

''(3) ALTERNATIVE ALLOTMENTS FOR FISCAL YEARS 2009 THROUGH 2012.—

''(A) IN GENERAL.—If the sum of the State allotments determined under paragraph (1)(A)(ii) for any of fiscal years 2009 through 2011 exceeds the available national allotment for the fiscal year, the Secretary shall allot to each subsection (b) State from the available national allotment for the fiscal year an amount equal to the product of—

''(i) the available national allotment for the fiscal year; and

''(ii) the percentage equal to the sum of the State allotment factors for the fiscal year determined under paragraph (4) with respect to the State.

''(B) SPECIAL RULES BEGINNING IN FISCAL YEAR 2012.—Beginning in fiscal year 2012—

''(i) this paragraph shall be applied separately with respect to each of the periods described in clauses (i) and (ii) of paragraph (1)(D) and the available national allotment for each such period shall be the amount appropriated for such period (rather than the amount appropriated for the entire fiscal year), reduced by the amount of the allotments made for the fiscal year under subsection (c) for each such period, and

''(ii) if—

''(I) the sum of the State allotments determined under paragraph (1)(A)(iii) for either such period exceeds the amount of such available national allotment for such period, the Secretary shall make the allotment for each State for such period in the same manner as under subparagraph (A), and

''(II) the amount of such available national allotment for either such period exceeds the sum of the State allotments determined under paragraph (1)(A)(iii) for such period, the Secretary shall increase the allotment for each State for such period by the amount that bears the same ratio to such excess as the State's allotment determined under paragraph (1)(A)(iii) for such period (without regard to this subparagraph) bears to the sum of such allotments for all States.

''(4) WEIGHTED FACTORS.—

''(A) FACTORS DESCRIBED.—For purposes of paragraph (3), the factors described in this subparagraph are the following:

''(i) PROJECTED STATE EXPENDITURES FOR THE FISCAL YEAR.—The ratio of the projected expenditures under the State child health plan for the fiscal year (as certified by the State to the Secretary by not later than August 31 of the preceding fiscal year) to the sum of the projected expenditures under all such plans for all subsection (b) States for the fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(ii) NUMBER OF LOW-INCOME CHILDREN IN THE STATE.—The ratio of the number of low-income children in the State, as determined on the basis of the most timely and accurate published estimates of the Bureau of the Census, to the sum of the number of low-income children so determined for all subsection (b) States for such fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(iii) PROJECTED STATE EXPENDITURES FOR THE PRECEDING FISCAL YEAR.—The ratio of the projected expenditures under the State child health plan for the preceding fiscal year (as determined on the basis of the projections certified by the State to the Secretary for November of the fiscal year), to the sum of the projected expenditures under all such plans for all subsection (b) States for such preceding fiscal year (as so determined), multiplied by the applicable percentage weight assigned under subparagraph (B).

''(iv) ACTUAL STATE EXPENDITURES FOR THE SECOND PRECEDING FISCAL YEAR.—The ratio of the actual expenditures under the State child health plan for the second preceding fiscal year, as determined by the Secretary on the basis of expenditure data reported by States on CMS Form 64 or CMS Form 21, to such sum of the actual expenditures under all such plans for all subsection (b) States for such second preceding fiscal year, multiplied by the applicable percentage weight assigned under subparagraph (B).

''(B) ASSIGNMENT OF WEIGHTS.—For each of fiscal years 2009 through 2012, the applicable weights assigned under this subparagraph are the following:

''(i) With respect to the factor described in subparagraph (A)(i), a weight of 75 percent for each such fiscal year.

''(ii) With respect to the factor described in subparagraph (A)(ii), a weight of 12½ percent for each such fiscal year.

''(iii) With respect to the factor described in subparagraph (A)(iii), a weight of 7½ percent for each such fiscal year.

''(iv) With respect to the factor described in subparagraph (A)(iv), a weight of 5 percent for each such fiscal year.

''(5) DEMONSTRATION OF NEED FOR INCREASED ALLOTMENT BASED ON PROJECTED STATE EXPENDITURES EXCEEDING 10 PERCENT OF THE PRECEDING FISCAL YEAR ALLOTMENT.—

''(A) IN GENERAL.—If the projected expenditures under the State child health plan described in paragraph (1)(B) for any of fiscal years 2009 through 2012 are at least 10 percent more than the allotment determined for the State for the preceding fiscal year (determined without regard to paragraph (2)(D) or paragraph (3)), and, during the preceding fiscal year, the State did not receive approval for a State plan amendment or waiver to expand coverage under the State child health plan or did not receive a CHIP contingency fund payment under subsection (k)—

''(i) the State shall submit to the Secretary, by not later than August 31 of the preceding fiscal year, information relating to the factors that contributed to the need for the increase in the State's allotment for the fiscal year, as well as any other additional information that the Secretary may require for the State to demonstrate the need for the increase in the State's allotment for the fiscal year;

''(ii) the Secretary shall—

''(I) review the information submitted under clause (i);

''(II) notify the State in writing within 60 days after receipt of the information that—

''(aa) the projected expenditures under the State child health plan are approved or disapproved (and if disapproved, the reasons for disapproval); or

''(bb) specified additional information is needed; and

''(III) if the Secretary disapproved the projected expenditures or determined additional information is needed, provide the State with a reasonable opportunity to submit additional information to demonstrate the need for the increase in the State's allotment for the fiscal year.

''(B) PROVISIONAL AND FINAL ALLOTMENT.—In the case of a State described in subparagraph (A) for which the Secretary has not determined by September 30 of a fiscal year whether the State has demonstrated the need for the increase in the State's allotment for the succeeding fiscal year, the Secretary shall provide the State with a provisional allotment for the fiscal year equal to

110 percent of the allotment determined for the State under this subsection for the preceding fiscal year (determined without regard to paragraph (2)(D) or paragraph (3)), and may, not later than November 30 of the fiscal year, adjust the State's allotment (and the allotments of other subsection (b) States), as necessary (and, if applicable, subject to paragraph (3)), on the basis of information submitted by the State in accordance with subparagraph (A).

''(6) SPECIAL RULES.—

''(A) DEADLINE AND DATA FOR DETERMINING FISCAL YEAR 2008 ALLOTMENTS.—In computing the amounts under paragraph (2)(A) and subsection (c)(5)(A) that determine the allotments to subsection (b) States and territories for fiscal year 2008, the Secretary shall use the most recent data available to the Secretary before the start of that fiscal year. The Secretary may adjust such amounts and allotments, as necessary, on the basis of the expenditure data for the prior year reported by States on CMS Form 64 or CMS Form 21 not later than November 30, 2007, but in no case shall the Secretary adjust the allotments provided under paragraph (2)(A) or subsection (c)(5)(A) for fiscal year 2008 after December 31, 2007.

''(B) INCLUSION OF CERTAIN EXPENDITURES.—

''(i) PROJECTED EXPENDITURES OF QUALIFYING STATES.—Payments made or projected to be made to a qualifying State described in paragraph (2) of section 2105(g) for expenditures described in paragraph (1)(B)(ii) or (4)(B) of that section shall be included for purposes of determining the projected expenditures described in paragraph (1)(B) with respect to the allotments determined for each of fiscal years 2009 through 2012 and for purposes of determining the amounts described in clauses (i) and (iv) of paragraph (2)(A) with respect to the allotments determined for fiscal year 2008.

''(ii) PROJECTED EXPENDITURES UNDER BLOCK GRANT SET-ASIDES FOR NONPREGNANT CHILDLESS ADULTS AND PARENTS.—Payments projected to be made to a State under subsection (a) or (b) of section 2111 shall be included for purposes of determining the projected expenditures described in paragraph (1)(B) with respect to the allotments determined for each of fiscal years 2009 through 2012 (to the extent such payments are permitted under such section), including for purposes of allocating such expenditures for purposes of clauses (i) and (ii) of paragraph (1)(D).

''(7) SUBSECTION (b) STATE.—In this paragraph, the term 'subsection (b) State' means 1 of the 50 States or the District of Columbia.''.

(b) CONFORMING AMENDMENTS.—Section 2104 (42 U.S.C. 1397dd) is amended—

(1) in subsection (a), by striking ''subsection (d)'' and inserting ''subsections (d), (h), and (i)'';

(2) in subsection (b)(1), by striking ''subsection (d)'' and inserting ''subsections (d), (h), and (i)''; and

(3) in subsection (c)(1), by striking ''subsection (d)'' and inserting ''subsections (d), (h), and (i)''.

SEC. 103. ONE-TIME APPROPRIATION.

There is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated, $12,500,000,000 to accompany the allotment made for the period beginning on October 1, 2011, and ending on March 31, 2012, under section 2104(a)(15)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(15)(A)) (as added by section 101), to remain available until expended. Such amount shall be used to provide allotments to States under subsections (c)(5) and (i) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for the first 6 months of fiscal year 2012 in the same manner as allotments are provided under subsection (a)(15)(A) of such section and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(15)(A).

SEC. 104. IMPROVING FUNDING FOR THE TERRITORIES UNDER CHIP AND MEDICAID.

(a) UPDATE OF CHIP ALLOTMENTS.—Section 2104(c) (42 U.S.C. 1397dd(c)) is amended—

(1) in paragraph (1), by inserting ''and paragraphs (5) and (6)'' after ''and (i)''; and

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

''(5) ANNUAL ALLOTMENTS FOR TERRITORIES BEGINNING WITH FISCAL YEAR 2008.—Of the total allotment amount appropriated under subsection (a) for a fiscal year beginning with fiscal year 2008, the Secretary shall allot to each of the commonwealths and territories described in paragraph (3) the following:

''(A) FISCAL YEAR 2008.—For fiscal year 2008, the highest amount of Federal payments to the commonwealth or territory under this title for any fiscal year occurring during the period of fiscal years 1998 through 2007, multiplied by the annual adjustment determined under subsection (i)(2)(B) for fiscal year 2008, except that clause (ii) thereof shall be applied by substituting 'the United States' for 'the State'.

''(B) FISCAL YEARS 2009 THROUGH 2012.—

''(i) IN GENERAL.—For each of fiscal years 2009 through 2012, except as provided in clause (ii), the amount determined under this paragraph for the preceding fiscal year multiplied by the annual adjustment determined under subsection (i)(2)(B) for the fiscal year, except that clause (ii) thereof shall be applied by substituting 'the United States' for 'the State'.

''(ii) SPECIAL RULE FOR FISCAL YEAR 2012.—In the case of fiscal year 2012—

''(I) 89 percent of the amount allocated to the commonwealth or territory for such fiscal year (without regard to this subclause) shall be allocated for the period beginning on October 1, 2011, and ending on March 31, 2012, and

''(II) 11 percent of such amount shall be allocated for the period beginning on April 1, 2012, and ending on September 30, 2012.''.

(b) REMOVAL OF FEDERAL MATCHING PAYMENTS FOR DATA REPORTING SYSTEMS FROM THE OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER TITLE XIX.—Section 1108(g) (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

''(4) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal years beginning with fiscal year 2008, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1903(a)(3) for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), and (3) of this subsection) to such commonwealth or territory for such fiscal year.''.

(c) GAO STUDY AND REPORT.—Not later than September 30, 2009, the Comptroller General of the United States shall submit a report to the appropriate committees of Congress regarding Federal funding under Medicaid and CHIP for Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. The report shall include the following:

(1) An analysis of all relevant factors with respect to—

(A) eligible Medicaid and CHIP populations in such commonwealths and territories;

(B) historical and projected spending needs of such commonwealths and territories and the ability of capped funding streams to respond to those spending needs;

(C) the extent to which Federal poverty guidelines are used by such commonwealths and territories to determine Medicaid and CHIP eligibility; and

(D) the extent to which such commonwealths and territories participate in data collection and reporting related to Medicaid and CHIP, including an analysis of territory participation in the Current Population Survey versus the American Community Survey.

(2) Recommendations for improving Federal funding under Medicaid and CHIP for such commonwealths and territories.

SEC. 105. INCENTIVE BONUSES FOR STATES.

(a) IN GENERAL.—Section 2104 (42 U.S.C. 1397dd), as amended by section 102, is amended by adding at the end the following new subsection:

''(j) INCENTIVE BONUSES.—

''(1) ESTABLISHMENT OF INCENTIVE POOL FROM UNOBLIGATED NATIONAL ALLOTMENT AND UNEXPENDED STATE ALLOTMENTS.—

''(A) IN GENERAL.—There is hereby established in the Treasury of the United States a fund which shall be known as the 'CHIP Incentive Bonuses Pool' (in this subsection referred to as the 'Incentive Pool'). Amounts in the Incentive Pool are authorized to be appropriated for payments under this subsection and shall remain available until expended.

''(B) DEPOSITS THROUGH INITIAL APPROPRIATION AND TRANSFERS OF FUNDS.—

''(i) INITIAL APPROPRIATION.—There is appropriated to the Incentive Pool, out of any money in the Treasury not otherwise appropriated, $3,000,000,000 for fiscal year 2008.

''(ii) TRANSFERS.—Notwithstanding any other provision of law, the following amounts are hereby appropriated or transferred to, deposited in, and made available for expenditure from the Incentive Pool on the following dates:

''(I) UNEXPENDED FISCAL YEAR 2006 AND 2007 ALLOTMENTS.—On December 31, 2007, the sum for all States of the excess (if any) for each State of—

''(aa) the aggregate allotments provided for the State under subsection (b) or (c) for fiscal years 2006 and 2007 that are not expended by September 30, 2007, over

''(bb) an amount equal to 50 percent of the allotment provided for the State under subsection (c) or (i) for fiscal year 2008 (as determined in accordance with subsection (i)(6)).

''(II) UNOBLIGATED NATIONAL ALLOTMENT.—

''(aa) FISCAL YEARS 2008 THROUGH 2011.—On December 31 of fiscal year 2008, and on December 31 of each succeeding fiscal year through fiscal year 2011, the portion, if any, of the amount appropriated under subsection (a) for such fiscal year that is unobligated for allotment to a State under subsection (c) or (i) for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 2111 for such fiscal year.

''(bb) FIRST HALF OF FISCAL YEAR 2012.—On December 31 of fiscal year 2012, the portion, if any, of the sum of the amounts appropriated under subsection (a)(15)(A) and under section 103 of the Children's Health Insurance Program Reauthorization Act of 2007 for the period beginning on October 1, 2011, and ending on March 31, 2012, that is unobligated for allotment to a State under subsection (c) or (i) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

''(cc) SECOND HALF OF FISCAL YEAR 2012.—On June 30 of fiscal year 2012, the portion, if any, of the amount appropriated under subsection (a)(15)(B) for the period beginning on April 1, 2012, and ending on September 30, 2012, that is unobligated for allotment to a

State under subsection (c) or (i) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

''(III) PERCENTAGE OF STATE ALLOTMENTS THAT ARE UNEXPENDED BY THE END OF THE FIRST YEAR OF AVAILABILITY BEGINNING WITH THE FISCAL YEAR 2009 ALLOTMENTS.—On October 1 of each of fiscal years 2009 through 2012, the sum for all States for such fiscal year (the 'current fiscal year') of the excess (if any) for each State of—

''(aa) the allotment made for the State under subsection (b), (c), or (i) for the fiscal year preceding the current fiscal year (reduced by any amounts set aside under section 2111(a)(3)) that is not expended by the end of such preceding fiscal year, over

''(bb) an amount equal to the applicable percentage (for the fiscal year) of the allotment made for the State under subsection (b), (c), or (i) (as so reduced) for such preceding fiscal year.

For purposes of item (bb), the applicable percentage is 20 percent for fiscal year 2009, and 10 percent for each of fiscal years 2010, 2011, and 2012.

''(IV) REMAINDER OF STATE ALLOTMENTS THAT ARE UNEXPENDED BY THE END OF THE PERIOD OF AVAILABILITY BEGINNING WITH THE FISCAL YEAR 2006 ALLOTMENTS.—On October 1 of each of fiscal years 2009 through 2012, the total amount of allotments made to States under subsection (b), (c), or (i) for the second preceding fiscal year (third preceding fiscal year in the case of the fiscal year 2006 allotments) and remaining after the application of subclause (III) that are not expended by September 30 of the preceding fiscal year.

''(V) UNEXPENDED TRANSITIONAL COVERAGE BLOCK GRANT FOR NONPREGNANT CHILDLESS ADULTS.—On October 1, 2009, any amounts set aside under section 2111(a)(3) that are not expended by September 30, 2009.

''(VI) EXCESS CHIP CONTINGENCY FUNDS.—

''(aa) AMOUNTS IN EXCESS OF THE AGGREGATE CAP.—On October 1 of each of fiscal years 2010 through 2012, any amount in excess of the aggregate cap applicable to the CHIP Contingency Fund for the fiscal year under subsection (k)(2)(B).

''(bb) UNEXPENDED CHIP CONTINGENCY FUND PAYMENTS.—On October 1 of each of fiscal years 2010 through 2012, any portion of a CHIP Contingency Fund payment made to a State that remains unexpended at the end of the period for which the payment is available for expenditure under subsection (e)(3).

''(VII) EXTENSION OF AVAILABILITY FOR PORTION OF UNEXPENDED STATE ALLOTMENTS.—The portion of the allotment made to a State for a fiscal year that is not transferred to the Incentive Pool under subclause (I) or (III) shall remain available for expenditure by the State only during the fiscal year in which such transfer occurs, in accordance with subclause (IV) and subsection (e)(4).

''(C) INVESTMENT OF FUND.—The Secretary of the Treasury shall invest, in interest bearing securities of the United States, such currently available portions of the Incentive Pool as are not immediately required for payments from the Pool. The income derived from these investments constitutes a part of the Incentive Pool.

''(2) PAYMENTS TO STATES INCREASING ENROLLMENT.—

''(A) IN GENERAL.—Subject to paragraph (3)(D), with respect to each of fiscal years 2009 through 2012, the Secretary shall make payments to States from the Incentive Pool determined under subparagraph (B).

''(B) DETERMINATION OF PAYMENTS.—If, for any coverage period ending in a fiscal year ending after September 30, 2008, the average monthly enrollment of children in the State plan under title XIX exceeds the baseline monthly average for such period, the payment made for the fiscal year shall be equal to the applicable amount determined under subparagraph (C).

''(C) APPLICABLE AMOUNT.—For purposes of subparagraph (B), the applicable amount is the product determined in accordance with the following:

''(i) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX does not exceed 2 percent, the product of $75 and the number of such individuals included in such excess.

''(ii) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 2, but does not exceed 5 percent, the product of $300 and the number of such individuals included in such excess, less the amount of such excess calculated in clause (i).

''(iii) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 5 percent, the product of $625 and the number of such individuals included in such excess, less the sum of the amount of such excess calculated in clauses (i) and (ii).

''(D) INDEXING OF DOLLAR AMOUNTS.—For each coverage period ending in a fiscal year ending after September 30, 2009, the dollar amounts specified in subparagraph (C) shall be increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year beginning on January 1 of the coverage period over the preceding coverage period, as most recently published by the Secretary before the beginning of the coverage period involved.

''(3) RULES RELATING TO ENROLLMENT INCREASES.—For purposes of paragraph (2)(B)—

''(A) BASELINE MONTHLY AVERAGE.—Except as provided in subparagraph (C), the baseline monthly average for any fiscal year for a State is equal to—

''(i) the baseline monthly average for the preceding fiscal year; multiplied by

''(ii) the sum of 1 plus the sum of—

''(I) 0.01; and

''(II) the percentage increase in the population of low-income children in the State from the preceding fiscal year to the fiscal year involved, as determined by the Secretary based on the most timely and accurate published estimates of the Bureau of the Census before the beginning of the fiscal year involved.

''(B) COVERAGE PERIOD.—Except as provided in subparagraph (C), the coverage period for any fiscal year consists of the last 2 quarters of the preceding fiscal year and the first 2 quarters of the fiscal year.

''(C) SPECIAL RULES FOR FISCAL YEAR 2009.—With respect to fiscal year 2009—

''(i) the coverage period for that fiscal year shall be based on the first 2 quarters of fiscal year 2009; and

''(ii) the baseline monthly average shall be—

''(I) the average monthly enrollment of low-income children enrolled in the State's plan under title XIX for the first 2 quarters of fiscal year 2007 (as determined over a 6-month period on the basis of the most recent information reported through the Medicaid Statistical Information System (MSIS)); multiplied by

''(II) the sum of 1 plus the sum of—

''(aa) 0.02; and

''(bb) the percentage increase in the population of low-income children in the State from fiscal year 2007 to fiscal year 2009, as determined by the Secretary based on the most timely and accurate published estimates of the Bureau of the Census before the beginning of the fiscal year involved.

''(D) ADDITIONAL REQUIREMENT FOR ELIGIBILITY FOR PAYMENT.—For purposes of subparagraphs (B) and (C), the average monthly enrollment shall be determined without regard to children who do not meet the income eligibility criteria in effect on July 19, 2007, for enrollment under the State plan under title XIX or under a waiver of such plan.

''(4) TIME OF PAYMENT.—Payments under paragraph (2) for any fiscal year shall be made during the last quarter of such year.

''(5) USE OF PAYMENTS.—Payments made to a State from the Incentive Pool shall be used for any purpose that the State determines is likely to reduce the percentage of low-income children in the State without health insurance.

''(6) PRORATION RULE.—If the amount available for payment from the Incentive Pool is less than the total amount of payments to be made for such fiscal year, the Secretary shall reduce the payments described in paragraph (2) on a proportional basis.

''(7) REFERENCES.—With respect to a State plan under title XIX, any references to a child in this subsection shall include a reference to any individual provided medical assistance under the plan who has not attained age 19 (or, if a State has so elected under such State plan, age 20 or 21).''.

(b) REDISTRIBUTION OF UNEXPENDED FISCAL YEAR 2005 ALLOTMENTS.—Notwithstanding section 2104(f) of the Social Security Act (42 U.S.C. 1397dd(f)), with respect to fiscal year 2008, the Secretary shall provide for a redistribution under such section from the allotments for fiscal year 2005 under subsection (b) and (c) of such section that are not expended by the end of fiscal year 2007, to each State described in clause (iii) of section 2104(i)(2)(A) of the Social Security Act, as added by section 102(a), of an amount that bears the same ratio to such unexpended fiscal year 2005 allotments as the ratio of the fiscal year 2007 allotment determined for each such State under subsection (b) of section 2104 of such Act for fiscal year 2007 (without regard to any amounts paid, allotted, or redistributed to the State under section 2104 for any preceding fiscal year) bears to the total amount of the fiscal year 2007 allotments for all such States (as so determined).

(c) CONFORMING AMENDMENT ELIMINATING RULES FOR REDISTRIBUTION OF UNEXPENDED ALLOTMENTS FOR FISCAL YEARS AFTER 2005.—Effective January 1, 2008, section 2104(f) (42 U.S.C. 1397dd(f)) is amended to read as follows:

''(f) UNALLOCATED PORTION OF NATIONAL ALLOTMENT AND UNUSED ALLOTMENTS.—For provisions relating to the distribution of portions of the unallocated national allotment under subsection (a) for fiscal years beginning with fiscal year 2008, and unexpended allotments for fiscal years beginning with fiscal year 2006, see subsection (j).''.

(d) ADDITIONAL FUNDING FOR THE SECRETARY TO IMPROVE TIMELINESS OF DATA REPORTING AND ANALYSIS FOR PURPOSES OF DETERMINING ENROLLMENT INCREASES UNDER MEDICAID AND CHIP.—

(1) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $5,000,000 to the Secretary for fiscal year 2008 for the purpose of improving the timeliness of the data reported and analyzed from the Medicaid Statistical Information System (MSIS) for purposes of carrying out section 2104(j)(2)(B) of the Social Security Act (as added by subsection (a)) and to provide guidance to States with respect to any new reporting requirements related to such improvements. Amounts appropriated under this paragraph shall remain available until expended.

(2) REQUIREMENTS.—The improvements made by the Secretary under paragraph (1) shall be designed and implemented (including with respect to any necessary guidance for States) so that, beginning no later than October 1, 2008, data regarding the enrollment of low-income children (as defined in

section 2110(c)(4) of the Social Security Act (42 U.S.C. 1397jj(c)(4)) of a State enrolled in the State plan under Medicaid or the State child health plan under CHIP with respect to a fiscal year shall be collected and analyzed by the Secretary within 6 months of submission.

SEC. 106. PHASE-OUT OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS UNDER CHIP; CONDITIONS FOR COVERAGE OF PARENTS.

(a) PHASE-OUT RULES.—

(1) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following new section:

"SEC. 2111. PHASE-OUT OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS; CONDITIONS FOR COVERAGE OF PARENTS.

''(a) TERMINATION OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

''(1) NO NEW CHIP WAIVERS; AUTOMATIC EXTENSIONS AT STATE OPTION THROUGH FISCAL YEAR 2008.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

''(A) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

''(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2008, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

''(2) TERMINATION OF CHIP COVERAGE UNDER APPLICABLE EXISTING WAIVERS AT THE END OF FISCAL YEAR 2008.—

''(A) IN GENERAL.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after September 30, 2008.

''(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2008, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only through September 30, 2008.

''(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during fiscal year 2008.

''(3) OPTIONAL 1-YEAR TRANSITIONAL COVERAGE BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Subject to paragraph (4)(B), each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may elect to provide nonpregnant childless adults who were provided child health assistance or health benefits coverage under the applicable existing waiver at any time during fiscal year 2008 with such assistance or coverage during fiscal year 2009, as if the authority to provide such assistance or coverage under an applicable existing waiver was extended through that fiscal year, but subject to the following terms and conditions:

''(A) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—The Secretary shall set aside for the State an amount equal to the Federal share of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all nonpregnant childless adults under such waiver for fiscal year 2008 (as certified by the State and submitted to the Secretary by not later than August 31, 2008, and without regard to whether any such individual lost coverage during fiscal year 2008 and was later provided child health assistance or other health benefits coverage under the waiver in that fiscal year), increased by the annual adjustment for fiscal year 2009 determined under section 2104(i)(2)(B)(i). The Secretary may adjust the amount set aside under the preceding sentence, as necessary, on the basis of the expenditure data for fiscal year 2008 reported by States on CMS Form 64 or CMS Form 21 not later than November 30, 2008, but in no case shall the Secretary adjust such amount after December 31, 2008.

''(B) NO COVERAGE FOR NONPREGNANT CHILDLESS ADULTS WHO WERE NOT COVERED DURING FISCAL YEAR 2008.—

''(i) FMAP APPLIED TO EXPENDITURES.—The Secretary shall pay the State for each quarter of fiscal year 2009, from the amount set aside under subparagraph (A), an amount equal to the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) of expenditures in the quarter for providing child health assistance or other health benefits coverage to a nonpregnant childless adult but only if such adult was enrolled in the State program under this title during fiscal year 2008 (without regard to whether the individual lost coverage during fiscal year 2008 and was reenrolled in that fiscal year or in fiscal year 2009).

''(ii) FEDERAL PAYMENTS LIMITED TO AMOUNT OF BLOCK GRANT SET-ASIDE.—No payments shall be made to a State for expenditures described in this subparagraph after the total amount set aside under subparagraph (A) for fiscal year 2009 has been paid to the State.

''(4) STATE OPTION TO APPLY FOR MEDICAID WAIVER TO CONTINUE COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

''(A) IN GENERAL.—Each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may submit, not later than June 30, 2009, an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a nonpregnant childless adult whose coverage is so terminated (in this subsection referred to as a 'Medicaid nonpregnant childless adults waiver').

''(B) DEADLINE FOR APPROVAL.—The Secretary shall make a decision to approve or deny an application for a Medicaid nonpregnant childless adults waiver submitted under subparagraph (A) within 90 days of the date of the submission of the application. If no decision has been made by the Secretary as of September 30, 2009, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by June 30, 2009, the application shall be deemed approved.

''(C) STANDARD FOR BUDGET NEUTRALITY.—The budget neutrality requirement applicable with respect to expenditures for medical assistance under a Medicaid nonpregnant childless adults waiver shall—

''(i) in the case of fiscal year 2010, allow expenditures for medical assistance under title XIX for all such adults to not exceed the total amount of payments made to the State under paragraph (3)(B) for fiscal year 2009, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for calendar year 2010 over calendar year 2009, as most recently published by the Secretary; and

''(ii) in the case of any succeeding fiscal year, allow such expenditures to not exceed the amount in effect under this subparagraph for the preceding fiscal year, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year that begins during the fiscal year involved over the preceding calendar year, as most recently published by the Secretary.

''(b) RULES AND CONDITIONS FOR COVERAGE OF PARENTS OF TARGETED LOW-INCOME CHILDREN.—

''(1) TWO-YEAR TRANSITION PERIOD; AUTOMATIC EXTENSION AT STATE OPTION THROUGH FISCAL YEAR 2009.—

''(A) NO NEW CHIP WAIVERS.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

''(i) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007 approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a parent of a targeted low-income child; and

''(ii) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2009, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

''(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2009, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only, subject to paragraph (2)(A), through September 30, 2009.

''(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a parent of a targeted low-income child during fiscal years 2008 and 2009.

''(2) RULES FOR FISCAL YEARS 2010 THROUGH 2012.—

''(A) PAYMENTS FOR COVERAGE LIMITED TO BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Any State that provides child health assistance or health benefits coverage under an applicable existing waiver for a parent of a targeted low-income child may elect to continue to provide such assistance or coverage through fiscal year 2010, 2011, or 2012, subject to the same terms and conditions that applied under the applicable existing waiver, unless otherwise modified in subparagraph (B).

''(B) TERMS AND CONDITIONS.—

''(i) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—If the State makes an election under subparagraph (A), the Secretary shall set aside for the State for each such fiscal year an amount equal to the Federal share of 110 percent of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all parents of targeted low-income children enrolled under such waiver for the fiscal year (as certified by the State and submitted to the Secretary by not later than August 31 of the preceding fiscal year). In the case of fiscal year 2012, the set aside for any State shall be computed separately for each period described in clauses (i) and (ii) of subsection (i))(1)(D) and any increase or reduction in the allotment for either such period under subsection

(i)(3)(B)(ii) shall be allocated on a pro rata basis to such set aside.

''(ii) PAYMENTS FROM BLOCK GRANT.—The Secretary shall pay the State from the amount set aside under clause (i) for the fiscal year, an amount for each quarter of such fiscal year equal to the applicable percentage determined under clause (iii) or (iv) for expenditures in the quarter for providing child health assistance or other health benefits coverage to a parent of a targeted low-income child.

''(iii) ENHANCED FMAP ONLY IN FISCAL YEAR 2010 FOR STATES WITH SIGNIFICANT CHILD OUTREACH OR THAT ACHIEVE CHILD COVERAGE BENCHMARKS; FMAP FOR ANY OTHER STATES.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2010 is equal to—

''(I) the enhanced FMAP determined under section 2105(b) in the case of a State that meets the outreach or coverage benchmarks described in any of subparagraphs (A), (B), or (C) of paragraph (3) for fiscal year 2009; or

''(II) the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) in the case of any other State.

''(iv) AMOUNT OF FEDERAL MATCHING PAYMENT IN 2011 OR 2012.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2011 or 2012 is equal to—

''(I) the REMAP percentage if the State met either of the coverage benchmarks described in subparagraph (B) or (C) of paragraph (3) for the preceding fiscal year; or

''(II) the Federal medical assistance percentage (as so determined) in the case of any State to which subclause (I) does not apply.

For purposes of subclause (I), the REMAP percentage is the percentage which is the sum of such Federal medical assistance percentage and a number of percentage points equal to one-half of the difference between such Federal medical assistance percentage and such enhanced FMAP.

''(v) NO FEDERAL PAYMENTS OTHER THAN FROM BLOCK GRANT SET ASIDE.—No payments shall be made to a State for expenditures described in clause (ii) after the total amount set aside under clause (i) for a fiscal year has been paid to the State.

''(vi) NO INCREASE IN INCOME ELIGIBILITY LEVEL FOR PARENTS.—No payments shall be made to a State from the amount set aside under clause (i) for a fiscal year for expenditures for providing child health assistance or health benefits coverage to a parent of a targeted low-income child whose family income exceeds the income eligibility level applied under the applicable existing waiver to parents of targeted low-income children on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

''(3) OUTREACH OR COVERAGE BENCHMARKS.—For purposes of paragraph (2), the outreach or coverage benchmarks described in this paragraph are as follows:

''(A) SIGNIFICANT CHILD OUTREACH CAMPAIGN.—The State—

''(i) was awarded a grant under section 2113 for fiscal year 2009;

''(ii) implemented 1 or more of the process measures described in section 2104(j)(3)(A)(i) for such fiscal year; or

''(iii) has submitted a specific plan for outreach for such fiscal year.

''(B) HIGH-PERFORMING STATE.—The State, on the basis of the most timely and accurate published estimates of the Bureau of the Census, ranks in the lowest ⅓ of States in terms of the State's percentage of low-income children without health insurance.

''(C) STATE INCREASING ENROLLMENT OF LOW-INCOME CHILDREN.—The State qualified for a payment from the Incentive Fund under paragraph (2)(C) of section 2104(j) for the most recent coverage period applicable under such section.

''(4) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting a State from submitting an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a parent of a targeted low-income child that was provided child health assistance or health benefits coverage under an applicable existing waiver.

''(c) APPLICABLE EXISTING WAIVER.—For purposes of this section—

''(1) IN GENERAL.—The term 'applicable existing waiver' means a waiver, experimental, pilot, or demonstration project under section 1115, grandfathered under section 6102(c)(3) of the Deficit Reduction Act of 2005, or otherwise conducted under authority that—

''(A) would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to—

''(i) a parent of a targeted low-income child;

''(ii) a nonpregnant childless adult; or

''(iii) individuals described in both clauses (i) and (ii); and

''(B) was in effect during fiscal year 2007.

''(2) DEFINITIONS.—

''(A) PARENT.—The term 'parent' includes a caretaker relative (as such term is used in carrying out section 1931) and a legal guardian.

''(B) NONPREGNANT CHILDLESS ADULT.—The term 'nonpregnant childless adult' has the meaning given such term by section 2107(f).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 2107(f) (42 U.S.C. 1397gg(f)) is amended—

(i) by striking '', the Secretary'' and inserting '':

''(1) The Secretary'';

(ii) in the first sentence, by inserting ''or a parent (as defined in section 2111(c)(2)(A)), who is not pregnant, of a targeted low-income child'' before the period;

(iii) by striking the second sentence; and

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

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2111.''.

(B) Section 6102(c) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 131) is amended by striking ''Nothing'' and inserting ''Subject to section 2111 of the Social Security Act, as added by section 106(a)(1) of the Children's Health Insurance Program Reauthorization Act of 2007, nothing''.

(b) GAO STUDY AND REPORT.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of whether—

(A) the coverage of a parent, a caretaker relative (as such term is used in carrying out section 1931), or a legal guardian of a targeted low-income child under a State health plan under title XXI of the Social Security Act increases the enrollment of, or the quality of care for, children, and

(B) such parents, relatives, and legal guardians who enroll in such a plan are more likely to enroll their children in such a plan or in a State plan under title XIX of such Act.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall report the results of the study to the appropriate committees of Congress, including recommendations (if any) for changes in legislation.

SEC. 107. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN UNDER CHIP THROUGH A STATE PLAN AMENDMENT.

(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 106(a), is amended by adding at the end the following new section:

''SEC. 2112. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN THROUGH A STATE PLAN AMENDMENT.

''(a) IN GENERAL.—Subject to the succeeding provisions of this section, a State may elect through an amendment to its State child health plan under section 2102 to provide pregnancy-related assistance under such plan for targeted low-income pregnant women.

''(b) CONDITIONS.—A State may only elect the option under subsection (a) if the following conditions are satisfied:

''(1) MEDICAID INCOME ELIGIBILITY LEVEL FOR PREGNANT WOMEN OF AT LEAST 185 PERCENT OF POVERTY.—The State has established an income eligibility level for pregnant women under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1902 that is at least 185 percent of the income official poverty line.

''(2) NO CHIP INCOME ELIGIBILITY LEVEL FOR PREGNANT WOMEN LOWER THAN THE STATE'S MEDICAID LEVEL.—The State does not apply an effective income level for pregnant women under the State plan amendment that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) specified under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1902, on the date of enactment of this paragraph to be eligible for medical assistance as a pregnant woman.

''(3) NO COVERAGE FOR HIGHER INCOME PREGNANT WOMEN WITHOUT COVERING LOWER INCOME PREGNANT WOMEN.—The State does not provide coverage for pregnant women with higher family income without covering pregnant women with a lower family income.

''(4) APPLICATION OF REQUIREMENTS FOR COVERAGE OF TARGETED LOW-INCOME CHILDREN.—The State provides pregnancy-related assistance for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the State provides child health assistance for targeted low-income children under the State child health plan, and in addition to providing child health assistance for such women.

''(5) NO PREEXISTING CONDITION EXCLUSION OR WAITING PERIOD.—The State does not apply any exclusion of benefits for pregnancy-related assistance based on any preexisting condition or any waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) for receipt of such assistance.

''(6) APPLICATION OF COST-SHARING PROTECTION.—The State provides pregnancy-related assistance to a targeted low-income woman consistent with the cost-sharing protections under section 2103(e) and applies the limitation on total annual aggregate cost sharing imposed under paragraph (3)(B) of such section to the family of such a woman.

''(c) OPTION TO PROVIDE PRESUMPTIVE ELIGIBILITY.—A State that elects the option under subsection (a) and satisfies the conditions described in subsection (b) may elect to apply section 1920 (relating to presumptive eligibility for pregnant women) to the State child health plan in the same manner as such section applies to the State plan under title XIX.

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

''(1) PREGNANCY-RELATED ASSISTANCE.—The term 'pregnancy-related assistance' has the meaning given the term 'child health assistance' in section 2110(a) and includes any medical assistance that the State would provide for a pregnant woman under the State plan under title XIX during pregnancy and the period described in paragraph (2)(A).

''(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means a woman—

''(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

''(B) whose family income does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

''(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

''(e) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING PREGNANCY-RELATED ASSISTANCE.—If a child is born to a targeted low-income pregnant woman who was receiving pregnancy-related assistance under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title, as appropriate, on the date of such birth and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the child health or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

''(f) STATES PROVIDING ASSISTANCE THROUGH OTHER OPTIONS.—

''(1) CONTINUATION OF OTHER OPTIONS FOR PROVIDING ASSISTANCE.—The option to provide assistance in accordance with the preceding subsections of this section shall not limit any other option for a State to provide—

''(A) child health assistance through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect after the final rule adopted by the Secretary and set forth at 67 Fed. Reg. 61956–61974 (October 2, 2002)), or

''(B) pregnancy-related services through the application of any waiver authority (as in effect on June 1, 2007).

''(2) CLARIFICATION OF AUTHORITY TO PROVIDE POSTPARTUM SERVICES.—Any State that provides child health assistance under any authority described in paragraph (1) may continue to provide such assistance, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends, in the same manner as such assistance and postpartum services would be provided if provided under the State plan under title XIX, but only if the mother would otherwise satisfy the eligibility requirements that apply under the State child health plan (other than with respect to age) during such period.

''(3) NO INFERENCE.—Nothing in this subsection shall be construed—

''(A) to infer congressional intent regarding the legality or illegality of the content of the sections specified in paragraph (1)(A); or

''(B) to modify the authority to provide pregnancy-related services under a waiver specified in paragraph (1)(B).''.

(b) ADDITIONAL CONFORMING AMENDMENTS.—

(1) NO COST SHARING FOR PREGNANCY-RELATED BENEFITS.—Section 2103(e)(2) (42 U.S.C. 1397cc(e)(2)) is amended—

(A) in the heading, by inserting ''OR PREGNANCY-RELATED ASSISTANCE'' after ''PREVENTIVE SERVICES''; and

(B) by inserting before the period at the end the following: ''or for pregnancy-related assistance''.

(2) NO WAITING PERIOD.—Section 2102(b)(1)(B) (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(A) in clause (i), by striking '', and'' at the end and inserting a semicolon;

(B) in clause (ii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income pregnant woman provided pregnancy-related assistance under section 2112.''.

SEC. 108. CHIP CONTINGENCY FUND.

Section 2104 (42 U.S.C. 1397dd), as amended by section 105, is amended by adding at the end the following new subsection:

''(k) CHIP CONTINGENCY FUND.—

''(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund which shall be known as the 'CHIP Contingency Fund' (in this subsection referred to as the 'Fund'). Amounts in the Fund are authorized to be appropriated for payments under this subsection.

''(2) DEPOSITS INTO FUND.—

''(A) INITIAL AND SUBSEQUENT APPROPRIATIONS.—Subject to subparagraphs (B) and (E), out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Fund—

''(i) for fiscal year 2009, an amount equal to 12.5 percent of the available national allotment under subsection (i)(1)(C) for the fiscal year; and

''(ii) for each of fiscal years 2010 through 2012, such sums as are necessary for making payments to eligible States for such fiscal year, but not in excess of the aggregate cap described in subparagraph (B).

''(B) AGGREGATE CAP.—Subject to subparagraph (E), the total amount available for payment from the Fund for each of fiscal years 2009 through 2012 (taking into account deposits made under subparagraph (C)), shall not exceed 12.5 percent of the available national allotment under subsection (i)(1)(C) for the fiscal year.

''(C) INVESTMENT OF FUND.—The Secretary of the Treasury shall invest, in interest bearing securities of the United States, such currently available portions of the Fund as are not immediately required for payments from the Fund. The income derived from these investments constitutes a part of the Fund.

''(D) TRANSFER OF EXCESS FUNDS TO THE INCENTIVE FUND.—The Secretary of the Treasury shall transfer to, and deposit in, the CHIP Incentive Bonuses Pool established under subsection (j) any amounts in excess of the aggregate cap described in subparagraph (B) for a fiscal year.

''(E) SPECIAL RULES FOR AMOUNTS SET ASIDE FOR PARENTS AND CHILDLESS ADULTS.—For purposes of subparagraphs (A) and (B)—

''(i) the available national allotment under subsection (i)(1)(C) shall be reduced by any amount set aside under section 2111(a)(3) for block grant payments for transitional coverage for childless adults; and

''(ii) the Secretary shall establish a separate account in the Fund for the portion of any amount appropriated to the Fund for any fiscal year which is allocable to the portion of the available national allotment under subsection (i)(1)(C) which is set aside for the fiscal year under section 2111(b)(2)(B)(i) for coverage of parents of low-income children.

The Secretary shall include in the account established under clause (ii) any income derived under subparagraph (C) which is allocable to amounts in such account.

''(3) CHIP CONTINGENCY FUND PAYMENTS.—

''(A) PAYMENTS.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii) and the succeeding subparagraphs of this paragraph, the Secretary shall pay from the Fund to a State that is an eligible State for a month of a fiscal year a CHIP contingency fund payment equal to the Federal share of the shortfall determined under subparagraph (D). In the case of an eligible State under subparagraph (D)(i), the Secretary shall not make the payment under this subparagraph until the State makes, and submits to the Secretary, a projection of the amount of the shortfall.

''(ii) SEPARATE DETERMINATIONS OF SHORTFALLS.—The Secretary shall separately compute the shortfall under subparagraph (D) for expenditures for eligible individuals other than nonpregnant childless adults and parents with respect to whom amounts are set aside under section 2111, for expenditures for such childless adults, and for expenditures for such parents.

''(iii) PAYMENTS.—

''(I) NONPREGNANT CHILDLESS ADULTS.—No payments shall be made from the Fund for nonpregnant childless adults with respect to whom amounts are set aside under section 2111(a)(3).

''(II) PARENTS.—Any payments with respect to any shortfall for parents who are paid from amounts set aside under section 2111(b)(2)(B)(i) shall be made only from the account established under paragraph (2)(E)(ii) and not from any other amounts in the Fund. No other payments may be made from such account.

''(iv) SPECIAL RULES.—Subparagraphs (B) and (C) shall be applied separately with respect to shortfalls described in clause (ii).

''(B) USE OF FUNDS.—Amounts paid to an eligible State from the Fund shall be used only to eliminate the Federal share of a shortfall in the State's allotment under subsection (i) for a fiscal year.

''(C) PRORATION RULE.—If the amounts available for payment from the Fund for a fiscal year are less than the total amount of payments determined under subparagraph (A) for the fiscal year, the amount to be paid under such subparagraph to each eligible State shall be reduced proportionally.

''(D) ELIGIBLE STATE.—

''(i) IN GENERAL.—A State is an eligible State for a month if the State is a subsection (b) State (as defined in subsection (i)(7)), the State requests access to the Fund for the month, and it is described in clause (ii) or (iii).

''(ii) SHORTFALL OF FEDERAL ALLOTMENT FUNDING OF NOT MORE THAN 5 PERCENT.—The Secretary estimates, on the basis of the most recent data available to the Secretary or requested from the State by the Secretary, that the State's allotment for the fiscal year is at least 95 percent, but less than 100 percent, of the projected expenditures under the State child health plan for the State for the fiscal year determined under subsection (i) (without regard to incentive bonuses or payments for which the State is eligible for under subsection (j)(2) for the fiscal year).

''(iii) SHORTFALL OF FEDERAL ALLOTMENT FUNDING OF MORE THAN 5 PERCENT CAUSED BY

SPECIFIC EVENTS.—The Secretary estimates, on the basis of the most recent data available to the Secretary or requested from the State by the Secretary, that the State's allotment for the fiscal year is less than 95 percent of the projected expenditures under the State child health plan for the State for the fiscal year determined under subsection (i) (without regard to incentive bonuses or payments for which the State is eligible for under subsection (j)(2) for the fiscal year) and that such shortfall is attributable to 1 or more of the following events:

''(I) STAFFORD ACT OR PUBLIC HEALTH EMERGENCY.—The State has—

''(aa) 1 or more parishes or counties for which a major disaster has been declared in accordance with section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170) and which the President has determined warrants individual and public assistance from the Federal Government under such Act; or

''(bb) a public health emergency declared by the Secretary under section 319 of the Public Health Service Act.

''(II) STATE ECONOMIC DOWNTURN.—The State unemployment rate is at least 5.5 percent during any 13-consecutive week period during the fiscal year and such rate is at least 120 percent of the State unemployment rate for the same period as averaged over the last 3 fiscal years.

''(III) EVENT RESULTING IN RISE IN PERCENTAGE OF LOW-INCOME CHILDREN WITHOUT HEALTH INSURANCE.—The State experienced a recent event that resulted in an increase in the percentage of low-income children in the State without health insurance (as determined on the basis of the most timely and accurate published estimates of the Bureau of the Census) that was outside the control of the State and warrants granting the State access to the Fund (as determined by the Secretary).

''(E) PAYMENTS MADE TO ALL ELIGIBLE STATES ON A MONTHLY BASIS; AUTHORITY FOR PRO RATA PAYMENTS.—The Secretary shall make monthly payments from the Fund to all States that are determined to be eligible States with respect to a month. If the sum of the payments to be made from the Fund for a month exceed the amount in the Fund, the Secretary shall reduce each such payment on a proportional basis.

''(F) PAYMENTS LIMITED TO FISCAL YEAR OF ELIGIBILITY DETERMINATION UNLESS NEW ELIGIBILITY BASIS DETERMINED.—No State shall receive a CHIP contingency fund payment under this section for a month beginning after September 30 of the fiscal year in which the State is determined to be an eligible State under this subsection, except that in the case of an event described in subclause (I) or (III) of subparagraph (D)(iii) that occurred after July 1 of the fiscal year, any such payment with respect to such event shall remain available until September 30 of the subsequent fiscal year. Nothing in the preceding sentence shall be construed as prohibiting a State from being determined to be an eligible State under this subsection for any fiscal year occurring after a fiscal year in which such a determination is made.

''(G) EXEMPTION FROM DETERMINATION OF PERCENTAGE OF ALLOTMENT RETAINED AFTER FIRST YEAR OF AVAILABILITY.—In no event shall payments made to a State under this subsection be treated as part of the allotment determined for a State for a fiscal year under subsection (i) for purposes of subsection (j)(1)(B)(ii)(III).

''(H) APPLICATION OF ALLOTMENT REPORTING RULES.—Rules applicable to States for purposes of receiving payments from an allotment determined under subsection (c) or (i) shall apply in the same manner to an eligible State for purposes of receiving a CHIP contingency fund payment under this subsection.

''(4) ANNUAL REPORTS.—The Secretary shall annually report to the Congress on the amounts in the Fund, the specific events that caused States to apply for payments from the Fund, and the payments made from the Fund.''.

SEC. 109. TWO-YEAR AVAILABILITY OF ALLOTMENTS; EXPENDITURES COUNTED AGAINST OLDEST ALLOTMENTS.

Section 2104(e) (42 U.S.C. 1397dd(e)) is amended to read as follows:

''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

''(1) IN GENERAL.—Except as provided in subsection (j)(1)(B)(ii)(III), amounts allotted to a State pursuant to this section—

''(A) for each of fiscal years 1998 through 2006, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

''(B) for each of fiscal years 2007 through 2012, shall remain available for expenditure by the State only through the end of the succeeding fiscal year for which such amounts are allotted.

''(2) INCENTIVE BONUSES.—Incentive bonuses paid to a State under subsection (j)(2) for a fiscal year shall remain available for expenditure by the State without limitation.

''(3) CHIP CONTINGENCY FUND PAYMENTS.—Except as provided in paragraph (3)(F) of subsection (k), CHIP Contingency Fund payments made to a State under such subsection for a month of a fiscal year shall remain available for expenditure by the State through the end of the fiscal year.

''(4) RULE FOR COUNTING EXPENDITURES AGAINST CHIP CONTINGENCY FUND PAYMENTS, FISCAL YEAR ALLOTMENTS, AND INCENTIVE BONUSES.—

''(A) IN GENERAL.—Expenditures under the State child health plan made on or after October 1, 2007, shall be counted against—

''(i) first, any CHIP Contingency Fund payment made to the State under subsection (k) for the earliest month of the earliest fiscal year for which the payment remains available for expenditure; and

''(ii) second, amounts allotted to the State for the earliest fiscal year for which amounts remain available for expenditure.

''(B) INCENTIVE BONUSES.—A State may elect, but is not required, to count expenditures under the State child health plan against any incentive bonuses paid to the State under subsection (j)(2) for a fiscal year.

''(C) BLOCK GRANT SET-ASIDES.—Expenditures for coverage of—

''(i) nonpregnant childless adults for fiscal year 2009 shall be counted only against the amount set aside for such coverage under section 2111(a)(3); and

''(ii) parents of targeted low-income children for each of fiscal years 2010 through 2012, shall be counted only against the amount set aside for such coverage under section 2111(b)(2)(B)(i).''.

SEC. 110. LIMITATION ON MATCHING RATE FOR STATES THAT PROPOSE TO COVER CHILDREN WITH EFFECTIVE FAMILY INCOME THAT EXCEEDS 300 PERCENT OF THE POVERTY LINE.

(a) FMAP APPLIED TO EXPENDITURES.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATION ON MATCHING RATE FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE PROVIDED TO CHILDREN WHOSE EFFECTIVE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—

''(A) FMAP APPLIED TO EXPENDITURES.—Except as provided in subparagraph (B), for fiscal years beginning with fiscal year 2008, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to any State that, on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, has an approved State plan amendment or waiver to provide, or has enacted a State law to submit a State plan amendment to provide, expenditures described in such subparagraph under the State child health plan.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

SEC. 111. OPTION FOR QUALIFYING STATES TO RECEIVE THE ENHANCED PORTION OF THE CHIP MATCHING RATE FOR MEDICAID COVERAGE OF CERTAIN CHILDREN.

Section 2105(g) (42 U.S.C. 1397ee(g)) is amended—

(1) in paragraph (1)(A), by inserting ''subject to paragraph (4),'' after ''Notwithstanding any other provision of law,''; and

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

''(4) OPTION FOR ALLOTMENTS FOR FISCAL YEARS 2008 THROUGH 2012.—

''(A) PAYMENT OF ENHANCED PORTION OF MATCHING RATE FOR CERTAIN EXPENDITURES.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 2104 for any of fiscal years 2008 through 2012 (insofar as the allotment is available to the State under subsections (e) and (i) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

''(B) EXPENDITURES DESCRIBED.—For purposes of subparagraph (A), the expenditures described in this subparagraph are expenditures made after the date of the enactment of this paragraph and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under title XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under title XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.''.

TITLE II—OUTREACH AND ENROLLMENT

SEC. 201. GRANTS FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 107, is amended by adding at the end the following:

''SEC. 2113. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

''(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

''(1) IN GENERAL.—From the amounts appropriated under subsection (g), subject to paragraph (2), the Secretary shall award grants to eligible entities during the period of fiscal years 2008 through 2012 to conduct

outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

''(2) TEN PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts shall be used by the Secretary for expenditures during such period to carry out a national enrollment campaign in accordance with subsection (h).

''(b) PRIORITY FOR AWARD OF GRANTS.—

''(1) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

''(A) propose to target geographic areas with high rates of—

''(i) eligible but unenrolled children, including such children who reside in rural areas; or

''(ii) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

''(B) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

''(2) TEN PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (g) shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

''(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

''(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

''(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

''(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

''(4) an assurance that the eligible entity shall—

''(A) conduct an assessment of the effectiveness of such activities against the performance measures;

''(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments; and

''(C) in the case of an eligible entity that is not the State, provide the State with enrollment data and other information as necessary for the State to make necessary projections of eligible children and pregnant women.

''(d) DISSEMINATION OF ENROLLMENT DATA AND INFORMATION DETERMINED FROM EFFECTIVENESS ASSESSMENTS; ANNUAL REPORT.—The Secretary shall—

''(1) make publicly available the enrollment data and information collected and reported in accordance with subsection (c)(4)(B); and

''(2) submit an annual report to Congress on the outreach and enrollment activities conducted with funds appropriated under this section.

''(e) MAINTENANCE OF EFFORT FOR STATES AWARDED GRANTS; NO STATE MATCH REQUIRED.—In the case of a State that is awarded a grant under this section—

''(1) the State share of funds expended for outreach and enrollment activities under the State child health plan shall not be less than the State share of such funds expended in the fiscal year preceding the first fiscal year for which the grant is awarded; and

''(2) no State matching funds shall be required for the State to receive a grant under this section.

''(f) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means any of the following:

''(A) A State with an approved child health plan under this title.

''(B) A local government.

''(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

''(D) A Federal health safety net organization.

''(E) A national, State, local, or community-based public or nonprofit private organization, including organizations that use community health workers or community-based doula programs.

''(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to nongovernmental entities.

''(G) An elementary or secondary school.

''(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term 'Federal health safety net organization' means—

''(A) a Federally-qualified health center (as defined in section 1905(l)(2)(B));

''(B) a hospital defined as a disproportionate share hospital for purposes of section 1923;

''(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

''(D) any other entity or consortium that serves children under a federally funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the Head Start and Early Head Start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

''(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian tribe', 'tribal organization', and 'urban Indian organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(4) 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 or nutrition needs; and

''(F) by providing referral and followup services.

''(g) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $100,000,000 for the period of fiscal years 2008 through 2012, to remain available until expended, for the purpose of awarding grants under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

''(h) NATIONAL ENROLLMENT CAMPAIGN.—From the amounts made available under subsection (a)(2), the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this title and title XIX. Such campaign may include—

''(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

''(2) the integration of information about the programs established under this title and title XIX in public health awareness campaigns administered by the Secretary;

''(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

''(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

''(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency; and

''(6) such other outreach initiatives as the Secretary determines would increase public awareness of the programs under this title and title XIX.''.

(b) ENHANCED ADMINISTRATIVE FUNDING FOR TRANSLATION OR INTERPRETATION SERVICES UNDER CHIP.—Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)), as amended by section 603, is amended—

(1) in the matter preceding subparagraph (A), by inserting ''(or, in the case of expenditures described in subparagraph (D)(iv), the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points)'' after ''enhanced FMAP''; and

(2) in subparagraph (D)—

(A) in clause (iii), by striking ''and'' at the end;

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following new clause:

''(iv) for translation or interpretation services in connection with the enrollment and use of services under this title by individuals for whom English is not their primary language (as found necessary by the Secretary for the proper and efficient administration of the State plan); and''.

(c) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2) (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following:

''(C) NONAPPLICATION TO CERTAIN EXPENDITURES.—The limitation under subparagraph (A) shall not apply with respect to the following expenditures:

''(i) EXPENDITURES FUNDED UNDER SECTION 2113.—Expenditures for outreach and enrollment activities funded under a grant awarded to the State under section 2113.''.

SEC. 202. INCREASED OUTREACH AND ENROLLMENT OF INDIANS.

(a) IN GENERAL.—Section 1139 (42 U.S.C. 1320b–9) is amended to read as follows:

"SEC. 1139. IMPROVED ACCESS TO, AND DELIVERY OF, HEALTH CARE FOR INDIANS UNDER TITLES XIX AND XXI.

''(a) AGREEMENTS WITH STATES FOR MEDICAID AND CHIP OUTREACH ON OR NEAR RESERVATIONS TO INCREASE THE ENROLLMENT OF INDIANS IN THOSE PROGRAMS.—

''(1) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under the Medicaid and State children's health insurance programs established under titles XIX and XXI, the Secretary shall encourage the State to take steps to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are appropriate.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting arrangements entered into between States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations for such Service, Tribes, or Organizations to conduct administrative activities under such titles.

''(b) REQUIREMENT TO FACILITATE COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under the programs established under title XIX or XXI.

''(c) DEFINITION OF INDIAN; INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—In this section, the terms 'Indian', 'Indian Tribe', 'Indian Health Program', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

(b) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as added by section 201(c), is amended by adding at the end the following new clause:

''(ii) EXPENDITURES TO INCREASE OUTREACH TO, AND THE ENROLLMENT OF, INDIAN CHILDREN UNDER THIS TITLE AND TITLE XIX.—Expenditures for outreach activities to families of Indian children likely to be eligible for child health assistance under the plan or medical assistance under the State plan under title XIX (or under a waiver of such plan), to inform such families of the availability of, and to assist them in enrolling their children in, such plans, including such activities conducted under grants, contracts, or agreements entered into under section 1139(a).''.

SEC. 203. DEMONSTRATION PROGRAM TO PERMIT STATES TO RELY ON FINDINGS BY AN EXPRESS LANE AGENCY TO DETERMINE COMPONENTS OF A CHILD'S ELIGIBILITY FOR MEDICAID OR CHIP.

(a) REQUIREMENT TO CONDUCT DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a 3–year demonstration program under which up to 10 States shall be authorized to rely on a finding made within the preceding 12 months by an Express Lane agency to determine whether a child has met 1 or more of the eligibility requirements, such as income, assets or resources, citizenship status, or other criteria, necessary to determine the child's initial eligibility, eligibility redetermination, or renewal of eligibility, for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan. A State selected to participate in the demonstration program—

(A) shall not be required to direct a child (or a child's family) to submit information or documentation previously submitted by the child or family to an Express Lane agency that the State relies on for its Medicaid or CHIP eligibility determination; and

(B) may rely on information from an Express Lane agency when evaluating a child's eligibility for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan without a separate, independent confirmation of the information at the time of enrollment, redetermination, or renewal.

(2) PAYMENTS TO STATES.—From the amount appropriated under paragraph (1) of subsection (f), after the application of paragraph (2) of that subsection, the Secretary shall pay the States selected to participate in the demonstration program such sums as the Secretary shall determine for expenditures made by the State for systems upgrades and implementation of the demonstration program. In no event shall a payment be made to a State from the amount appropriated under subsection (f) for any expenditures incurred for providing medical assistance or child health assistance to a child enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency.

(b) REQUIREMENTS; OPTIONS FOR APPLICATION.—

(1) STATE REQUIREMENTS.—A State selected to participate in the demonstration program established under this section may rely on a finding of an Express Lane agency only if the following conditions are met:

(A) REQUIREMENT TO DETERMINE ELIGIBILITY USING REGULAR PROCEDURES IF CHILD IS FIRST FOUND INELIGIBLE.—If reliance on a finding from an Express Lane agency results in a child not being found eligible for the State Medicaid plan or the State CHIP plan, the State would be required to determine eligibility under such plan using its regular procedures.

(B) NOTICE.—The State shall inform the families (especially those whose children are enrolled in the State CHIP plan) that they may qualify for lower premium payments or more comprehensive health coverage under the State Medicaid plan if the family's income were directly evaluated for an eligibility determination by the State Medicaid agency, and that, at the family's option, the family may seek an eligibility determination by the State Medicaid agency.

(C) COMPLIANCE WITH DEPARTMENT OF HOMELAND SECURITY PROCEDURES.—The State may rely on an Express Lane agency finding that a child is a qualified alien as long as the Express Lane agency complies with guidance and regulatory procedures issued by the Secretary of Homeland Security for eligibility determinations of qualified aliens (as defined in subsections (b) and (c) of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641)).

(D) VERIFICATION OF CITIZENSHIP OR NATIONALITY STATUS.—The State shall satisfy the requirements of section 1902(a)(46)(B) or 2105(c)(9) of the Social Security Act, as applicable (and as added by section 301 of this Act) for verifications of citizenship or nationality status.

(E) CODING; APPLICATION TO ENROLLMENT ERROR RATES.—

(i) IN GENERAL.—The State agrees to—

(I) assign such codes as the Secretary shall require to the children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State's participation in the demonstration program;

(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate with respect to the enrollment of such children;

(III) submit the error rate determined under subclause (II) to the Secretary;

(IV) if such error rate exceeds 3 percent for either of the first 2 fiscal years in which the State participates in the demonstration program, demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

(V) if such error rate exceeds 3 percent for any fiscal year in which the State participates in the demonstration program, a reduction in the amount otherwise payable to the State under section 1903(a) of the Social Security Act (42 Secretary 1396b(a)) for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children included in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

(ii) NO PUNITIVE ACTION BASED ON ERROR RATE.—The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

(iii) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as relieving a State that participates in the demonstration program established under this section from being subject to a penalty under section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

(2) STATE OPTIONS FOR APPLICATION.—A State selected to participate in the demonstration program may elect to apply any of the following:

(A) SATISFACTION OF CHIP SCREEN AND ENROLL REQUIREMENTS.—If the State relies on a finding of an Express Lane agency for purposes of determining eligibility under the State CHIP plan, the State may meet the screen and enroll requirements imposed under subparagraphs (A) and (B) of section 2102(b)(3) of the Social Security Act (42 U.S.C. 1397bb(b) (3)) by using any of the following:

(i) Establishing a threshold percentage of the poverty line that is 30 percentage points (or such other higher number of percentage points) as the State determines reflects the income methodologies of the program administered by the Express Lane Agency and the State Medicaid plan.

(ii) Providing that a child satisfies all income requirements for eligibility under the State Medicaid plan.

(iii) Providing that a child has a family income that exceeds the Medicaid applicable income level.

(B) PRESUMPTIVE ELIGIBILITY.—The State may provide for presumptive eligibility under the State CHIP plan for a child who, based on an eligibility determination of an income finding from an Express Lane agency, would qualify for child health assistance under the State CHIP plan. During the period of presumptive eligibility, the State may determine the child's eligibility for child health assistance under the State CHIP plan based on telephone contact with family members, access to data available in electronic or paper format, or other means that minimize to the maximum extent feasible the burden on the family.

(C) AUTOMATIC ENROLLMENT.—

(i) IN GENERAL.—The State may initiate and determine eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan without a program application from, or on behalf of, the child based on data obtained from sources other than the child (or the child's family), but a child can only be automatically enrolled in the State Medicaid plan or the State CHIP plan if the child or the family affirmatively consents to being enrolled through affirmation and signature on an Express Lane agency application.

(ii) INFORMATION REQUIREMENT.—A State that elects the option under clause (i) shall have procedures in place to inform the child or the child's family of the services that will be covered under the State Medicaid plan or the State CHIP plan (as applicable), appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations created by the enrollment (if applicable), and the actions the child or the child's family must take to maintain enrollment and renew coverage.

(iii) OPTION TO WAIVE SIGNATURES.—The State may waive any signature requirements for enrollment for a child who consents to, or on whose behalf consent is provided for, enrollment in the State Medicaid plan or the State CHIP plan.

(3) SIGNATURE REQUIREMENTS.—In the case of a State selected to participate in the demonstration program—

(A) no signature under penalty of perjury shall be required on an application form for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan to attest to any element of the application for which eligibility is based on information received from an Express Lane agency or a source other than an applicant; and

(B) any signature requirement for determination of an application for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan may be satisfied through an electronic signature.

(4) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed to—

(A) relieve a State of the obligation under section 1902(a)(5) of the Social Security Act (42 U.S.C. 1396a(a)(5)) to determine eligibility for medical assistance under the State Medicaid plan; or

(B) prohibit any State options otherwise permitted under Federal law (without regard to this paragraph or the demonstration program established under this section) that are intended to increase the enrollment of eligible children for medical assistance under the State Medicaid plan or child health assistance under the State CHIP plan, including options related to outreach, enrollment, applications, or the determination or redetermination of eligibility.

(c) LIMITED WAIVER OF OTHER APPLICABLE REQUIREMENTS.—

(1) SOCIAL SECURITY ACT.—The Secretary shall waive only such requirements of the Social Security Act as the Secretary determines are necessary to carry out the demonstration program established under this section.

(2) AUTHORIZATION FOR PARTICIPATING STATES TO RECEIVE CERTAIN DATA DIRECTLY RELEVANT TO DETERMINING ELIGIBILITY AND CORRECT AMOUNT OF ASSISTANCE.—For provisions relating to the authority of States participating in the demonstration program to receive certain data directly, see section 204(c).

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct, by grant, contract, or interagency agreement, a comprehensive, independent evaluation of the demonstration program established under this section. Such evaluation shall include an analysis of the effectiveness of the program, and shall include—

(A) obtaining a statistically valid sample of the children who were enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency and determining the percentage of children who were erroneously enrolled in such plans;

(B) determining whether enrolling children in such plans through reliance on a finding made by an Express Lane agency improves the ability of a State to identify and enroll low-income, uninsured children who are eligible but not enrolled in such plans;

(C) evaluating the administrative costs or savings related to identifying and enrolling children in such plans through reliance on such findings, and the extent to which such costs differ from the costs that the State otherwise would have incurred to identify and enroll low-income, uninsured children who are eligible but not enrolled in such plans; and

(D) any recommendations for legislative or administrative changes that would improve the effectiveness of enrolling children in such plans through reliance on such findings.

(2) REPORT TO CONGRESS.—Not later than September 30, 2012, the Secretary shall submit a report to Congress on the results of the evaluation of the demonstration program established under this section.

(e) DEFINITIONS.—In this section:

(1) CHILD; CHILDREN.—With respect to a State selected to participate in the demonstration program established under this section, the terms ''child'' and ''children'' have the meanings given such terms for purposes of the State plans under titles XIX and XXI of the Social Security Act.

(2) EXPRESS LANE AGENCY.—

(A) IN GENERAL.—The term ''Express Lane agency'' means a public agency that—

(i) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of 1 or more eligibility requirements described in subsection (a)(1);

(ii) is identified in the State Medicaid plan or the State CHIP plan; and

(iii) notifies the child's family—

(I) of the information which shall be disclosed in accordance with this section;

(II) that the information disclosed will be used solely for purposes of determining eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan; and

(III) that the family may elect to not have the information disclosed for such purposes; and

(iv) enters into, or is subject to, an interagency agreement to limit the disclosure and use of the information disclosed.

(B) INCLUSION OF SPECIFIC PUBLIC AGENCIES.—Such term includes the following:

(i) A public agency that determines eligibility for assistance under any of the following:

(I) The temporary assistance for needy families program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

(II) A State program funded under part D of title IV of such Act (42 U.S.C. 651 et seq.).

(III) The State Medicaid plan.

(IV) The State CHIP plan.

(V) The Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).

(VI) The Head Start Act (42 U.S.C. 9801 et seq.).

(VII) The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

(VIII) The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.).

(IX) The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.).

(X) The Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11301 et seq.).

(XI) The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.).

(XII) The Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.).

(ii) A State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.

(iii) A public agency that is subject to an interagency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.

(C) EXCLUSIONS.—Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under title XX of the Social Security Act (42 U.S.C. 1397 et seq.) or a private, for-profit organization.

(D) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

(i) affecting the authority of a State Medicaid agency to enter into contracts with nonprofit and for-profit agencies to administer the Medicaid application process;

(ii) exempting a State Medicaid agency from complying with the requirements of section 1902(a)(4) of the Social Security Act (relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest); or

(iii) authorizing a State Medicaid agency that participates in the demonstration program established under this section to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

(3) MEDICAID APPLICABLE INCOME LEVEL.—With respect to a State, the term ''Medicaid applicable income level'' has the meaning given that term for purposes of such State under section 2110(b)(4) of the Social Security Act (42 U.S.C. 1397jj(4)).

(4) POVERTY LINE.—The term ''poverty line'' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(5) STATE.—The term ''State'' means 1 of the 50 States or the District of Columbia.

(6) STATE CHIP AGENCY.—The term ''State CHIP agency'' means the State agency responsible for administering the State CHIP plan.

(7) STATE CHIP PLAN.—The term ''State CHIP plan'' means the State child health plan established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.), and includes any waiver of such plan.

(8) STATE MEDICAID AGENCY.—The term ''State Medicaid agency'' means the State agency responsible for administering the State Medicaid plan.

(9) STATE MEDICAID PLAN.—The term ''State Medicaid plan'' means the State plan established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and includes any waiver of such plan.

(f) APPROPRIATION.—

(1) OPERATIONAL FUNDS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out the demonstration program established under this section, $49,000,000 for the period of fiscal years 2008 through 2012.

(2) EVALUATION FUNDS.—$5,000,000 of the funds appropriated under paragraph (1) shall be used to conduct the evaluation required under subsection (d).

(3) BUDGET AUTHORITY.—Paragraph (1) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment to States selected to participate in the demonstration program established under this section of the amounts provided under such paragraph (after the application of paragraph (2)).

SEC. 204. AUTHORIZATION OF CERTAIN INFORMATION DISCLOSURES TO SIMPLIFY HEALTH COVERAGE DETERMINATIONS.

(a) AUTHORIZATION OF INFORMATION DISCLOSURE.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1939 as section 1940; and

(2) by inserting after section 1938 the following new section:

''AUTHORIZATION TO RECEIVE PERTINENT INFORMATION

''SEC. 1939. (a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data directly relevant to eligibility determinations under this title (including eligibility files, information described in paragraph (2) or (3) of section 1137(a), vital records information about births in any State, and information described in sections 453(i) and 1902(a)(25)(I)) is authorized to convey such data or information to the State agency administering the State plan under this title, but only if such conveyance meets the requirements of subsection (b).

''(b) REQUIREMENTS FOR CONVEYANCE.—Data or information may be conveyed pursuant to this section only if the following requirements are met:

''(1) The child whose circumstances are described in the data or information (or such child's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

''(2) Such data or information are used solely for the purposes of—

''(A) identifying children who are eligible or potentially eligible for medical assistance under this title and enrolling (or attempting to enroll) such children in the State plan; and

''(B) verifying the eligibility of children for medical assistance under the State plan.

''(3) An interagency or other agreement, consistent with standards developed by the Secretary—

''(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements for safeguarding privacy and data security; and

''(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll children in the plan.

''(c) CRIMINAL PENALTY.—A person described in subsection (a) who publishes, divulges, discloses, or makes known in any manner, or to any extent, not authorized by Federal law, any information obtained under this section shall be fined not more than $1,000 or imprisoned not more than 1 year, or both, for each such unauthorized activity.

''(d) RULE OF CONSTRUCTION.—The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).''.

(b) CONFORMING AMENDMENT TO TITLE XXI.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

''(E) Section 1939 (relating to authorization to receive data directly relevant to eligibility determinations).''.

(c) AUTHORIZATION FOR STATES PARTICIPATING IN THE EXPRESS LANE DEMONSTRATION PROGRAM TO RECEIVE CERTAIN DATA DIRECTLY RELEVANT TO DETERMINING ELIGIBILITY AND CORRECT AMOUNT OF ASSISTANCE.—Only in the case of a State selected to participate in the Express Lane demonstration program established under section 203, the Secretary shall enter into such agreements as are necessary to permit such a State to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under the State CHIP plan or the State Medicaid plan (as such terms are defined in paragraphs (7) and (9) section 203(e)) from the following:

(1) The National Directory of New Hires established under section 453(i) of the Social Security Act (42 U.S.C. 653(i)).

(2) The National Income Data collected by the Commissioner of Social Security from information described in subparagraphs (A) and (B) of section 6103(l)(7) of the Internal Revenue Code of 1986, in accordance with the requirements of that section.

(3) Data regarding enrollment in insurance that may help to facilitate outreach and enrollment under the State Medicaid plan, the State CHIP plan, and such other programs as the Secretary may specify.

TITLE III—REDUCING BARRIERS TO ENROLLMENT

SEC. 301. VERIFICATION OF DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID AND CHIP.

(a) STATE OPTION TO VERIFY DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID THROUGH VERIFICATION OF NAME AND SOCIAL SECURITY NUMBER.—

(1) ALTERNATIVE TO DOCUMENTATION REQUIREMENT.—

(A) IN GENERAL.—Section 1902 (42 U.S.C. 1396a) is amended—

(i) in subsection (a)(46)—

(I) by inserting ''(A)'' after ''(46)'';

(II) by adding ''and'' after the semicolon; and

(III) by adding at the end the following new subparagraph:

''(B) provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, that the State shall satisfy the requirements of—

''(i) section 1903(x); or

''(ii) subsection (dd);''; and

(ii) by adding at the end the following new subsection:

''(dd)(1) For purposes of section 1902(a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under section 1903(x) (if the individual is not described in paragraph (2) of that section), as follows:

''(A) The State submits the name and social security number of the individual to the Commissioner of Social Security as part of the plan established under paragraph (2).

''(B) If the State receives notice from the Commissioner of Social Security that the name or social security number of the individual is invalid, the State—

''(i) notifies the individual of such fact;

''(ii) provides the individual with an opportunity to cure the invalid determination with the Commissioner of Social Security, followed by a period of 90 days from the date on which the notice required under clause (i) is received by the individual to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)); and

''(iii) disenrolls the individual from the State plan under this title within 30 days after the end of such 90-day period if no such documentary evidence is presented.

''(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1902(a)(46)(B) shall establish a program under which the State submits each month to the Commissioner of Social Security for verification the name and social security number of each individual enrolled in the State plan under this title that month who has attained the age of 1 before the date of the enrollment.

''(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of Social Security to provide for the electronic submission and verification of the name and social security number of an individual before the individual is enrolled in the State plan.

''(3)(A) The State agency implementing the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the invalid names and numbers submitted bears to the total submitted for verification.

''(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 7 percent—

''(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this title and to identify and implement changes in such procedures to improve their accuracy; and

''(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided invalid information as the number of individuals with invalid information in excess of 7 percent of such total submitted bears to the total number of individuals with invalid information.

''(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

''(D) This paragraph shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year.

''(4) Nothing in this subsection shall affect the rights of any individual under this title to appeal any disenrollment from a State plan.''.

(B) COSTS OF IMPLEMENTING AND MAINTAINING SYSTEM.—Section 1903(a)(3) (42 U.S.C. 1396b(a)(3)) is amended—

(i) by striking ''plus'' at the end of subparagraph (E) and inserting ''and'', and

(ii) by adding at the end the following new subparagraph:

''(F)(i) 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1902(dd) (including a system described in paragraph (2)(B) thereof), and

''(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies, plus''.

(2) LIMITATION ON WAIVER AUTHORITY.—Notwithstanding any provision of section 1115 of the Social Security Act (42 U.S.C. 1315), or any other provision of law, the Secretary may not waive the requirements of section 1902(a)(46)(B) of such Act (42 U.S.C. 1396a(a)(46)(B)) with respect to a State.

(3) CONFORMING AMENDMENTS.—Section 1903 (42 U.S.C. 1396b) is amended—

(A) in subsection (i)(22), by striking ''subsection (x)'' and inserting ''section 1902(a)(46)(B)''; and

(B) in subsection (x)(1), by striking ''subsection (i)(22)'' and inserting ''section 1902(a)(46)(B)(i)''.

(b) CLARIFICATION OF REQUIREMENTS RELATING TO PRESENTATION OF SATISFACTORY DOCUMENTARY EVIDENCE OF CITIZENSHIP OR NATIONALITY.—

(1) ACCEPTANCE OF DOCUMENTARY EVIDENCE ISSUED BY A FEDERALLY RECOGNIZED INDIAN TRIBE.—Section 1903(x)(3)(B) (42 U.S.C. 1396b(x)(3)(B)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following new clause:

''(v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

''(II) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.''.

(2) REQUIREMENT TO PROVIDE REASONABLE OPPORTUNITY TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE.—Section 1903(x) (42 U.S.C. 1396b(x)) is amended by adding at the end the following new paragraph:

''(4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B)(i), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.''.

(3) CHILDREN BORN IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MEDICAID.—

(A) CLARIFICATION OF RULES.—Section 1903(x) (42 U.S.C. 1396b(x)), as amended by paragraph (2), is amended—

(i) in paragraph (2)—

(I) in subparagraph (C), by striking ''or'' at the end;

(II) by redesignating subparagraph (D) as subparagraph (E); and

(III) by inserting after subparagraph (C) the following new subparagraph:

''(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or''; and

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

''(5) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.''.

(B) STATE REQUIREMENT TO ISSUE SEPARATE IDENTIFICATION NUMBER.—Section 1902(e)(4) (42 U.S.C. 1396a(e)(4)) is amended by adding at the end the following new sentence: ''Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1903(v), the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.''.

(4) TECHNICAL AMENDMENTS.—Section 1903(x)(2) (42 U.S.C. 1396b(x)) is amended—

(A) in subparagraph (B)—

(i) by realigning the left margin of the matter preceding clause (i) 2 ems to the left; and

(ii) by realigning the left margins of clauses (i) and (ii), respectively, 2 ems to the left; and

(B) in subparagraph (C)—

(i) by realigning the left margin of the matter preceding clause (i) 2 ems to the left; and

(ii) by realigning the left margins of clauses (i) and (ii), respectively, 2 ems to the left.

(c) APPLICATION OF DOCUMENTATION SYSTEM TO CHIP.—

(1) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 110(a), is amended by adding at the end the following new paragraph:

''(9) CITIZENSHIP DOCUMENTATION REQUIREMENTS.—

''(A) IN GENERAL.—No payment may be made under this section with respect to an individual who has, or is, declared to be a citizen or national of the United States for purposes of establishing eligibility under this title unless the State meets the requirements of section 1902(a)(46)(B) with respect to the individual.

''(B) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures described in clause (i) or (ii) of section 1903(a)(3)(F) necessary to comply with subparagraph (A) shall in no event be less than 90 percent and 75 percent, respectively.''.

(2) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as amended by section 202(b), is amended by adding at the end the following:

''(iii) EXPENDITURES TO COMPLY WITH CITIZENSHIP OR NATIONALITY VERIFICATION REQUIREMENTS.—Expenditures necessary for the State to comply with paragraph (9)(A).''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on October 1, 2008.

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on October 1, 2008, was determined to be ineligible for medical assistance under a State Medicaid plan, including any waiver of such plan, solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by subsection (b), had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

(3) SPECIAL TRANSITION RULE FOR INDIANS.—During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by subsection (b)(1)(B)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act.

SEC. 302. REDUCING ADMINISTRATIVE BARRIERS TO ENROLLMENT.

Section 2102(b) (42 U.S.C. 1397bb(b)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

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

''(4) REDUCTION OF ADMINISTRATIVE BARRIERS TO ENROLLMENT.—

''(A) IN GENERAL.—Subject to subparagraph (B), the plan shall include a description of the procedures used to reduce administrative barriers to the enrollment of children and pregnant women who are eligible for medical assistance under title XIX or for child health assistance or health benefits coverage under this title. Such procedures shall be established and revised as often as the State determines appropriate to take into account the most recent information available to the State identifying such barriers.

''(B) DEEMED COMPLIANCE IF JOINT APPLICATION AND RENEWAL PROCESS THAT PERMITS APPLICATION OTHER THAN IN PERSON.—A State shall be deemed to comply with subparagraph (A) if the State's application and renewal forms and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children and pregnant women for medical assistance under title XIX and child health assistance under this title, and such process does not require an application to be made in person or a face-to-face interview.''.

TITLE IV—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

SEC. 401. ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE.

(a) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 301(c), is amended by adding at the end the following:

''(10) STATE OPTION TO OFFER PREMIUM ASSISTANCE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer-sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph.

''(B) QUALIFIED EMPLOYER-SPONSORED COVERAGE.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), in this paragraph, the term 'qualified employer-sponsored coverage' means a group health plan or health insurance coverage offered through an employer—

''(I) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;

''(II) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

''(III) to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

''(ii) EXCEPTION.—Such term does not include coverage consisting of—

''(I) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

''(II) a high deductible health plan (as defined in section 223(c)(2) of such Code) purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

''(iii) COST-EFFECTIVENESS ALTERNATIVE TO REQUIRED EMPLOYER CONTRIBUTION.—A group health plan or health insurance coverage offered through an employer that would be considered qualified employer-sponsored coverage but for the application of clause (i)(II) may be deemed to satisfy the requirement of such clause if either of the following applies:

''(I) APPLICATION OF CHILD-BASED OR FAMILY-BASED TEST.—The State establishes to the satisfaction of the Secretary that the cost of such coverage is less than the expenditures that the State would have made to enroll the child or the family (as applicable) in the State child health plan.

''(II) AGGREGATE PROGRAM OPERATIONAL COSTS DO NOT EXCEED THE COST OF PROVIDING COVERAGE UNDER THE STATE CHILD HEALTH PLAN.—If subclause (I) does not apply, the State establishes to the satisfaction of the Secretary that the aggregate amount of expenditures by the State for the purchase of all such coverage for targeted low-income children under the State child health plan (including administrative expenditures) does not exceed the aggregate amount of expenditures that the State would have made for providing coverage under the State child health plan for all such children.

''(C) PREMIUM ASSISTANCE SUBSIDY.—

''(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer-sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan (subject to the limitations imposed under section 2103(e), including the requirement to count the total amount of the employee contribution required for enrollment of the employee and the child in such coverage toward the annual aggregate cost-sharing limit applied under paragraph (3)(B) of such section).

''(ii) STATE PAYMENT OPTION.—A State may provide a premium assistance subsidy either as reimbursement to an employee for out-of-pocket expenditures or, subject to clause (iii), directly to the employee's employer.

''(iii) EMPLOYER OPT-OUT.—An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee. In the event of such a notification, an employer shall withhold the total amount of the employee contribution required for enrollment of the employee and the child in the qualified employer-sponsored coverage and the State shall pay the premium assistance subsidy directly to the employee.

''(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

''(D) APPLICATION OF SECONDARY PAYOR RULES.—The State shall be a secondary payor for any items or services provided under the qualified employer-sponsored coverage for which the State provides child health assistance under the State child health plan.

''(E) REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

''(i) IN GENERAL.—Notwithstanding section 2110(b)(1)(C), the State shall provide for each targeted low-income child enrolled in qualified employer-sponsored coverage, supplemental coverage consisting of—

''(I) items or services that are not covered, or are only partially covered, under the qualified employer-sponsored coverage; and

''(II) cost-sharing protection consistent with section 2103(e).

''(ii) RECORD KEEPING REQUIREMENTS.—For purposes of carrying out clause (i), a State may elect to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified employer-sponsored coverage and collect or not collect all or any portion of such expenditures from the parent of the child.

''(F) APPLICATION OF WAITING PERIOD IMPOSED UNDER THE STATE.—Any waiting period imposed under the State child health plan prior to the provision of child health assistance to a targeted low-income child under the State plan shall apply to the same extent to the provision of a premium assistance subsidy for the child under this paragraph.

''(G) OPT-OUT PERMITTED FOR ANY MONTH.—A State shall establish a process for permitting the parent of a targeted low-income child receiving a premium assistance subsidy to disenroll the child from the qualified employer-sponsored coverage and enroll the child in, and receive child health assistance under, the State child health plan, effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child.

''(H) APPLICATION TO PARENTS.—If a State provides child health assistance or health benefits coverage to parents of a targeted low-income child in accordance with section 2111(b), the State may elect to offer a premium assistance subsidy to a parent of a targeted low-income child who is eligible for such a subsidy under this paragraph in the same manner as the State offers such a subsidy for the enrollment of the child in qualified employer-sponsored coverage, except that—

''(i) the amount of the premium assistance subsidy shall be increased to take into account the cost of the enrollment of the parent in the qualified employer-sponsored coverage or, at the option of the State if the State determines it cost-effective, the cost of the enrollment of the child's family in such coverage; and

''(ii) any reference in this paragraph to a child is deemed to include a reference to the parent or, if applicable under clause (i), the family of the child.

''(I) ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE.—

''(i) IN GENERAL.—A State may establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least 1 employee who is a pregnant woman eligible for assistance under the State child health plan (including through the application of an option described in section 2112(f)) or a member of a family with at least 1 targeted low-income child and to provide a premium assistance subsidy under this paragraph for enrollment in coverage made available through such pool.

''(ii) ACCESS TO CHOICE OF COVERAGE.—A State that elects the option under clause (i) shall identify and offer access to not less than 2 private health plans that are health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2) for employees described in clause (i).

''(J) NO EFFECT ON PREVIOUSLY APPROVED PREMIUM ASSISTANCE PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect prior to the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

''(K) NOTICE OF AVAILABILITY.—If a State elects to provide premium assistance subsidies in accordance with this paragraph, the State shall—

''(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer-sponsored coverage;

''(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

''(iii) establish such other procedures as the State determines necessary to ensure that parents are fully informed of the choices for receiving child health assistance under the State child health plan or through the receipt of premium assistance subsidies.

''(L) APPLICATION TO QUALIFIED EMPLOYER-SPONSORED BENCHMARK COVERAGE.—If a group health plan or health insurance coverage offered through an employer is certified by an actuary as health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2), the State may provide premium

assistance subsidies for enrollment of targeted low-income children in such group health plan or health insurance coverage in the same manner as such subsidies are provided under this paragraph for enrollment in qualified employer-sponsored coverage, but without regard to the requirement to provide supplemental coverage for benefits and cost-sharing protection provided under the State child health plan under subparagraph (E).''.

(b) APPLICATION TO MEDICAID.—Section 1906 (42 U.S.C. 1396e) is amended by inserting after subsection (c) the following:

''(d) A State may elect to offer a premium assistance subsidy (as defined in section 2105(c)(10)(C)) for qualified employer-sponsored coverage (as defined in section 2105(c)(10)(B)) to a child who is eligible for medical assistance under the State plan under this title, to the parent of such a child, and to a pregnant woman, in the same manner as such a subsidy for such coverage may be offered under a State child health plan under title XXI in accordance with section 2105(c)(10) (except that subparagraph (E)(i)(II) of such section shall be applied by substituting '1916 or, if applicable, 1916A' for '2103(e)').''.

(c) GAO STUDY AND REPORT.—Not later than January 1, 2009, the Comptroller General of the United States shall study cost and coverage issues relating to any State premium assistance programs for which Federal matching payments are made under title XIX or XXI of the Social Security Act, including under waiver authority, and shall submit a report to the appropriate committees of Congress on the results of such study.

SEC. 402. OUTREACH, EDUCATION, AND ENROLLMENT ASSISTANCE.

(a) REQUIREMENT TO INCLUDE DESCRIPTION OF OUTREACH, EDUCATION, AND ENROLLMENT EFFORTS RELATED TO PREMIUM ASSISTANCE SUBSIDIES IN STATE CHILD HEALTH PLAN.—Section 2102(c) (42 U.S.C. 1397bb(c)) is amended by adding at the end the following new paragraph:

''(3) PREMIUM ASSISTANCE SUBSIDIES.—Outreach, education, and enrollment assistance for families of children likely to be eligible for premium assistance subsidies under the State child health plan in accordance with paragraphs (2)(B), (3), or (10) of section 2105(c), or a waiver approved under section 1115, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and for employers likely to provide coverage that is eligible for such subsidies, including the specific, significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan.''.

(b) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as amended by section 301(c)(2), is amended by adding at the end the following new clause:

''(iv) EXPENDITURES FOR OUTREACH TO INCREASE THE ENROLLMENT OF CHILDREN UNDER THIS TITLE AND TITLE XIX THROUGH PREMIUM ASSISTANCE SUBSIDIES.—Expenditures for outreach activities to families of children likely to be eligible for premium assistance subsidies in accordance with paragraphs (2)(B), (3), or (10), or a waiver approved under section 1115, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and to employers likely to provide qualified employer-sponsored coverage (as defined in subparagraph (B) of such paragraph).''.

Subtitle B—Coordinating Premium Assistance With Private Coverage

SEC. 411. SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF TERMINATION OF MEDICAID OR CHIP COVERAGE OR ELIGIBILITY FOR ASSISTANCE IN PURCHASE OF EMPLOYMENT-BASED COVERAGE; COORDINATION OF COVERAGE.

(a) AMENDMENTS TO INTERNAL REVENUE CODE OF 1986.—Section 9801(f) of the Internal Revenue Code of 1986 (relating to special enrollment periods) is amended by adding at the end the following new paragraph:

''(3) SPECIAL RULES RELATING TO MEDICAID AND CHIP.—

''(A) IN GENERAL.—A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

''(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan not later than 60 days after the date of termination of such coverage.

''(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

''(B) EMPLOYEE OUTREACH AND DISCLOSURE.—

''(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

''(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this clause, the employer may use any State-specific model notice issued by the Secretary of Labor or the Secretary of Health and Human Services in accordance with section 701(f)(3)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)).

''(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF SUMMARY PLAN DESCRIPTION.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024).

''(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 411(b)(2)(C) of the Children's Health Insurance Program Reauthorization Act of 2007, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.''.

(b) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT.—

(A) IN GENERAL.—Section 701(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)) is amended by adding at the end the following new paragraph:

''(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

''(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

''(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

''(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.''.

''(B) COORDINATION WITH MEDICAID AND CHIP.—

''(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

''(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium

assistance under such plans for health coverage of the employee or the employee's dependents.

''(II) MODEL NOTICE.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary and the Secretary of Health and Human Services, in consultation with Directors of State Medicaid agencies under title XIX of the Social Security Act and Directors of State CHIP agencies under title XXI of such Act, shall jointly develop national and State-specific model notices for purposes of subparagraph (A). The Secretary shall provide employers with such model notices so as to enable employers to timely comply with the requirements of subparagraph (A). Such model notices shall include information regarding how an employee may contact the State in which the employee resides for additional information regarding potential opportunities for such premium assistance, including how to apply for such assistance.

''(III) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF SUMMARY PLAN DESCRIPTION.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of the summary plan description as provided in section 104(b).

''(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 411(b)(2)(C) of the Children's Health Insurance Program Reauthorization Act of 2007, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.''.

(B) CONFORMING AMENDMENT.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(i) by striking ''and the remedies'' and inserting '', the remedies''; and

(ii) by inserting before the period the following: '', and if the employer so elects for purposes of complying with section 701(f)(3)(B)(i), the model notice applicable to the State in which the participants and beneficiaries reside''.

(C) WORKING GROUP TO DEVELOP MODEL COVERAGE COORDINATION DISCLOSURE FORM.—

(i) MEDICAID, CHIP, AND EMPLOYER-SPONSORED COVERAGE COORDINATION WORKING GROUP.—

(I) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services and the Secretary of Labor shall jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group (in this subparagraph referred to as the ''Working Group''). The purpose of the Working Group shall be to develop the model coverage coordination disclosure form described in subclause (II) and to identify the impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health plans and members who are eligible for medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

(II) MODEL COVERAGE COORDINATION DISCLOSURE FORM DESCRIBED.—The model form described in this subclause is a form for plan administrators of group health plans to complete for purposes of permitting a State to determine the availability and cost-effectiveness of the coverage available under such plans to employees who have family members who are eligible for premium assistance offered under a State plan under title XIX or XXI of such Act and to allow for coordination of coverage for enrollees of such plans. Such form shall provide the following information in addition to such other information as the Working Group determines appropriate:

(aa) A determination of whether the employee is eligible for coverage under the group health plan.

(bb) The name and contract information of the plan administrator of the group health plan.

(cc) The benefits offered under the plan.

(dd) The premiums and cost-sharing required under the plan.

(ee) Any other information relevant to coverage under the plan.

(ii) MEMBERSHIP.—The Working Group shall consist of not more than 30 members and shall be composed of representatives of—

(I) the Department of Labor;

(II) the Department of Health and Human Services;

(III) State directors of the Medicaid program under title XIX of the Social Security Act;

(IV) State directors of the State Children's Health Insurance Program under title XXI of the Social Security Act;

(V) employers, including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals;

(VI) plan administrators and plan sponsors of group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974); and

(VII) children and other beneficiaries of medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

(iii) COMPENSATION.—The members of the Working Group shall serve without compensation.

(iv) ADMINISTRATIVE SUPPORT.—The Department of Health and Human Services and the Department of Labor shall jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group may use the services and facilities of either such Department, with or without reimbursement, as jointly determined by such Departments.

(v) REPORT.—

(I) REPORT BY WORKING GROUP TO THE SECRETARIES.—Not later than 18 months after the date of the enactment of this Act, the Working Group shall submit to the Secretary of Labor and the Secretary of Health and Human Services the model form described in clause (i)(II) along with a report containing recommendations for appropriate measures to address the impediments to the effective coordination of coverage between group health plans and the State plans under titles XIX and XXI of the Social Security Act.

(II) REPORT BY SECRETARIES TO THE CONGRESS.—Not later than 2 months after receipt of the report pursuant to subclause (I), the Secretaries shall jointly submit a report to each House of the Congress regarding the recommendations contained in the report under such subclause.

(vi) TERMINATION.—The Working Group shall terminate 30 days after the date of the issuance of its report under clause (v).

(D) EFFECTIVE DATES.—The Secretary of Labor and the Secretary of Health and Human Services shall develop the initial model notices under section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974, and the Secretary of Labor shall provide such notices to employers, not later than the date that is 1 year after the date of enactment of this Act, and each employer shall provide the initial annual notices to such employer's employees beginning with the first plan year that begins after the date on which such initial model notices are first issued. The model coverage coordination disclosure form developed under subparagraph (C) shall apply with respect to requests made by States beginning with the first plan year that begins after the date on which such model coverage coordination disclosure form is first issued.

(E) ENFORCEMENT.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(i) in subsection (a)(6), by striking ''or (8)'' and inserting ''(8), or (9)''; and

(ii) in subsection (c), by redesignating paragraph (9) as paragraph (10), and by inserting after paragraph (8) the following:

''(9)(A) The Secretary may assess a civil penalty against any employer of up to $100 a day from the date of the employer's failure to meet the notice requirement of section 701(f)(3)(B)(i)(I). For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.

''(B) The Secretary may assess a civil penalty against any plan administrator of up to $100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 701(f)(3)(B)(ii). For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.''.

TITLE V—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES OF CHILDREN

SEC. 501. CHILD HEALTH QUALITY IMPROVEMENT ACTIVITIES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.

(a) DEVELOPMENT OF CHILD HEALTH QUALITY MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1139 the following new section:

''SEC. 1139A. CHILD HEALTH QUALITY MEASURES.

''(a) DEVELOPMENT OF AN INITIAL CORE SET OF HEALTH CARE QUALITY MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

''(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall identify and publish for general comment an initial, recommended core set of child health quality measures for use by State programs administered under titles XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

''(2) IDENTIFICATION OF INITIAL CORE MEASURES.—In consultation with the individuals and entities described in subsection (b)(3), the Secretary shall identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the

presence and duration of health insurance coverage over time.

''(3) RECOMMENDATIONS AND DISSEMINATION.—Based on such existing and identified measures, the Secretary shall publish an initial core set of child health quality measures that includes (but is not limited to) the following:

''(A) The duration of children's health insurance coverage over a 12-month time period.

''(B) The availability of a full range of—

''(i) preventive services, treatments, and services for acute conditions, including services to promote healthy birth and prevent and treat premature birth; and

''(ii) treatments to correct or ameliorate the effects of chronic physical and mental conditions in infants, young children, school-age children, and adolescents.

''(C) The availability of care in a range of ambulatory and inpatient health care settings in which such care is furnished.

''(D) The types of measures that, taken together, can be used to estimate the overall national quality of health care for children and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.

''(4) ENCOURAGE VOLUNTARY AND STANDARDIZED REPORTING.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary, in consultation with States, shall develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under titles XIX and XXI.

''(5) ADOPTION OF BEST PRACTICES IN IMPLEMENTING QUALITY PROGRAMS.—The Secretary shall disseminate information to States regarding best practices among States with respect to measuring and reporting on the quality of health care for children, and shall facilitate the adoption of such best practices. In developing best practices approaches, the Secretary shall give particular attention to State measurement techniques that ensure the timeliness and accuracy of provider reporting, encourage provider reporting compliance, encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

''(6) REPORTS TO CONGRESS.—Not later than January 1, 2010, and every 3 years thereafter, the Secretary shall report to Congress on—

''(A) the status of the Secretary's efforts to improve—

''(i) quality related to the duration and stability of health insurance coverage for children under titles XIX and XXI;

''(ii) the quality of children's health care under such titles, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and

''(iii) the quality of children's health care under such titles across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care;

''(B) the status of voluntary reporting by States under titles XIX and XXI, utilizing the initial core quality measurement set; and

''(C) any recommendations for legislative changes needed to improve the quality of care provided to children under titles XIX and XXI, including recommendations for quality reporting by States.

''(7) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States to assist them in adopting and utilizing core child health quality measures in administering the State plans under titles XIX and XXI.

''(8) DEFINITION OF CORE SET.—In this section, the term 'core set' means a group of valid, reliable, and evidence-based quality measures that, taken together—

''(A) provide information regarding the quality of health coverage and health care for children;

''(B) address the needs of children throughout the developmental age span; and

''(C) allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services whose purpose is to correct or ameliorate physical, mental, or developmental conditions that could, if untreated or poorly treated, become chronic.

''(b) ADVANCING AND IMPROVING PEDIATRIC QUALITY MEASURES.—

''(1) ESTABLISHMENT OF PEDIATRIC QUALITY MEASURES PROGRAM.—Not later than January 1, 2010, the Secretary shall establish a pediatric quality measures program to—

''(A) improve and strengthen the initial core child health care quality measures established by the Secretary under subsection (a);

''(B) expand on existing pediatric quality measures used by public and private health care purchasers and advance the development of such new and emerging quality measures; and

''(C) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers.

''(2) EVIDENCE-BASED MEASURES.—The measures developed under the pediatric quality measures program shall, at a minimum, be—

''(A) evidence-based and, where appropriate, risk adjusted;

''(B) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;

''(C) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

''(D) periodically updated; and

''(E) responsive to the child health needs, services, and domains of health care quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A).

''(3) PROCESS FOR PEDIATRIC QUALITY MEASURES PROGRAM.—In identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures, the Secretary shall consult with—

''(A) States;

''(B) pediatricians, children's hospitals, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

''(C) dental professionals, including pediatric dental professionals;

''(D) health care providers that furnish primary health care to children and families who live in urban and rural medically underserved communities or who are members of distinct population sub-groups at heightened risk for poor health outcomes;

''(E) national organizations representing consumers and purchasers of children's health care;

''(F) national organizations and individuals with expertise in pediatric health quality measurement; and

''(G) voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

''(4) DEVELOPING, VALIDATING, AND TESTING A PORTFOLIO OF PEDIATRIC QUALITY MEASURES.—As part of the program to advance pediatric quality measures, the Secretary shall—

''(A) award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services across the domains of quality described in clauses (i),(ii), and (iii) of subsection (a)(6)(A); and

''(B) award grants and contracts for—

''(i) the development of consensus on evidence-based measures for children's health care services;

''(ii) the dissemination of such measures to public and private purchasers of health care for children; and

''(iii) the updating of such measures as necessary.

''(5) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning no later than January 1, 2012, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection paragraphs (1) through (4).

''(6) DEFINITION OF PEDIATRIC QUALITY MEASURE.—In this subsection, the term 'pediatric quality measure' means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess 1 or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care.

''(c) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID OR CHIP.—

''(1) ANNUAL STATE REPORTS.—Each State with a State plan approved under title XIX or a State child health plan approved under title XXI shall annually report to the Secretary on the—

''(A) State-specific child health quality measures applied by the States under such plans, including measures described in subparagraphs (A) and (B) of subsection (a)(6); and

''(B) State-specific information on the quality of health care furnished to children under such plans, including information collected through external quality reviews of managed care organizations under section 1932 of the Social Security Act (42 U.S.C. 1396u–4) and benchmark plans under sections 1937 and 2103 of such Act (42 U.S.C. 1396u–7, 1397cc).

''(2) PUBLICATION.—Not later than September 30, 2009, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

''(d) DEMONSTRATION PROJECTS FOR IMPROVING THE QUALITY OF CHILDREN'S HEALTH CARE AND THE USE OF HEALTH INFORMATION TECHNOLOGY.—

''(1) IN GENERAL.—During the period of fiscal years 2008 through 2012, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under title XIX or XXI, including projects to—

''(A) experiment with, and evaluate the use of, new measures of the quality of children's health care under such titles (including testing the validity and suitability for reporting of such measures);

''(B) promote the use of health information technology in care delivery for children under such titles;

''(C) evaluate provider-based models which improve the delivery of children's health care services under such titles, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety, and efficiency of health care services for children; or

''(D) demonstrate the impact of the model electronic health record format for children developed and disseminated under subsection (f) on improving pediatric health, including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs.

''(2) REQUIREMENTS.—In awarding grants under this subsection, the Secretary shall ensure that—

''(A) only 1 demonstration project funded under a grant awarded under this subsection shall be conducted in a State; and

''(B) demonstration projects funded under grants awarded under this subsection shall be conducted evenly between States with large urban areas and States with large rural areas.

''(3) AUTHORITY FOR MULTISTATE PROJECTS.—A demonstration project conducted with a grant awarded under this subsection may be conducted on a multistate basis, as needed.

''(4) FUNDING.—$20,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

''(e) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—

''(1) AUTHORITY TO CONDUCT DEMONSTRATION.—The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such project. Such model shall—

''(A) identify, through self-assessment, behavioral risk factors for obesity among children;

''(B) identify, through self-assessment, needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors;

''(C) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits; and

''(D) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under title XIX or child health assistance is available under title XXI among such target individuals.

''(2) ELIGIBILITY ENTITIES.—For purposes of this subsection, an eligible entity is any of the following:

''(A) A city, county, or Indian tribe.

''(B) A local or tribal educational agency.

''(C) An accredited university, college, or community college.

''(D) A Federally-qualified health center.

''(E) A local health department.

''(F) A health care provider.

''(G) A community-based organization.

''(H) Any other entity determined appropriate by the Secretary, including a consortia or partnership of entities described in any of subparagraphs (A) through (G).

''(3) USE OF FUNDS.—An eligible entity awarded a grant under this subsection shall use the funds made available under the grant to—

''(A) carry out community-based activities related to reducing childhood obesity, including by—

''(i) forming partnerships with entities, including schools and other facilities providing recreational services, to establish programs for after school and weekend community activities that are designed to reduce childhood obesity;

''(ii) forming partnerships with daycare facilities to establish programs that promote healthy eating behaviors and physical activity; and

''(iii) developing and evaluating community educational activities targeting good nutrition and promoting healthy eating behaviors;

''(B) carry out age-appropriate school-based activities that are designed to reduce childhood obesity, including by—

''(i) developing and testing educational curricula and intervention programs designed to promote healthy eating behaviors and habits in youth, which may include—

''(I) after hours physical activity programs; and

''(II) science-based interventions with multiple components to prevent eating disorders including nutritional content, understanding and responding to hunger and satiety, positive body image development, positive self-esteem development, and learning life skills (such as stress management, communication skills, problemsolving and decisionmaking skills), as well as consideration of cultural and developmental issues, and the role of family, school, and community;

''(ii) providing education and training to educational professionals regarding how to promote a healthy lifestyle and a healthy school environment for children;

''(iii) planning and implementing a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity; and

''(iv) planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity for children;

''(C) carry out educational, counseling, promotional, and training activities through the local health care delivery systems including by—

''(i) promoting healthy eating behaviors and physical activity services to treat or prevent eating disorders, being overweight, and obesity;

''(ii) providing patient education and counseling to increase physical activity and promote healthy eating behaviors;

''(iii) training health professionals on how to identify and treat obese and overweight individuals which may include nutrition and physical activity counseling; and

''(iv) providing community education by a health professional on good nutrition and physical activity to develop a better understanding of the relationship between diet, physical activity, and eating disorders, obesity, or being overweight; and

''(D) provide, through qualified health professionals, training and supervision for community health workers to—

''(i) educate families regarding the relationship between nutrition, eating habits, physical activity, and obesity;

''(ii) educate families about effective strategies to improve nutrition, establish healthy eating patterns, and establish appropriate levels of physical activity; and

''(iii) educate and guide parents regarding the ability to model and communicate positive health behaviors.

''(4) PRIORITY.—In awarding grants under paragraph (1), the Secretary shall give priority to awarding grants to eligible entities—

''(A) that demonstrate that they have previously applied successfully for funds to carry out activities that seek to promote individual and community health and to prevent the incidence of chronic disease and that can cite published and peer-reviewed research demonstrating that the activities that the entities propose to carry out with funds made available under the grant are effective;

''(B) that will carry out programs or activities that seek to accomplish a goal or goals set by the State in the Healthy People 2010 plan of the State;

''(C) that provide non-Federal contributions, either in cash or in-kind, to the costs of funding activities under the grants;

''(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal years for which they receive grants under this subsection;

''(E) located in communities that are medically underserved, as determined by the Secretary;

''(F) located in areas in which the average poverty rate is at least 150 percent or higher of the average poverty rate in the State involved, as determined by the Secretary; and

''(G) that submit plans that exhibit multisectoral, cooperative conduct that includes the involvement of a broad range of stakeholders, including—

''(i) community-based organizations;

''(ii) local governments;

''(iii) local educational agencies;

''(iv) the private sector;

''(v) State or local departments of health;

''(vi) accredited colleges, universities, and community colleges;

''(vii) health care providers;

''(viii) State and local departments of transportation and city planning; and

''(ix) other entities determined appropriate by the Secretary.

''(5) PROGRAM DESIGN.—

''(A) INITIAL DESIGN.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

''(B) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary shall award 1 grant that is specifically designed to determine whether programs similar to programs to be conducted by other grantees under this subsection should be implemented with respect to the general population of children who are eligible for child health assistance under State

child health plans under title XXI in order to reduce the incidence of childhood obesity among such population.

''(6) REPORT TO CONGRESS.—Not later than 3 years after the date the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates the beneficiary satisfaction under the project, and includes any such other information as the Secretary determines to be appropriate.

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

''(A) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given that term in section 1905(l)(2)(B).

''(B) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given that term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

''(C) SELF-ASSESSMENT.—The term 'self-assessment' means a form that—

''(i) includes questions regarding—

''(I) behavioral risk factors;

''(II) needed preventive and screening services; and

''(III) target individuals' preferences for receiving follow-up information;

''(ii) is assessed using such computer generated assessment programs; and

''(iii) allows for the provision of such ongoing support to the individual as the Secretary determines appropriate.

''(D) ONGOING SUPPORT.—The term 'ongoing support' means—

''(i) to provide any target individual with information, feedback, health coaching, and recommendations regarding—

''(I) the results of a self-assessment given to the individual;

''(II) behavior modification based on the self-assessment; and

''(III) any need for clinical preventive and screening services or treatment including medical nutrition therapy;

''(ii) to provide any target individual with referrals to community resources and programs available to assist the target individual in reducing health risks; and

''(iii) to provide the information described in clause (i) to a health care provider, if designated by the target individual to receive such information.

''(8) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2008 through 2012.

''(f) DEVELOPMENT OF MODEL ELECTRONIC HEALTH RECORD FORMAT FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

''(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under title XIX or the State child health plan under title XXI that is—

''(A) subject to State laws, accessible to parents, caregivers, and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, such as appropriate immunizations or physicals;

''(B) designed to allow interoperable exchanges that conform with Federal and State privacy and security requirements;

''(C) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality; and

''(D) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records.

''(2) FUNDING.—$5,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

''(g) STUDY OF PEDIATRIC HEALTH AND HEALTH CARE QUALITY MEASURES.—

''(1) IN GENERAL.—Not later than July 1, 2009, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments aimed at ameliorating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

''(A) consider all of the major national population-based reporting systems sponsored by the Federal Government that are currently in place, including reporting requirements under Federal grant programs and national population surveys and estimates conducted directly by the Federal Government;

''(B) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information so generated is made widely available through publication;

''(C) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment; and

''(D) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality.

''(2) FUNDING.—Up to $1,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

''(h) RULE OF CONSTRUCTION.—Notwithstanding any other provision in this section, no evidence based 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 child who is eligible for and receiving medical assistance under title XIX or child health assistance under title XXI .

''(i) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2008 through 2012, $45,000,000 for the purpose of carrying out this section (other than subsection (e)). Funds appropriated under this subsection shall remain available until expended.''.

(b) INCREASED MATCHING RATE FOR COLLECTING AND REPORTING ON CHILD HEALTH MEASURES.—Section 1903(a)(3)(A) (42 U.S.C. 1396b(a)(3)(A)), is amended—

(1) by striking ''and'' at the end of clause (i); and

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

''(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and''.

SEC. 502. IMPROVED INFORMATION REGARDING ACCESS TO COVERAGE UNDER CHIP.

(a) INCLUSION OF PROCESS AND ACCESS MEASURES IN ANNUAL STATE REPORTS.—Section 2108 (42 U.S.C. 1397hh) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''The State'' and inserting ''Subject to subsection (e), the State''; and

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

''(e) INFORMATION REQUIRED FOR INCLUSION IN STATE ANNUAL REPORT.—The State shall include the following information in the annual report required under subsection (a):

''(1) Eligibility criteria, enrollment, and retention data (including data with respect to continuity of coverage or duration of benefits).

''(2) Data regarding the extent to which the State uses process measures with respect to determining the eligibility of children under the State child health plan, including measures such as 12-month continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility.

''(3) Data regarding denials of eligibility and redeterminations of eligibility.

''(4) Data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

''(5) If the State provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for child health assistance under the State child health plan, the range of the monthly amount of such assistance provided on behalf of a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost-sharing protection provided under the State child health plan to supplement the coverage purchased with such premium assistance, the effective strategies the State engages in to reduce any administrative barriers to the provision of such assistance, and, the effects, if any, of the provision of such assistance on preventing the coverage provided under the State child health plan from substituting for coverage provided under employer-sponsored health insurance offered in the State.

''(6) To the extent applicable, a description of any State activities that are designed to reduce the number of uncovered children in the State, including through a State health insurance connector program or support for innovative private health coverage initiatives.''.

(b) GAO STUDY AND REPORT ON ACCESS TO PRIMARY AND SPECIALITY SERVICES.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including—

(A) the extent to which providers are willing to treat children eligible for such programs;

(B) information on such children's access to networks of care;

(C) geographic availability of primary and specialty services under such programs;

(D) the extent to which care coordination is provided for children's care under Medicaid and CHIP; and

(E) as appropriate, information on the degree of availability of services for children under such programs.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the appropriate committees of Congress on the study conducted under paragraph (1) that includes recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist.

SEC. 503. APPLICATION OF CERTAIN MANAGED CARE QUALITY SAFEGUARDS TO CHIP.

Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by section 204(b), is amended by redesignating subparagraph (E) (as added by such section) as subparagraph (F) and by inserting after subparagraph (D) the following new subparagraph:

''(E) Subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care).''.

TITLE VI—MISCELLANEOUS

SEC. 601. TECHNICAL CORRECTION REGARDING CURRENT STATE AUTHORITY UNDER MEDICAID.

(a) IN GENERAL.—Only with respect to expenditures for medical assistance under a State Medicaid plan, including any waiver of such plan, for fiscal years 2007 and 2008, a State may elect, notwithstanding the fourth sentence of subsection (b) of section 1905 of the Social Security Act (42 U.S.C. 1396d) or subsection (u) of such section—

(1) to cover individuals described in section 1902(a)(10)(A)(ii)(IX) of the Social Security Act and, at its option, to apply less restrictive methodologies to such individuals under section 1902(r)(2) of such Act or 1931(b)(2)(C) of such Act and thereby receive Federal financial participation for medical assistance for such individuals under title XIX of the Social Security Act; or

(2) to receive Federal financial participation for expenditures for medical assistance under title XIX of such Act for children described in paragraph (2)(B) or (3) of section 1905(u) of such Act based on the Federal medical assistance percentage, as otherwise determined based on the first and third sentences of subsection (b) of section 1905 of the Social Security Act, rather than on the basis of an enhanced FMAP (as defined in section 2105(b) of such Act).

(b) REPEAL.—Effective October 1, 2008, subsection (a) is repealed.

(c) HOLD HARMLESS.—No State that elects the option described in subsection (a) shall be treated as not having been authorized to make such election and to receive Federal financial participation for expenditures for medical assistance described in that subsection for fiscal years 2007 and 2008 as a result of the repeal of the subsection under subsection (b).

SEC. 602. PAYMENT ERROR RATE MEASUREMENT ("PERM").

(a) EXPENDITURES RELATED TO COMPLIANCE WITH REQUIREMENTS.—

(1) ENHANCED PAYMENTS.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 401(a), is amended by adding at the end the following new paragraph:

''(11) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations) shall in no event be less than 90 percent.''.

(2) EXCLUSION OF FROM CAP ON ADMINISTRATIVE EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)C)), as amended by section 402(b), is amended by adding at the end the following:

''(v) PAYMENT ERROR RATE MEASUREMENT (PERM) EXPENDITURES.—Expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations).''.

(b) FINAL RULE REQUIRED TO BE IN EFFECT FOR ALL STATES.—Notwithstanding parts 431 and 457 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act), the Secretary shall not calculate or publish any national or State-specific error rate based on the application of the payment error rate measurement (in this section referred to as ''PERM'') requirements to CHIP until after the date that is 6 months after the date on which a final rule implementing such requirements in accordance with the requirements of subsection (c) is in effect for all States. Any calculation of a national error rate or a State specific error rate after such final rule in effect for all States may only be inclusive of errors, as defined in such final rule or in guidance issued within a reasonable time frame after the effective date for such final rule that includes detailed guidance for the specific methodology for error determinations.

(c) REQUIREMENTS FOR FINAL RULE.—For purposes of subsection (b), the requirements of this subsection are that the final rule implementing the PERM requirements shall include—

(1) clearly defined criteria for errors for both States and providers;

(2) a clearly defined process for appealing error determinations by review contractors; and

(3) clearly defined responsibilities and deadlines for States in implementing any corrective action plans.

(d) OPTION FOR APPLICATION OF DATA FOR CERTAIN STATES UNDER THE INTERIM FINAL RULE.—

(1) OPTION FOR STATES IN FIRST APPLICATION CYCLE.—After the final rule implementing the PERM requirements in accordance with the requirements of subsection (c) is in effect for all States, a State for which the PERM requirements were first in effect under an interim final rule for fiscal year 2007 may elect to accept any payment error rate determined in whole or in part for the State on the basis of data for that fiscal year or may elect to not have any payment error rate determined on the basis of such data and, instead, shall be treated as if fiscal year 2010 were the first fiscal year for which the PERM requirements apply to the State.

(2) OPTION FOR STATES IN SECOND APPLICATION CYCLE.—If such final rule is not in effect for all States by July 1, 2008, a State for which the PERM requirements were first in effect under an interim final rule for fiscal year 2008 may elect to accept any payment error rate determined in whole or in part for the State on the basis of data for that fiscal year or may elect to not have any payment error rate determined on the basis of such data and, instead, shall be treated as if fiscal year 2011 were the first fiscal year for which the PERM requirements apply to the State.

(e) HARMONIZATION OF MEQC AND PERM.—

(1) REDUCTION OF REDUNDANCIES.—The Secretary shall review the Medicaid Eligibility Quality Control (in this subsection referred to as the ''MEQC'') requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies.

(2) STATE OPTION TO APPLY PERM DATA.—A State may elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the State for a fiscal year under section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) to substitute data resulting from the application of the PERM requirements to the State after the final rule implementing such requirements is in effect for all States for data obtained from the application of the MEQC requirements to the State with respect to a fiscal year.

(f) IDENTIFICATION OF IMPROVED STATE-SPECIFIC SAMPLE SIZES.—The Secretary shall establish State-specific sample sizes for application of the PERM requirements with respect to State child health plans for fiscal years beginning with fiscal year 2009, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable—

(1) minimize the administrative cost burden on States under Medicaid and CHIP; and

(2) maintain State flexibility to manage such programs.

SEC. 603. ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT.

Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''(or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)))''; and

(2) by striking subparagraph (B) and inserting the following new subparagraph:

''(B) [reserved]''.

SEC. 604. IMPROVING DATA COLLECTION.

(a) INCREASED APPROPRIATION.—Section 2109(b)(2) (42 U.S.C. 1397ii(b)(2)) is amended by striking ''$10,000,000 for fiscal year 2000'' and inserting ''$20,000,000 for fiscal year 2008''.

(b) USE OF ADDITIONAL FUNDS.—Section 2109(b) (42 U.S.C. 1397ii(b)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (2) as paragraph (4); and

(2) by inserting after paragraph (1), the following new paragraphs:

''(2) ADDITIONAL REQUIREMENTS.—In addition to making the adjustments required to produce the data described in paragraph (1), with respect to data collection occurring for fiscal years beginning with fiscal year 2008, in appropriate consultation with the Secretary of Health and Human Services, the Secretary of Commerce shall do the following:

''(A) Make appropriate adjustments to the Current Population Survey to develop more accurate State-specific estimates of the number of children enrolled in health coverage under title XIX or this title.

''(B) Make appropriate adjustments to the Current Population Survey to improve the survey estimates used to compile the State-specific and national number of low-income children without health insurance for purposes of determining allotments under subsections (c) and (i) of section 2104 and making payments to States from the CHIP Incentive Bonuses Pool established under subsection (j) of such section, the CHIP Contingency Fund established under subsection (k) of such section, and, to the extent applicable to a State, from the block grant set aside under section 2112(b)(2)(A)(i) for each of fiscal years 2010 through 2012.

''(C) Include health insurance survey information in the American Community Survey related to children.

''(D) Assess whether American Community Survey estimates, once such survey data are first available, produce more reliable estimates than the Current Population Survey with respect to the purposes described in subparagraph (B).

''(E) On the basis of the assessment required under subparagraph (D), recommend to the Secretary of Health and Human Services whether American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in subparagraph (B).

''(F) Continue making the adjustments described in the last sentence of paragraph (1) with respect to expansion of the sample size used in State sampling units, the number of sampling units in a State, and using an appropriate verification element.

''(3) AUTHORITY FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TRANSITION TO THE USE OF ALL, OR SOME COMBINATION OF, ACS ESTIMATES UPON RECOMMENDATION OF THE SECRETARY OF COMMERCE.—If, on the basis of the assessment required under paragraph (2)(D), the Secretary of Commerce recommends to the Secretary of Health and Human Services that American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in paragraph (2)(B), the Secretary of Health and Human Services may provide for a period during which the Secretary may transition from carrying out such purposes through the use of Current Population Survey estimates to the use of American Community Survey estimates (in lieu of, or in combination with the Current Population Survey estimates, as recommended), provided that any such transition is implemented in a manner that is designed to avoid adverse impacts upon States with approved State child health plans under this title.''.

SEC. 605. DEFICIT REDUCTION ACT TECHNICAL CORRECTIONS.

(a) STATE FLEXIBILITY IN BENEFIT PACKAGES.—

(1) CLARIFICATION OF REQUIREMENT TO PROVIDE EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK BENEFIT PACKAGES.—Section 1937(a)(1) (42 U.S.C. 1396u–7(a)(1)), as inserted by section 6044(a) of the Deficit Reduction Act of 2005 (Public Law 109–171, 120 Stat. 88), is amended—

(A) in subparagraph (A)—

(i) in the matter before clause (i), by striking ''enrollment in coverage that provides'' and inserting ''coverage that'';

(ii) in clause (i), by inserting ''provides'' after ''(i)''; and

(iii) by striking clause (ii) and inserting the following:

''(ii) for any individual described in section 1905(a)(4)(B) who is eligible under the State plan in accordance with paragraphs (10) and (17) of section 1902(a), consists of the items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43).'';

(B) in subparagraph (C)—

(i) in the heading, by striking ''WRAP-AROUND'' and inserting ''ADDITIONAL''; and

(ii) by striking ''wrap-around or''; and

(C) by adding at the end the following new subparagraph:

''(E) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

''(i) requiring a State to offer all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or

''(ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2).''.

(2) CORRECTION OF REFERENCE TO CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—Section 1937(a)(2)(B)(viii) (42 U.S.C. 1396u–7(a)(2)(B)(viii), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended by striking ''aid or assistance is made available under part B of title IV to children in foster care and individuals'' and inserting ''child welfare services are made available under part B of title IV on the basis of being a child in foster care or''.

(3) TRANSPARENCY.—Section 1937 (42 U.S.C. 1396u–7), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended by adding at the end the following:

''(c) PUBLICATION OF PROVISIONS AFFECTED.—Not later than 30 days after the date the Secretary approves a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b), the Secretary shall publish in the Federal Register and on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this title that the Secretary has determined do not apply in order to enable the State to carry out such plan amendment and the reason for each such determination.''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

SEC. 606. ELIMINATION OF CONFUSING PROGRAM REFERENCES.

Section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, as enacted into law by division B of Public Law 106–113 (113 Stat. 1501A–402) is repealed.

SEC. 607. MENTAL HEALTH PARITY IN CHIP PLANS.

(a) ASSURANCE OF PARITY.—Section 2103(c) (42 U.S.C. 1397cc(c)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4), the following:

''(5) MENTAL HEALTH SERVICES PARITY.—

''(A) IN GENERAL.—In the case of a State child health plan that provides both medical and surgical benefits and mental health or substance abuse benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance abuse benefits are no more restrictive than the financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

''(B) DEEMED COMPLIANCE.—To the extent that a State child health plan includes coverage with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), such plan shall be deemed to satisfy the requirements of subparagraph (A).''.

(b) CONFORMING AMENDMENTS.—Section 2103 (42 U.S.C. 1397cc) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''subsection (c)(5)'' and inserting ''paragraphs (5) and (6) of subsection (c)''; and

(2) in subsection (c)(2), by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

SEC. 608. DENTAL HEALTH GRANTS.

Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 201, is amended by adding at the end the following:

''SEC. 2114. DENTAL HEALTH GRANTS.

''(a) AUTHORITY TO AWARD GRANTS.—

''(1) IN GENERAL.—From the amount appropriated under subsection (e), the Secretary shall award grants from amounts to eligible States for the purpose of carrying out programs and activities that are designed to improve the availability of dental services and strengthen dental coverage for targeted low-income children enrolled in State child health plans.

''(2) ELIGIBLE STATE.—In this section, the term 'eligible State' means a State with an approved State child health plan under this title that submits an application under subsection (b) that is approved by Secretary.

''(b) APPLICATION.—An eligible State that desires to receive a grant under this paragraph shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may require. Such application shall include—

''(1) a detailed description of the programs and activities proposed to be conducted with funds awarded under the grant;

''(2) quality and outcomes performance measures to evaluate the effectiveness of such activities; and

''(3) an assurance that the State shall—

''(A) conduct an assessment of the effectiveness of such activities against such performance measures; and

''(B) cooperate with the collection and reporting of data and other information determined as a result of conducting such assessments to the Secretary, in such form and manner as the Secretary shall require.

''(c) MAINTENANCE OF EFFORT FOR STATES AWARDED GRANTS; NO STATE MATCH REQUIRED.—In the case of a State that is awarded a grant under this section—

''(1) the State share of funds expended for dental services under the State child health plan shall not be less than the State share of such funds expended in the fiscal year preceding the first fiscal year for which the grant is awarded; and

''(2) no State matching funds shall be required for the State to receive a grant under this section.

''(d) ANNUAL REPORT.—The Secretary shall submit an annual report to the appropriate committees of Congress regarding the grants awarded under this section that includes—

''(1) State specific descriptions of the programs and activities conducted with funds awarded under such grants; and

''(2) information regarding the assessments required of States under subsection (b)(3).

''(e) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated, $200,000,000 for the period of fiscal years 2008 through 2012, to remain available until expended, for the purpose of awarding grants to States under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105.''.

SEC. 609. APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) APPLICATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by sections

204(b) and 503, is amended by inserting after subparagraph (A) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

''(B) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services provided on or after October 1, 2008.

(b) TRANSITION GRANTS.—

(1) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for fiscal year 2008, $5,000,000, to remain available until expended, for the purpose of awarding grants to States with State child health plans under CHIP that are operated separately from the State Medicaid plan under title XIX of the Social Security Act (including any waiver of such plan), or in combination with the State Medicaid plan, for expenditures related to transitioning to compliance with the requirement of section 2107(e)(1)(B) of the Social Security Act (as added by subsection (a)) to apply the prospective payment system established under section 1902(bb) of the such Act (42 U.S.C. 1396a(bb)) to services provided by Federally-qualified health centers and rural health clinics.

(2) MONITORING AND REPORT.—The Secretary shall monitor the impact of the application of such prospective payment system on the States described in paragraph (1) and, not later than October 1, 2010, shall report to Congress on any effect on access to benefits, provider payment rates, or scope of benefits offered by such States as a result of the application of such payment system.

TITLE VII—REVENUE PROVISIONS

SEC. 701. INCREASE IN EXCISE TAX RATE ON TOBACCO PRODUCTS.

(a) CIGARS.—Section 5701(a) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)'' in paragraph (1) and inserting ''$50.00 per thousand'',

(2) by striking ''20.719 percent (18.063 percent on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''53.13 percent'', and

(3) by striking ''$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''$10.00 per cigar''.

(b) CIGARETTES.—Section 5701(b) of such Code is amended—

(1) by striking ''$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (1) and inserting ''$50.00 per thousand'', and

(2) by striking ''$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (2) and inserting ''$104.9999 cents per thousand''.

(c) CIGARETTE PAPERS.—Section 5701(c) of such Code is amended by striking ''1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)'' and inserting ''3.13 cents''.

(d) CIGARETTE TUBES.—Section 5701(d) of such Code is amended by striking ''2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)'' and inserting ''6.26 cents''.

(e) SMOKELESS TOBACCO.—Section 5701(e) of such Code is amended—

(1) by striking ''58.5 cents (51 cents on snuff removed during 2000 or 2001)'' in paragraph (1) and inserting ''$1.50'', and

(2) by striking ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)'' in paragraph (2) and inserting ''50 cents''.

(f) PIPE TOBACCO.—Section 5701(f) of such Code is amended by striking ''$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)'' and inserting ''$2.8126 cents''.

(g) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking ''$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)'' and inserting ''$8.8889 cents''.

(h) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States which are removed before January 1, 2008, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on January 1, 2008, for which such person is liable.

(3) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding tobacco products, cigarette papers, or cigarette tubes on January 1, 2008, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before April 1, 2008.

(4) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.) or any other provision of law, any article which is located in a foreign trade zone on January 1, 2008, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of an officer of the United States Customs and Border Protection of the Department of Homeland Security pursuant to the 2d proviso of such section 3(a).

(5) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Any term used in this subsection which is also used in section 5702 of the Internal Revenue Code of 1986 shall have the same meaning as such term has in such section.

(B) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(6) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(7) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after December 31, 2007.

SEC. 702. ADMINISTRATIVE IMPROVEMENTS.

(a) PERMIT, REPORT, AND RECORD REQUIREMENTS FOR MANUFACTURERS AND IMPORTERS OF PROCESSED TOBACCO.—

(1) PERMITS.—

(A) APPLICATION.—Section 5712 of the Internal Revenue Code of 1986 is amended by inserting ''or processed tobacco'' after ''tobacco products''.

(B) ISSUANCE.—Section 5713(a) of such Code is amended by inserting ''or processed tobacco'' after ''tobacco products''.

(2) INVENTORIES AND REPORTS.—

(A) INVENTORIES.—Section 5721 of such Code is amended by inserting '', processed tobacco,'' after ''tobacco products''.

(B) REPORTS.—Section 5722 of such Code is amended by inserting '', processed tobacco,'' after ''tobacco products''.

(3) RECORDS.—Section 5741 of such Code is amended by inserting '', processed tobacco,'' after ''tobacco products''.

(4) MANUFACTURER OF PROCESSED TOBACCO.—Section 5702 of such Code is amended by adding at the end the following new subsection:

''(p) MANUFACTURER OF PROCESSED TOBACCO.—

''(1) IN GENERAL.—The term 'manufacturer of processed tobacco' means any person who processes any tobacco other than tobacco products.

''(2) PROCESSED TOBACCO.—The processing of tobacco shall not include the farming or growing of tobacco or the handling of tobacco solely for sale, shipment, or delivery to a manufacturer of tobacco products or processed tobacco.''.

(5) CONFORMING AMENDMENT.—Section 5702(k) of such Code is amended by inserting '', or any processed tobacco,'' after ''nontax-paid tobacco products or cigarette papers or tubes''.

(6) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2008.

(b) BASIS FOR DENIAL, SUSPENSION, OR REVOCATION OF PERMITS.—

(1) DENIAL.—Paragraph (3) of section 5712 of such Code is amended to read as follows:

''(3) such person (including, in the case of a corporation, any officer, director, or principal stockholder and, in the case of a partnership, a partner)—

''(A) is, by reason of his business experience, financial standing, or trade connections or by reason of previous or current legal proceedings involving a felony violation of any other provision of Federal criminal law relating to tobacco products, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter,

''(B) has been convicted of a felony violation of any provision of Federal or State criminal law relating to tobacco products, cigarette paper, or cigarette tubes, or

''(C) has failed to disclose any material information required or made any material false statement in the application therefor.''.

(2) SUSPENSION OR REVOCATION.—Subsection (b) of section 5713 of such Code is amended to read as follows:

''(b) SUSPENSION OR REVOCATION.—

''(1) SHOW CAUSE HEARING.—If the Secretary has reason to believe that any person holding a permit—

''(A) has not in good faith complied with this chapter, or with any other provision of this title involving intent to defraud,

''(B) has violated the conditions of such permit,

''(C) has failed to disclose any material information required or made any material false statement in the application for such permit,

''(D) has failed to maintain his premises in such manner as to protect the revenue,

''(E) is, by reason of previous or current legal proceedings involving a felony violation of any other provision of Federal criminal law relating to tobacco products, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter, or

''(F) has been convicted of a felony violation of any provision of Federal or State criminal law relating to tobacco products, cigarette paper, or cigarette tubes,

the Secretary shall issue an order, stating the facts charged, citing such person to show cause why his permit should not be suspended or revoked.

''(2) ACTION FOLLOWING HEARING.—If, after hearing, the Secretary finds that such person has not shown cause why his permit should not be suspended or revoked, such permit shall be suspended for such period as the Secretary deems proper or shall be revoked.''.

(c) APPLICATION OF INTERNAL REVENUE CODE STATUTE OF LIMITATIONS FOR ALCOHOL AND TOBACCO EXCISE TAXES.—Section 514(a) of the Tariff Act of 1930 (19 U.S.C. 1514(a)) is amended by striking ''and section 520 (relating to refunds)'' and inserting ''section 520 (relating to refunds), and section 6501 of the Internal Revenue Code of 1986 (but only with respect to taxes imposed under chapters 51 and 52 of such Code)''.

(d) EXPANSION OF DEFINITION OF ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Section 5702(o) of the Internal Revenue Code of 1986 is amended by inserting ''or cigars, or for use as wrappers thereof'' before the period at the end.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after December 31, 2007.

(e) TIME OF TAX FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—Section 5703(b)(2) of such Code is amended by adding at the end the following new subparagraph:

''(F) SPECIAL RULE FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—In the case of any tobacco products, cigarette paper, or cigarette tubes produced in the United States at any place other than the premises of a manufacturer of tobacco products, cigarette paper, or cigarette tubes that has filed the bond and obtained the permit required under this chapter, tax shall be due and payable immediately upon manufacture.''.

SEC. 703. TIME FOR PAYMENT OF CORPORATE ESTIMATED TAXES.

Subparagraph (B) of section 401(1) of the Tax Increase Prevention and Reconciliation Act of 2005 is amended by striking ''114.50 percent'' and inserting ''113.25 percent''.

TITLE VIII—EFFECTIVE DATE

SEC. 801. EFFECTIVE DATE.

(a) IN GENERAL.—Unless otherwise provided in this Act, subject to subsection (b), the amendments made by this Act shall take effect on October 1, 2007, and shall apply to child health assistance and medical assistance provided on or after that date without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX or XXI of the Social Security Act, which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by an amendment made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

S 2531. Mr. MARTINEZ submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other puuposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. __. CREDITS FOR HURRICANE AND TORNADO MITIGATION EXPENDITURES.

(a) NONREFUNDABLE PERSONAL CREDIT FOR HURRICANE AND TORNADO MITIGATION PROPERTY.—

(1) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 25D the following new section:

''SEC. 25E. HURRICANE AND TORNADO MITIGATION PROPERTY.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 25 percent of the qualified hurricane and tornado mitigation property expenditures made by the taxpayer during such taxable year.

''(b) MAXIMUM CREDIT.—The credit allowed under subsection (a) for any taxable year shall not exceed $5,000.

''(c) QUALIFIED HURRICANE AND TORNADO MITIGATION EXPENDITURE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified hurricane and tornado mitigation property expenditure' means an expenditure for property—

''(A) to improve the strength of a roof deck attachment,

''(B) to create a secondary water barrier to prevent water intrusion,

''(C) to improve the durability of a roof covering,

''(D) to brace gable-end walls,

''(E) to reinforce the connection between a roof and supporting wall,

''(F) to protect openings from penetration by windborne debris, or

''(G) to protect exterior doors and garages, in a qualified dwelling unit owned by the taxpayer.

''(2) QUALIFIED DWELLING UNIT.—The term 'qualified dwelling unit' means a dwelling unit that is assessed at a value that is less than $1,000,000 by the locality in which such dwelling unit is located and with respect to the taxable year for which the credit described in subsection (a) is allowed.

''(d) LIMITATION.—An expenditure shall be taken into account in determining the qualified hurricane and tornado mitigation property expenditures made by the taxpayer during the taxable year only if the onsite preparation, assembly, or original installation of the property with respect to which such expenditure is made has been completed in a manner that is deemed to be adequate by a State-certified inspector.

''(e) LABOR COSTS.—For purposes of this section, expenditures for labor costs properly allocable to the onsite preparation, assembly, or original installation of the property described in subsection (c) shall be taken into account in determining the qualified hurricane and tornado mitigation property expenditures made by the taxpayer during the taxable year.

''(f) INSPECTION COSTS.—For purposes of this section, expenditures for inspection costs properly allocable to the inspection of the preparation, assembly, or installation of the property described in subsection (c) shall be taken into account in determining the qualified hurricane and tornado mitigation property expenditures made by the taxpayer during the taxable year.''.

(2) CONFORMING AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25D the following new item:

''Sec. 25E. Hurricane and tornado mitigation property.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2007.

(b) BUSINESS RELATED CREDIT FOR HURRICANE AND TORNADO MITIGATION.—

(1) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 45N the following new section:

''SEC. 45O. HURRICANE AND TORNADO MITIGATION CREDIT.

''(a) GENERAL RULE.—For purposes of section 38, the hurricane and tornado mitigation credit determined under this section for any taxable year is an amount equal to 25 percent of the qualified hurricane and tornado mitigation property expenditures made by the taxpayer during the taxable year.

''(b) MAXIMUM CREDIT.—The amount of the credit determined under subsection (a) for any taxable year shall not exceed $5,000.

''(c) QUALIFIED HURRICANE AND TORNADO MITIGATION EXPENDITURE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified hurricane and tornado mitigation property expenditure' means an expenditure for property—

''(A) to improve the strength of a roof deck attachment,

''(B) to create a secondary water barrier to prevent water intrusion,

''(C) to improve the durability of a roof covering,

''(D) to brace gable-end walls,

''(E) to reinforce the connection between a roof and supporting wall,

''(F) to protect openings from penetration by windborne debris, or

''(G) to protect exterior doors and garages, in a qualified place of business owned by the taxpayer.

''(2) QUALIFIED PLACE OF BUSINESS.—The term 'qualified place of business' means a place of business that is assessed at a value that is less than $5,000,000 by the locality in which such business is located and with respect to the taxable year for which the credit described in subsection (a) is allowed.

''(d) LIMITATION.—An expenditure shall be taken into account in determining the qualified hurricane and tornado mitigation property expenditures made by the taxpayer during the taxable year only if the onsite preparation, assembly, or original installation of the property with respect to which such expenditure is made has been completed in a manner that is deemed to be adequate by a State-certified inspector.

''(e) LABOR COSTS.—For purposes of this section, expenditures for labor costs properly allocable to the onsite preparation, assembly, or original installation of the property described in subsection (c) shall be taken into account in determining the qualified hurricane and tornado mitigation property expenditures made by the taxpayer during the taxable year.

''(f) INSPECTION COSTS.—For purposes of this section, expenditures for inspection

costs properly allocable to the inspection of the preparation, assembly, or installation of the property described in subsection (c) shall be taken into account in determining the qualified hurricane and tornado mitigation property expenditures made by the taxpayer during the taxable year.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 38(b) of such Code is amended by striking ''plus'' at the end of paragraph (30), by striking the period at the end of paragraph (31) and inserting '', plus'', and by adding at the end the following new paragraph:

''(32) the hurricane and tornado mitigation credit determined under section 45O(a).''.

(B) 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 45N the following new item:

''Sec. 45O. Hurricane and tornado mitigation credit.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2007.

SA 2532. Mr. MARTINEZ (for himself and Mr. VITTER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. 61__. CREDIT FOR QUALIFIED ELEMENTARY AND SECONDARY EDUCATION TUITION.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25D the following new section:

''SEC. 25E. QUALIFIED ELEMENTARY AND SECONDARY EDUCATION TUITION.

''(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for a taxable year an amount equal to the qualified elementary and secondary education tuition paid or incurred by the taxpayer during the taxable year.

''(b) DOLLAR LIMITATION.—The amount allowed as a credit under subsection (a) with respect to the taxpayer for any taxable year shall not exceed—

''(1) $4,500 in the case of a joint return,

''(2) $4,500 in the case of an individual who is not married, and

''(3) $2,250 in the case of a married individual filing a separate return.

''(c) QUALIFIED ELEMENTARY AND SECONDARY EDUCATION TUITION.—

''(1) IN GENERAL.—The term 'qualified elementary and secondary education tuition' means expenses for tuition which are incurred in connection with the enrollment or attendance of any dependent of the taxpayer with respect to whom the taxpayer is allowed a deduction under section 151 as an elementary or secondary school student at a private or religious school.

''(2) SCHOOL.—The term 'school' means any school which provides elementary education or secondary education (kindergarten through grade 12), as determined under State law.''.

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25D the following new item:

''Sec. 25E. Qualified elementary and secondary education tuition.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2006.

SA 2533. Mr. MARTINEZ submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. 61__. SPACEPORTS TREATED LIKE AIRPORTS UNDER EXEMPT FACILITY BOND RULES.

(a) IN GENERAL.—Paragraph (1) of section 142(a) of the Internal Revenue Code of 1986 (relating to exempt facility bonds) is amended to read as follows:

''(1) airports and spaceports,''.

(b) TREATMENT OF GROUND LEASES.—Paragraph (1) of section 142(b) of the Internal Revenue Code of 1986 (relating to certain facilities must be governmentally owned) is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULE FOR SPACEPORT GROUND LEASES.—For purposes of subparagraph (A), spaceport property which is located on land owned by the United States and which is used by a governmental unit pursuant to a lease (as defined in section 168(h)(7)) from the United States shall be treated as owned by such unit if—

''(i) the lease term (within the meaning of section 168(i)(3)) is at least 15 years, and

''(ii) such unit would be treated as owning such property if such lease term were equal to the useful life of such property.''.

(c) DEFINITION OF SPACEPORT.—Section 142 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(n) SPACEPORT.—

''(1) IN GENERAL.—For purposes of subsection (a)(1), the term 'spaceport' means—

''(A) any facility directly related and essential to servicing spacecraft, enabling spacecraft to launch or reenter, or transferring passengers or space cargo to or from spacecraft, but only if such facility is located at, or in close proximity to, the launch site or reentry site, and

''(B) any other functionally related and subordinate facility at or adjacent to the launch site or reentry site at which launch services or reentry services are provided, including a launch control center, repair shop, maintenance or overhaul facility, and rocket assembly facility.

''(2) ADDITIONAL TERMS.—For purposes of paragraph (1)—

''(A) SPACE CARGO.—The term 'space cargo' includes satellites, scientific experiments, other property transported into space, and any other type of payload, whether or not such property returns from space.

''(B) SPACECRAFT.—The term 'spacecraft' means a launch vehicle or a reentry vehicle.

''(C) OTHER TERMS.—The terms 'launch', 'launch site', 'launch services', 'launch vehicle', 'payload', 'reenter', 'reentry services', 'reentry site', and 'reentry vehicle' shall have the respective meanings given to such terms by section 70102 of title 49, United States Code (as in effect on the date of enactment of this subsection).''.

(d) EXCEPTION FROM FEDERALLY GUARANTEED BOND PROHIBITION.—Paragraph (3) of section 149(b) of the Internal Revenue Code of 1986 (relating to exceptions) is amended by adding at the end the following new subparagraph:

''(E) EXCEPTION FOR SPACEPORTS.—Paragraph (1) shall not apply to any exempt facility bond issued as part of an issue described in paragraph (1) of section 142(a) to provide a spaceport in situations where—

''(i) the guarantee of the United States (or an agency or instrumentality thereof) is the result of payment of rent, user fees, or other charges by the United States (or any agency or instrumentality thereof), and

''(ii) the payment of the rent, user fees, or other charges is for, and conditioned upon, the use of the spaceport by the United States (or any agency or instrumentality thereof).''.

(e) CONFORMING AMENDMENT.—The heading for section 142(c) of the Internal Revenue Code of 1986 is amended by inserting ''SPACEPORTS,'' after ''AIRPORTS,''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to obligations issued after the date of the enactment of this Act.

SA 2534. Mr. DORGAN (for himself, Mr. JOHNSON, Ms. MURKOWSKI, Mr. STEVENS, and Mr. BINGAMAN) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

At the end, add the following:

TITLE ____—INDIAN HEALTH CARE IMPROVEMENT

SEC. __01. SHORT TITLE.

This title may be cited as the ''Indian Health Care Improvement Act Amendments of 2007''.

Subtitle A—Amendments to Indian Laws

SEC. __11. 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. 1. Short title; table of contents.
''Sec. 2. Findings.
''Sec. 3. Declaration of national Indian health policy.
''Sec. 4. Definitions.

''TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

''Sec. 101. Purpose.
''Sec. 102. Health professions recruitment program for Indians.
''Sec. 103. Health professions preparatory scholarship program for Indians.
''Sec. 104. Indian health professions scholarships.
''Sec. 105. American Indians Into Psychology Program.
''Sec. 106. Scholarship programs for Indian Tribes.
''Sec. 107. Indian Health Service extern programs.
''Sec. 108. Continuing education allowances.
''Sec. 109. Community Health Representative Program.
''Sec. 110. Indian Health Service Loan Repayment Program.
''Sec. 111. Scholarship and Loan Repayment Recovery Fund.

''Sec. 112. Recruitment activities.
''Sec. 113. Indian recruitment and retention program.
''Sec. 114. Advanced training and research.
''Sec. 115. Quentin N. Burdick American Indians Into Nursing Program.
''Sec. 116. Tribal cultural orientation.
''Sec. 117. INMED Program.
''Sec. 118. Health training programs of community colleges.
''Sec. 119. Retention bonus.
''Sec. 120. Nursing residency program.
''Sec. 121. Community Health Aide Program.
''Sec. 122. Tribal Health Program administration.
''Sec. 123. Health professional chronic shortage demonstration programs.
''Sec. 124. National Health Service Corps.
''Sec. 125. Substance abuse counselor educational curricula demonstration programs.
''Sec. 126. Behavioral health training and community education programs.
''Sec. 127. Authorization of appropriations.

''TITLE II—HEALTH SERVICES

''Sec. 201. Indian Health Care Improvement Fund.
''Sec. 202. Catastrophic Health Emergency Fund.
''Sec. 203. Health promotion and disease prevention services.
''Sec. 204. Diabetes prevention, treatment, and control.
''Sec. 205. Shared services for long-term care.
''Sec. 206. Health services research.
''Sec. 207. Mammography and other cancer screening.
''Sec. 208. Patient travel costs.
''Sec. 209. Epidemiology centers.
''Sec. 210. Comprehensive school health education programs.
''Sec. 211. Indian youth program.
''Sec. 212. Prevention, control, and elimination of communicable and infectious diseases.
''Sec. 213. Other authority for provision of services.
''Sec. 214. Indian women's health care.
''Sec. 215. Environmental and nuclear health hazards.
''Sec. 216. Arizona as a contract health service delivery area.
''Sec. 216A. North Dakota and South Dakota as contract health service delivery area.
''Sec. 217. California contract health services program.
''Sec. 218. California as a contract health service delivery area.
''Sec. 219. Contract health services for the Trenton service area.
''Sec. 220. Programs operated by Indian Tribes and Tribal Organizations.
''Sec. 221. Licensing.
''Sec. 222. Notification of provision of emergency contract health services.
''Sec. 223. Prompt action on payment of claims.
''Sec. 224. Liability for payment.
''Sec. 225. Office of Indian Men's Health.
''Sec. 226. Authorization of appropriations.

''TITLE III—FACILITIES

''Sec. 301. Consultation; construction and renovation of facilities; reports.
''Sec. 302. Sanitation facilities.
''Sec. 303. Preference to Indians and Indian firms.
''Sec. 304. Expenditure of non-Service funds for renovation.
''Sec. 305. Funding for the construction, expansion, and modernization of small ambulatory care facilities.
''Sec. 306. Indian health care delivery demonstration projects.
''Sec. 307. Land transfer.
''Sec. 308. Leases, contracts, and other agreements.
''Sec. 309. Study on loans, loan guarantees, and loan repayment.
''Sec. 310. Tribal leasing.
''Sec. 311. Indian Health Service/tribal facilities joint venture program.
''Sec. 312. Location of facilities.
''Sec. 313. Maintenance and improvement of health care facilities.
''Sec. 314. Tribal management of Federally-owned quarters.
''Sec. 315. Applicability of Buy American Act requirement.
''Sec. 316. Other funding for facilities.
''Sec. 317. Authorization of appropriations.

''TITLE IV—ACCESS TO HEALTH SERVICES

''Sec. 401. Treatment of payments under Social Security Act health benefits programs.
''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 and other health benefits programs.
''Sec. 403. Reimbursement from certain third parties of costs of health services.
''Sec. 404. Crediting of reimbursements.
''Sec. 405. Purchasing health care coverage.
''Sec. 406. Sharing arrangements with Federal agencies.
''Sec. 407. Payor of last resort.
''Sec. 408. Nondiscrimination under Federal health care programs in qualifications for reimbursement for services.
''Sec. 409. Consultation.
''Sec. 410. State Children's Health Insurance Program (SCHIP).
''Sec. 411. Exclusion waiver authority for affected Indian Health Programs and safe harbor transactions under the Social Security Act.
''Sec. 412. Premium and cost sharing protections and eligibility determinations under Medicaid and SCHIP and protection of certain Indian property from Medicaid estate recovery.
''Sec. 413. Treatment under Medicaid and SCHIP managed care.
''Sec. 414. Navajo Nation Medicaid Agency feasibility study.
''Sec. 415. General exceptions.
''Sec. 416. Authorization of appropriations.

''TITLE V—HEALTH SERVICES FOR URBAN INDIANS

''Sec. 501. Purpose.
''Sec. 502. Contracts with, and grants to, Urban Indian Organizations.
''Sec. 503. Contracts and grants for the provision of health care and referral services.
''Sec. 504. Contracts and grants for the determination of unmet health care needs.
''Sec. 505. Evaluations; renewals.
''Sec. 506. Other contract and grant requirements.
''Sec. 507. Reports and records.
''Sec. 508. Limitation on contract authority.
''Sec. 509. Facilities.
''Sec. 510. Division of Urban Indian Health.
''Sec. 511. Grants for alcohol and substance abuse-related services.
''Sec. 512. Treatment of certain demonstration projects.
''Sec. 513. Urban NIAAA transferred programs.
''Sec. 514. Conferring with Urban Indian Organizations.
''Sec. 515. Urban youth treatment center demonstration.
''Sec. 516. Grants for diabetes prevention, treatment, and control.
''Sec. 517. Community Health Representatives.
''Sec. 518. Effective date.
''Sec. 519. Eligibility for services.
''Sec. 520. Further authorizations.
''Sec. 521. Authorization of appropriations.

''TITLE VI—ORGANIZATIONAL IMPROVEMENTS

''Sec. 601. Establishment of the Indian Health Service as an agency of the Public Health Service.
''Sec. 602. Automated management information system.
''Sec. 603. Authorization of appropriations.

''TITLE VII—BEHAVIORAL HEALTH PROGRAMS

''Sec. 701. Behavioral health prevention and treatment services.
''Sec. 702. Memoranda of agreement with the Department of the Interior.
''Sec. 703. Comprehensive behavioral health prevention and treatment program.
''Sec. 704. Mental health technician program.
''Sec. 705. Licensing requirement for mental health care workers.
''Sec. 706. Indian women treatment programs.
''Sec. 707. Indian youth program.
''Sec. 708. Indian youth telemental health demonstration project.
''Sec. 709. Inpatient and community-based mental health facilities design, construction, and staffing.
''Sec. 710. Training and community education.
''Sec. 711. Behavioral health program.
''Sec. 712. Fetal alcohol spectrum disorders programs.
''Sec. 713. Child sexual abuse and prevention treatment programs.
''Sec. 714. Domestic and sexual violence prevention and treatment.
''Sec. 715. Behavioral health research.
''Sec. 716. Definitions.
''Sec. 717. Authorization of appropriations.

''TITLE VIII—MISCELLANEOUS

''Sec. 801. Reports.
''Sec. 802. Regulations.
''Sec. 803. Plan of implementation.
''Sec. 804. Availability of funds.
''Sec. 805. Limitation on use of funds appropriated to Indian Health Service.
''Sec. 806. Eligibility of California Indians.
''Sec. 807. Health services for ineligible persons.
''Sec. 808. Reallocation of base resources.
''Sec. 809. Results of demonstration projects.
''Sec. 810. Provision of services in Montana.
''Sec. 811. Moratorium.
''Sec. 812. Tribal employment.
''Sec. 813. Severability provisions.
''Sec. 814. Establishment of National Bipartisan Commission on Indian Health Care.
''Sec. 815. Confidentiality of medical quality assurance records; qualified immunity for participants.
''Sec. 816. Appropriations; availability.
''Sec. 817. Authorization of appropriations.

''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 and the general population of the United States.

''(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 Healthy People 2010 or successor objectives;

''(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

''(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 that all actions under this Act shall be carried out with active and meaningful consultation with Indian Tribes and Tribal Organizations, and conference with Urban Indian Organizations, to implement this Act and the national policy of Indian self-determination;

''(6) to ensure that the United States and Indian Tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and

''(7) to provide funding for programs and facilities operated by Indian Tribes and Tribal 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 for Indian Health.

''(4)(A) The term 'behavioral health' means the blending of substance (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 806.

''(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, 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 spectrum 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) such other activities identified by the Service, a Tribal Health Program, or an Urban Indian Organization, 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 806, 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(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

''(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.—The Secretary shall not make a grant 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 degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, 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 2007 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.—

''(A) IN GENERAL.—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—

''(i) it is not possible for the recipient to meet that obligation or make that payment;

''(ii) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

''(iii) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

''(B) FACTORS FOR CONSIDERATION.—Before waiving or suspending an obligation of service or payment under subparagraph (A), the Secretary shall consult with the affected Area Office, Indian Tribes, or Tribal Organizations, or confer with the affected Urban Indian Organizations, and may take into consideration whether the obligation may be satisfied in a teaching capacity at a tribal college or university nursing program under subsection (b)(1)(D).

''(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 to carry out this section $2,700,000 for each of fiscal years 2008 through 2017.

"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) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

''(C) meet the professional standards for civil service employment in the Service; or

''(D) 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 (k), 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.—Notwithstanding 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 (hereinafter 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 (l) 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 in accordance with subsection (f); and

''(D) 's' is the number of months of such period served by such individual in accordance with this section.

''(3) 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.

''(4) 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.

''(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 section 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 section 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 Tribal Health Programs and Urban Indian Organizations to recruit, place, and retain health professionals to meet their staffing needs.

''(b) ELIGIBLE ENTITIES; APPLICATION.—Any Tribal 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 2007, 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(l)(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 technicals), 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 in subsection (l) of section 110 in the manner provided for in such subsection.

''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, acting through the Service, shall, by contract or otherwise, provide training for Indians in the administration and planning of Tribal Health Programs.

''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) EXEMPTION FROM LIMITATIONS.—National Health Service Corps scholars qualifying for the Commissioned Corps in the Public Health Service shall be exempt from the full-time equivalent limitations of the National Health Service Corps and the Service when serving as a commissioned corps officer in a Tribal Health Program or an Urban Indian Organization.

''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 2007, 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 and Tribal Organizations (without regard to the funding source).

''(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 or Tribal 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 2007, 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. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 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 spectrum disorders) 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 2007, 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. 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. 203. 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 and Tribal Health Programs, 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. 204. 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 2007, any such other diabetes programs operated by the Service or Tribal Health Programs, and any additional diabetes projects, such as the Medical Vanguard program provided for in title IV of Public Law 108–87, as implemented to serve Indian Tribes. Tribal Health Programs shall receive recurring funding for the diabetes projects that they operate pursuant to this section, both at the date of enactment of the Indian Health Care Improvement Act Amendments of 2007 and for projects which are added and funded thereafter.

''(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. 205. 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. 206. 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. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

''The Secretary, acting through the Service or Tribal Health Programs, 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. 208. 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 and Tribal Health Programs, 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. 209. 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 2007 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.—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 (Public Law 104–191; 110 Stat. 2033), as such entities are defined in part 164.501 of title 45, Code of Federal Regulations (or a successor regulation). The Secretary shall grant such grantees access to and use of data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.

''SEC. 210. 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 and Urban 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, and affected Indian Tribes and Tribal Organizations, 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. 211. 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 pre-adolescent 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 and Tribal 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 or Tribal 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 and Tribal Organizations, and in conference with Urban Indian Organizations, shall establish criteria for the review and approval of applications or proposals under this section.

''SEC. 212. 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 and Tribal 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 and Tribal 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 or Tribal 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. 213. OTHER AUTHORITY FOR PROVISION OF SERVICES.

''(a) FUNDING AUTHORIZED.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, 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 not otherwise described in this Act, including—

''(1) hospice care;

''(2) assisted living;

''(3) long-term care; and

''(4) home- and community-based services.

''(b) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Any service provided under this section shall be in accordance with such terms and conditions as are consistent with accepted and appropriate standards relating to the service, including any licensing term or condition under this Act.

''(2) STANDARDS.—

''(A) STATE STANDARDS.—Any service authorized under this section provided by the Service, an Indian Tribe, or a Tribal Organization shall be in accordance with the standards for such service established by the State in which such service is or will be provided.

''(B) SECRETARIAL STANDARDS.—In the absence of State standards for provision of a service authorized under this section as described in paragraph (1), the Secretary may, by regulation, establish standards for the provision of such service.

''(C) TRIBAL STANDARDS.—In the absence of State standards as described in subparagraph (A) and Secretarial standards as described in subparagraph (B) for provision of a service authorized under this section, an Indian Tribe or Tribal Organization, pursuant to the fourth sentence of section 102(a)(2) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f(a)(2)), shall propose standards under which the Indian Tribe or Tribal Organization will provide such service, which shall be the standards applicable to such service on approval of the agreement of the Indian Tribe or Tribal Organization pursuant to that Act (25 U.S.C. 450 et seq.).

''(D) VERIFICATION.—If a service authorized under this section is provided by an Indian Tribe or Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), the verification by the Secretary that the service meets the State standards described in subparagraph (A) shall be considered to meet the terms and conditions required under this subsection.

''(3) ELIGIBILITY.—The following individuals shall be eligible to receive long-term care under this section:

''(A) Individuals who are unable to perform a certain number of activities of daily living without assistance.

''(B) 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.

''(C) 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 '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 the standards described in subsection (b).

''(2) 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.

''(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. 214. 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. 215. 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 sources 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 2007 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 2007. 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 Assistant Secretary.

''(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. 216. 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, 2016, 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. 216A. NORTH DAKOTA AND SOUTH DAKOTA AS A 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 the California Rural Indian Health Board (hereafter in this section referred to as the 'CRIHB') 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 CRIHB to reimburse the CRIHB for costs (including reasonable administrative costs) incurred pursuant to this section, in providing medical treatment under contract to California Indians described in section 806(a) throughout the California contract health services delivery area described in section 218 with respect to high cost contract care cases.

''(c) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of the amounts provided to the CRIHB under this section for any fiscal year may be for reimbursement for administrative expenses incurred by the CRIHB 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 CRIHB in carrying out this section. The advisory board shall be composed of representatives, selected by the CRIHB, from not less than 8 Tribal Health Programs serving California Indians covered under this section at least ½ of whom of whom are not affiliated with the CRIHB.

"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 and facilities operated by Tribal Health Programs on the same basis as such funds are provided to programs and facilities operated directly by the Service.

"SEC. 221. LICENSING.

''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.).

"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 223(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 2007, 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. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 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, or any portion of such facility, 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 the 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 2007 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 2007, 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 and Tribal Organizations; and

''(B) review the total unmet needs of all Indian Tribes and Tribal 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 and Tribal Organizations, and confer with 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 for operation, management, and maintenance of their sanitation facilities.

''(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) LABOR STANDARDS.—

''(1) IN GENERAL.—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'), unless such construction or renovation—

''(A) is performed by a contractor pursuant to a contract with an Indian Tribe or Tribal Organization with funds supplied through a contract or compact authorized by the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other statutory authority; and

''(B) is subject to prevailing wage rates for similar construction or renovation in the locality as determined by the Indian Tribes or Tribal Organizations to be served by the construction or renovation.

''(2) EXCEPTION.—This subsection shall not apply to construction or renovation carried out by an Indian Tribe or Tribal Organization with its own employees.

''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 807(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 807(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 non-eligible 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 PROJECTS.

''(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to carry out, or to enter into contracts under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) with Indian Tribes or Tribal Organizations to carry 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) HEALTH CARE DEMONSTRATION PROJECTS.—

''(1) GENERAL PROJECTS.—

''(A) CRITERIA.—The Secretary may approve under this section demonstration projects that meet the following criteria:

''(i) There is a need for a new facility or program, such as a program for convenient care services, or the reorientation of an existing facility or program.

''(ii) A significant number of Indians, including Indians with low health status, will be served by the project.

''(iii) The project has the potential to deliver services in an efficient and effective manner.

''(iv) The project is economically viable.

''(v) For projects carried out by an Indian Tribe or Tribal Organization, the Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

''(vi) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services in order to expand the availability of services.

''(B) PRIORITY.—In approving demonstration projects under this paragraph, the Secretary shall give priority to demonstration projects, to the extent the projects meet the criteria described in subparagraph (A), located in any of the following Service Units:

''(i) Cass Lake, Minnesota.

''(ii) Mescalero, New Mexico.

''(iii) Owyhee, Nevada.

''(iv) Schurz, Nevada.

''(v) Ft. Yuma, California.

''(2) CONVENIENT CARE SERVICE PROJECTS.—

''(A) DEFINITION OF CONVENIENT CARE SERVICE.—In this paragraph, the term 'convenient care service' means any primary health care service, such as urgent care services, non-emergent care services, prevention services and screenings, and any service authorized by sections 203 or 213(d), that is—

''(i) provided outside the regular hours of operation of a health care facility; or

''(ii) offered at an alternative setting.

''(B) APPROVAL.—In addition to projects described in paragraph (1), in any fiscal year, the Secretary is authorized to approve not more than 10 applications for health care delivery demonstration projects that—

''(i) include a convenient care services program as an alternative means of delivering health care services to Indians; and

''(ii) meet the criteria described in subparagraph (C).

''(C) CRITERIA.—The Secretary shall approve under subparagraph (B) demonstration projects that meet all of the following criteria:

''(i) The criteria set forth in paragraph (1)(A).

''(ii) There is a lack of access to health care services at existing health care facilities, which may be due to limited hours of operation at those facilities or other factors.

''(iii) The project—

''(I) expands the availability of services; or

''(II) reduces—

''(aa) the burden on Contract Health Services; or

''(bb) the need for emergency room visits.

''(d) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications using the criteria described in paragraphs (1)(A) and (2)(C) of subsection (c).

''(e) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with this section.

''(f) SERVICE TO INELIGIBLE PERSONS.—Subject to section 807, 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 807, may be included, subject to the terms of that section, in any demonstration project approved pursuant to this section.

''(g) EQUITABLE TREATMENT.—For purposes of subsection (c), the Secretary, 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.), shall use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

''(h) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities that 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 807(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, 2009, 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; or

''(2) has not begun the process of acquisition or construction of a health facility for use in the joint venture project.

''(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 maximum renovation cost threshold shall be determined through the negotiated rulemaking process provided for under section 802.

''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) 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 for each fiscal year through fiscal year 2017 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 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 the Social Security Act.

''(B) USE OF FUNDS.—Amounts received by a facility of the Service under subparagraph (A) 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 titles XVIII and XIX of the Social Security Act. 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 reducing the health resource deficiencies (as determined under section 201(d)) of such Indian Tribes.

''(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 or XIX of the Social Security Act or from any other third party payor.

''(2) DIRECT REIMBURSEMENT.—

''(A) USE OF FUNDS.—Each Tribal Health Program making the election described in paragraph (1) with respect to a program under a title 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 purpose of making any improvements in facilities of the Tribal Health Program that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such items and services under the program under such title and to provide additional health care services, improvements in health care facilities and Tribal Health Programs, any health care related purpose, or otherwise to achieve the objectives provided in section 3 of this Act.

''(B) AUDITS.—The amounts paid to a Tribal Health Program making the election described in paragraph (1) with respect to a program under a title 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 a title 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 AND OTHER HEALTH BENEFITS PROGRAMS.

''(a) INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—From funds appropriated to carry out this title in accordance with section 416, 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 and trust lands 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 other health benefits programs; 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.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI of the Social Security Act.

''(e) AGREEMENTS RELATING TO IMPROVING ENROLLMENT OF INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.—For provisions relating to agreements between the Secretary, acting through the Service, and Indian Tribes, Tribal Organizations, and Urban Indian Organizations for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and State 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) DEFINITION OF PREMIUMS AND COST SHARING.—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.

"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 billed by the Secretary, an Indian Tribe, or Tribal Organization 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 or expenses 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 2007 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) USE OF AMOUNTS.—

''(1) RETENTION BY PROGRAM.—Except as provided in section 202(f) (relating to the Catastrophic Health Emergency Fund) and section 807 (relating to health services for ineligible persons), all reimbursements received or recovered under any of the programs described in paragraph (2), including under section 807, 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.

''(2) PROGRAMS COVERED.—The programs referred to in paragraph (1) are the following:

''(A) Titles XVIII, XIX, and XXI of the Social Security Act.

''(B) This Act, including section 807.

''(C) Public Law 87–693.

''(D) Any other provision of law.

''(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) 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 for such beneficiaries in any manner, including through—

''(1) a tribally owned and operated health care plan;

''(2) a State or locally authorized or licensed health care plan;

''(3) a health insurance provider or managed care organization; or

''(4) a self-insured plan.

The purchase of such coverage by an Indian Tribe, Tribal Organization, or Urban Indian Organization may be based on the financial needs of such 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. 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. 408. NONDISCRIMINATION UNDER FEDERAL HEALTH CARE PROGRAMS IN QUALIFICATIONS FOR REIMBURSEMENT FOR SERVICES.

''(a) REQUIREMENT TO SATISFY GENERALLY APPLICABLE PARTICIPATION REQUIREMENTS.—

''(1) IN GENERAL.—A Federal health care program must accept an entity that is operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.

''(2) SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221, the absence of the licensure of a health care professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

''(b) APPLICATION OF EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.—

''(1) EXCLUDED ENTITIES.—No entity operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment or reimbursement under any such program for health care services furnished to an Indian.

''(2) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension shall be eligible to receive payment or reimbursement under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to receive payment for health care services, to an Indian.

''(3) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, 'Federal health care program' has the meaning given that term in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code.

''(c) RELATED PROVISIONS.—For provisions related to nondiscrimination against providers operated by the Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, see section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)).

''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. EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS AND SAFE HARBOR TRANSACTIONS UNDER THE SOCIAL SECURITY ACT.

''For provisions relating to—

''(1) exclusion waiver authority for affected Indian Health Programs under the Social Security Act, see section 1128(k) of the Social Security Act (42 U.S.C. 1320a–7(k)); and

''(2) certain transactions involving Indian Health Programs deemed to be in safe harbors under that Act, see section 1128B(b)(4) of the Social Security Act (42 U.S.C. 1320a–7b(b)(4)).

''SEC. 412. 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. 413. 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. 414. 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 then 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, 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. 415. GENERAL EXCEPTIONS.

''The requirements of this title shall not apply to any 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).

''SEC. 416. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 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. 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. 505. 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. 506. 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. 507. 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 2007, the Secretary, acting through the Service and working with a national membership-based consortium of Urban Indian Organizations, 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, including unmet health care facilities needs.

''(B) CONSULTATION AND CONTRACTS.—In preparing the report under paragraph (1), the Secretary—

''(i) shall confer 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. 508. 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. 509. 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. 510. 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 working with a national membership-based consortium of Urban Indian Organizations.

''SEC. 511. 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, including fetal alcohol spectrum disorders, 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. 512. 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. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

''(a) GRANTS AND CONTRACTS.—The Secretary, through the Division of Urban Indian Health, shall make grants to, 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. 514. 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. 515. 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. 516. 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 204(e) 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. 517. 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. 518. EFFECTIVE DATE.

''The amendments made by the Indian Health Care Improvement Act Amendments of 2007 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. 519. 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. 520. FURTHER AUTHORIZATIONS.

''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 sections 126, 210, 212, 701, and 707(g).

''SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title.

''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 FOR INDIAN HEALTH.—The Service shall be administered by an Assistant Secretary for 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, 2007, 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 2007 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 2007, 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) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service;

''(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.—Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.

''(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 for each fiscal year through fiscal year 2017 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, Indian Tribes and Tribal Organizations 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, Indian Tribes, and Tribal Organizations, shall encourage Indian Tribes and Tribal Organizations to develop tribal plans and 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, and Tribal Organizations to meet their responsibilities under the plans.

''(2) COORDINATION WITH NATIONAL CLEARINGHOUSES AND INFORMATION CENTERS.—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, and Service Areas relating to behavioral health. The Secretary shall ensure access to these plans and outcomes by any Indian Tribe, Tribal Organization, or the Service.

''(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes and Tribal 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, Indian Tribes, and Tribal Organizations, 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 spectrum 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 a fetal alcohol-exposed pregnancy; 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 or Tribal 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 or Tribal Organization, the Bureau of Indian Affairs and the Service shall cooperate with and provide technical assistance to the Indian Tribe or Tribal 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, Indian Tribes, and Tribal Organizations, 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 2007, 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 2007, 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, Indian Tribes, and Tribal Organizations, shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, 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, Indian Tribes, and Tribal Organizations, 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, Indian Tribes, and Tribal Organizations, 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, Indian Tribes, and Tribal Organizations, 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 spectrum 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) EARMARK OF CERTAIN FUNDS.—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, Indian Tribes, and Tribal Organizations, 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, Indian Tribes, and Tribal Organizations, may provide intermediate behavioral health services 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, Indian Tribes, and Tribal Organizations, 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, Indian Tribes, and Tribal Organizations, 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 to carry out this section $1,500,000 for each of fiscal years 2008 through 2011.

''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 2007, the Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, 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, either directly or through Indian Tribes and Tribal Organizations, 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 spectrum 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 for preventing and treating behavioral health problems.

''SEC. 711. BEHAVIORAL HEALTH PROGRAM.

''(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, 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 SPECTRUM DISORDERS PROGRAMS.

''(a) PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary, consistent with section 701, acting through the Service, Indian Tribes, and Tribal Organizations, is authorized to establish and operate fetal alcohol spectrum disorders 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 spectrum 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 spectrum disorders-affected Indians and their families or caretakers.

''(iv) To develop and implement counseling and support programs in schools for fetal alcohol spectrum disorders-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 spectrum disorders.

''(vii) To develop and implement, in consultation with Indian Tribes and Tribal Organizations, and in conference with Urban Indian Organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol spectrum disorders 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 spectrum disorders 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 spectrum disorders.

''(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, Indian Tribes, and Tribal Organizations, shall—

''(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol spectrum disorders 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 spectrum disorders.

''(c) TASK FORCE.—The Secretary shall establish a task force to be known as the Fetal Alcohol Spectrum Disorders 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 communities.

''(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 PREVENTION AND TREATMENT PROGRAMS.

''(a) ESTABLISHMENT.—The Secretary, acting through the Service, and the Secretary of the Interior, Indian Tribes, and Tribal Organizations, 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 2007, 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 2007, 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 2007, 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 any 1 of a spectrum of effects that—

''(A) may occur when a woman drinks alcohol during pregnancy; and

''(B) involves a central nervous system abnormality that may be structural, neurological, or functional.

''(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 to restore the ability or capacity to engage in usual and customary life activities through education and therapy.

''(8) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse.

''SEC. 717. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 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 2007, 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 808.

''(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(n).

''(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 808.

''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 2007, 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 titles II (except section 202) and VII, the sections of title III for which negotiated rulemaking is specifically required, and section 807. Unless otherwise required, the Secretary may promulgate regulations to carry out titles I, III, IV, and V, and section 202, using the procedures required by chapter V 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 2007 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 2007.

''(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.

''(e) INCONSISTENT REGULATIONS.—The provisions of this Act shall supersede any conflicting provisions of law in effect on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, and the Secretary is authorized to repeal any regulation inconsistent with the provisions of this Act.

''SEC. 803. PLAN OF IMPLEMENTATION.

''Not later than 9 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, the Secretary, in consultation with Indian Tribes and Tribal Organizations, and in conference with 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).

''SEC. 804. AVAILABILITY OF FUNDS.

''The funds appropriated pursuant to this Act shall remain available until expended.

''SEC. 805. 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. 806. 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. 807. 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 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.—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.

''(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. 808. 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. 809. 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. 810. PROVISION OF SERVICES IN MONTANA.

''(a) CONSISTENT WITH COURT DECISION.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cir. 1987).

''(b) CLARIFICATION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

''SEC. 811. 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 806 and 807, 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. 812. TRIBAL EMPLOYMENT.

''For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter 372), an Indian Tribe or Tribal Organization carrying out a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall not be considered an 'employer'.

''SEC. 813. 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. 814. ESTABLISHMENT OF NATIONAL BIPARTISAN COMMISSION ON INDIAN HEALTH CARE.

''(a) ESTABLISHMENT.—There is established the National Bipartisan Indian Health Care Commission (the 'Commission').

''(b) DUTIES OF COMMISSION.—The duties of the Commission are the following:

''(1) To establish a study committee composed of those members of the Commission appointed by the Director of the Service and at least 4 members of Congress from among the members of the Commission, the duties of which shall be the following:

''(A) To the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, which may include authorizing and making funds available for feasibility studies of various models for providing and funding health services for all Indian beneficiaries, including those who live outside of a reservation, temporarily or permanently.

''(B) To make legislative recommendations to the Commission regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

''(C) To determine the effect of the enactment of such recommendations on (i) the existing system of delivery of health services for Indians, and (ii) the sovereign status of Indian Tribes.

''(D) Not later than 12 months after the appointment of all members of the Commission, to submit a written report of its findings and recommendations to the full Commission. The report shall include a statement of the minority and majority position of the Committee and shall be disseminated, at a minimum, to every Indian Tribe, Tribal Organization, and Urban Indian Organization for comment to the Commission.

''(E) To report regularly to the full Commission regarding the findings and recommendations developed by the study committee in the course of carrying out its duties under this section.

''(2) To review and analyze the recommendations of the report of the study committee.

''(3) To make legislative recommendations to Congress regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

''(4) Not later than 18 months following the date of appointment of all members of the Commission, submit a written report to Congress regarding the delivery of Federal health care services to Indians. Such recommendations shall include those related to issues of eligibility, benefits, the range of service providers, the cost of such services, financing such services, and the optimal manner in which to provide such services.

''(c) MEMBERS.—

''(1) APPOINTMENT.—The Commission shall be composed of 25 members, appointed as follows:

''(A) Ten members of Congress, including 3 from the House of Representatives and 2 from the Senate, appointed by their respective majority leaders, and 3 from the House of Representatives and 2 from the Senate, appointed by their respective minority leaders, and who shall be members of the standing committees of Congress that consider legislation affecting health care to Indians.

''(B) Twelve persons chosen by the congressional members of the Commission, 1 from each Service Area as currently designated by the Director of the Service to be chosen from among 3 nominees from each Service Area put forward by the Indian Tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and to a reasonable representation on the commission of members who are familiar with various health care delivery modes and who represent Indian Tribes of various size populations.

''(C) Three persons appointed by the Director who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees put forward by those programs whose funds are provided in whole or in part by the Service primarily or exclusively for the benefit of Urban Indians.

''(D) All those persons chosen by the congressional members of the Commission and by the Director shall be members of federally recognized Indian Tribes.

''(2) CHAIR; VICE CHAIR.—The Chair and Vice Chair of the Commission shall be selected by the congressional members of the Commission.

''(3) TERMS.—The terms of members of the Commission shall be for the life of the Commission.

''(4) DEADLINE FOR APPOINTMENTS.—Congressional members of the Commission shall be appointed not later than 180 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2007, and the remaining members of the Commission shall be appointed not later than 60 days following the appointment of the congressional members.

''(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(d) COMPENSATION.—

''(1) CONGRESSIONAL MEMBERS.—Each congressional member of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

''(2) OTHER MEMBERS.—Remaining members of the Commission, while serving on the business of the Commission (including travel time), shall be entitled to receive 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 Chairman of the Commission. For purpose of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(e) MEETINGS.—The Commission shall meet at the call of the Chair.

''(f) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, provided that no less than 6 of the members of Congress who are Commission members are present and no less than 9 of the members who are Indians are present.

''(g) EXECUTIVE DIRECTOR; STAFF; FACILITIES.—

''(1) APPOINTMENT; PAY.—The Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

''(2) STAFF APPOINTMENT.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

''(3) STAFF PAY.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

''(4) TEMPORARY SERVICES.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

''(5) FACILITIES.—The Administrator of General Services shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

''(h) HEARINGS.—(1) For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, provided that at least 6 regional hearings are held in different areas of the United States in which large numbers of Indians are present. Such hearings are to be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this subsection, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established in this section may count toward the number of regional hearings required by this subsection.

''(2)(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

''(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of that Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

''(3) Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

''(4) Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

''(5) The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

''(6) The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

''(7) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

''(8) For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of Congress.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out the provisions of this section, which sum shall not be deducted from or affect any other appropriation for health care for Indian persons.

''(j) NONAPPLICABILITY OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

''SEC. 815. 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. Such requirement does not apply to the release of information pursuant to section 552a of title 5.

''(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.

''(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.

''SEC. 816. APPROPRIATIONS; AVAILABILITY.

''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.

''SEC. 817. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2017 to carry out this title.''.

(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. __12. SOBOBA SANITATION FACILITIES.

The Act of December 17, 1970 (84 Stat. 1465), is amended by adding at the end the following:

''SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).''.

SEC. __13. 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''.

Subtitle B—Improvement of Indian Health Care Provided Under the Social Security Act

SEC. __21. 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.—The Indian Health Service and an Indian Tribe, Tribal Organization, or an Urban Indian Organization 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 Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization 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) COMPLIANCE WITH CONDITIONS AND REQUIREMENTS.—Subsection (b) of such section is amended to read as follows:

''(b) COMPLIANCE WITH CONDITIONS AND REQUIREMENTS.—A facility of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization which is eligible for payment under subsection (a) with respect to the furnishing of items and services, but which does not meet all of the conditions and requirements of this title and under a State plan or waiver authority which are applicable generally to such facility, shall make such improvements as are necessary to achieve or maintain compliance with such conditions and requirements in accordance with a plan submitted to and accepted by the Secretary for achieving or maintaining compliance with such conditions and requirements, and shall be deemed to meet such conditions and requirements (and to be eligible for payment under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.''.

(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.''.

(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:

''(d) 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.

''(e) DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program or an Urban Indian Organization to elect to directly bill for, and receive payment for, health care items and services provided by such Program or Organization for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.

''(f) DEFINITIONS.—In this section, the terms 'Indian Health Program', 'Indian Tribe','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.''.

(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), the Indian Health Service and an Indian Tribe, Tribal Organization, or an Urban Indian Organization shall be eligible for payments under this title with respect to items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization 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) COMPLIANCE WITH CONDITIONS AND REQUIREMENTS.—Subsection (b) of such section is amended to read as follows:

''(b) COMPLIANCE WITH CONDITIONS AND REQUIREMENTS.—Subject to subsection (e), a facility of the Indian Health Service or an Indian Tribe, Tribal Organization, or an Urban Indian Organization which is eligible for payment under subsection (a) with respect to the furnishing of items and services, but which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, shall make such improvements as are necessary to achieve or maintain compliance with such conditions and requirements in accordance with a plan submitted to and accepted by the Secretary for achieving or maintaining compliance with such conditions and requirements, and shall be deemed to meet such conditions and requirements (and to be eligible for payment under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.''.

(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:

''(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, 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.

''(d) DIRECT BILLING.—For provisions relating to the authority of a Tribal Health Program or an Urban Indian Organization to elect to directly bill for, and receive payment for, health care items and services provided by such Program or Organization for which payment is made under this title, see section 401(d) of the Indian Health Care Improvement Act.''.

(B) CONFORMING AMENDMENT.—Paragraph (3) of section 1880(e) of such Act (42 U.S.C. 1395qq(e)) is amended by inserting ''and section 401(c)(1) of the Indian Health Care Improvement Act'' after ''Subsection (c)''.

(4) DEFINITIONS.—Such section is further amended by amending subsection (f) to read as follows:

''(f) 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 subparagraph (D) as subparagraph (E); and

(2) by inserting after subparagraph (C), the following new subparagraph:

''(D) Section 1911 (relating to Indian Health Programs, other than subsection (d) of such section).''.

SEC. __22. INCREASED OUTREACH TO INDIANS UNDER MEDICAID AND SCHIP AND IMPROVED COOPERATION IN THE PROVISION OF ITEMS AND SERVICES TO INDIANS UNDER SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9) is amended to read as follows:

''SEC. 1139. IMPROVED ACCESS TO, AND DELIVERY OF, HEALTH CARE FOR INDIANS UNDER TITLES XVIII, XIX, AND XXI.

''(a) AGREEMENTS WITH STATES FOR MEDICAID AND SCHIP OUTREACH ON OR NEAR RESERVATIONS TO INCREASE THE ENROLLMENT OF INDIANS IN THOSE PROGRAMS.—

''(1) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under the Medicaid and State children's health insurance programs established under titles XIX and XXI, the Secretary shall encourage the State to take steps to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are appropriate.

''(2) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as affecting arrangements entered into between States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations for such Service, Tribes, or Organizations to conduct administrative activities under such titles.

''(b) REQUIREMENT TO FACILITATE COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under the programs established under title XVIII, XIX, or XXI.

''(c) DEFINITION OF INDIAN; INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—In this section, the terms 'Indian', 'Indian Tribe', 'Indian Health Program', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

SEC. __23. ADDITIONAL PROVISIONS TO INCREASE OUTREACH TO, AND ENROLLMENT OF, INDIANS IN SCHIP AND MEDICAID.

(a) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2) of the Social Security Act (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following new subparagraph:

''(C) NONAPPLICATION TO EXPENDITURES FOR OUTREACH TO INCREASE THE ENROLLMENT OF INDIAN CHILDREN UNDER THIS TITLE AND TITLE XIX.—The limitation under subparagraph (A) on expenditures for items described in subsection (a)(1)(D) shall not apply in the case of expenditures for outreach activities to families of Indian children likely to be eligible for child health assistance under the plan or medical assistance under the State plan under title XIX (or under a waiver of such plan), to inform such families of the availability of, and to assist them in enrolling their children in, such plans, including such activities conducted under grants, contracts, or agreements entered into under section 1139(a).''.

(b) ASSURANCE OF PAYMENTS TO INDIAN HEALTH CARE PROVIDERS FOR CHILD HEALTH ASSISTANCE.—Section 2102(b)(3)(D) of such 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''.

(c) 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''.

(d) SATISFACTION OF MEDICAID DOCUMENTATION REQUIREMENTS.—

(1) IN GENERAL.—Section 1903(x)(3)(B) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following new clause:

''(v)(I) Except as provided in subclause (II), a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe.

''(II) With respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.''.

(2) TRANSITION RULE.—During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by paragraph (1)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act.

(e) 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. __24. PREMIUMS AND COST SHARING PROTECTIONS UNDER MEDICAID, ELIGIBILITY DETERMINATIONS UNDER MEDICAID AND SCHIP, AND PROTECTION OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.

(a) PREMIUMS AND COST SHARING PROTECTION UNDER MEDICAID.—

(1) IN GENERAL.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking ''and (i)'' and inserting '', (i), and (j)''; and

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

''(j) NO PREMIUMS OR COST SHARING FOR INDIANS FURNISHED ITEMS OR SERVICES DIRECTLY BY INDIAN HEALTH PROGRAMS OR THROUGH REFERRAL UNDER THE CONTRACT HEALTH SERVICE.—

''(1) NO COST SHARING FOR ITEMS OR SERVICES FURNISHED TO INDIANS THROUGH INDIAN HEALTH PROGRAMS.—

''(A) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under the contract health service for which payment may be made under this title.

''(B) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under the contract health service for the furnishing of an item or service to an Indian who is eligible for assistance under such title, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

''(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.

''(3) DEFINITIONS.—In this subsection, the terms 'contract health service', 'Indian', 'Indian Tribe', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.''.

(2) CONFORMING AMENDMENT.—Section 1916A (a)(1) of such Act (42 U.S.C. 1396o–

1(a)(1)) is amended by striking ''section 1916(g)'' and inserting ''subsections (g), (i), or (j) of section 1916''.

(b) TREATMENT OF CERTAIN PROPERTY FOR MEDICAID AND SCHIP ELIGIBILITY.—

(1) MEDICAID.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new paragraph:

''(13) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property for purposes of determining the eligibility of an individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act) for medical assistance under this title:

''(A) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

''(B) For any federally recognized Tribe not described in subparagraph (A), property located within the most recent boundaries of a prior Federal reservation.

''(C) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

''(D) Ownership interests in or usage rights to items not covered by subparagraphs (A) through (C) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.''.

(2) APPLICATION TO SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B) through (E), as subparagraphs (C) through (F), respectively; and

(B) by inserting after subparagraph (A), the following new subparagraph:

''(B) Section 1902(e)(13) (relating to disregard of certain property for purposes of making eligibility determinations).''.

(c) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Section 1917(b)(3) of the Social Security Act (42 U.S.C. 1396p(b)(3)) is amended—

(1) by inserting ''(A)'' after ''(3)''; and

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

''(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this title for Indians.''.

SEC. __25. NONDISCRIMINATION IN QUALIFICATIONS FOR PAYMENT FOR SERVICES UNDER FEDERAL HEALTH CARE PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1320b–9), as amended by section __22, is amended by redesignating subsection (c) as subsection (d), and inserting after subsection (b) the following new subsection:

''(c) NONDISCRIMINATION IN QUALIFICATIONS FOR PAYMENT FOR SERVICES UNDER FEDERAL HEALTH CARE PROGRAMS.—

''(1) REQUIREMENT TO SATISFY GENERALLY APPLICABLE PARTICIPATION REQUIREMENTS.—

''(A) IN GENERAL.—A Federal health care program must accept an entity that is operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.

''(B) SATISFACTION OF STATE OR LOCAL LICENSURE OR RECOGNITION REQUIREMENTS.—Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221 of the Indian Health Care Improvement Act, the absence of the licensure of a health care professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

''(2) PROHIBITION ON FEDERAL PAYMENTS TO ENTITIES OR INDIVIDUALS EXCLUDED FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS OR WHOSE STATE LICENSES ARE UNDER SUSPENSION OR HAVE BEEN REVOKED.—

''(A) EXCLUDED ENTITIES.—No entity operated by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization that has been excluded from participation in any Federal health care program or for which a license is under suspension or has been revoked by the State where the entity is located shall be eligible to receive payment under any such program for health care services furnished to an Indian.

''(B) EXCLUDED INDIVIDUALS.—No individual who has been excluded from participation in any Federal health care program or whose State license is under suspension or has been revoked shall be eligible to receive payment under any such program for health care services furnished by that individual, directly or through an entity that is otherwise eligible to receive payment for health care services, to an Indian.

''(C) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this subsection, the term, 'Federal health care program' has the meaning given that term in section 1128B(f), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code.''.

SEC. __26. CONSULTATION ON MEDICAID, SCHIP, AND OTHER HEALTH CARE PROGRAMS FUNDED UNDER THE SOCIAL SECURITY ACT INVOLVING INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.

(a) IN GENERAL.—Section 1139 of the Social Security Act (42 U.S.C. 1320b–9), as amended by sections 202 and 205, is amended by redesignating subsection (d) as subsection (e), and inserting after subsection (c) the following new subsection:

''(d) CONSULTATION WITH TRIBAL TECHNICAL ADVISORY GROUP (TTAG).—The Secretary shall maintain within the Centers for Medicaid & Medicare Services (CMS) a Tribal Technical Advisory Group, established in accordance with requirements of the charter dated September 30, 2003, and in such group shall include a representative of the Service.''.

(b) SOLICITATION OF ADVICE UNDER MEDICAID AND SCHIP.—

(1) MEDICAID STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (69), by striking ''and'' at the end;

(B) in paragraph (70)(B)(iv), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (70)(B)(iv), the following new paragraph:

''(71) in the case of any State in which the Indian Health Service operates or funds health care programs, or in which 1 or more Indian Health Programs or Urban Indian Organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act) provide health care in the State for which medical assistance is available under such title, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

''(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

''(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title.''.

(2) APPLICATION TO SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by section __24(b)(2), is amended—

(A) by redesignating subparagraphs (B) through (F) as subparagraphs (C) through (G), respectively; and

(B) by inserting after subparagraph (A), the following new subparagraph:

''(B) Section 1902(a)(71) (relating to the option of certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).''.

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians.

SEC. __27. EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS AND SAFE HARBOR TRANSACTIONS UNDER THE SOCIAL SECURITY ACT.

(a) EXCLUSION WAIVER AUTHORITY.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended by adding at the end the following new subsection:

''(k) ADDITIONAL EXCLUSION WAIVER AUTHORITY FOR AFFECTED INDIAN HEALTH PROGRAMS.—In addition to the authority granted the Secretary under subsections (c)(3)(B) and (d)(3)(B) to waive an exclusion under subsection (a)(1), (a)(3), (a)(4), or (b), the Secretary may, in the case of an Indian Health Program, waive such an exclusion upon the

request of the administrator of an affected Indian Health Program (as defined in section 4 of the Indian Health Care Improvement Act) who determines that the exclusion would impose a hardship on individuals entitled to benefits under or enrolled in a Federal health care program.''.

(b) CERTAIN TRANSACTIONS INVOLVING INDIAN HEALTH CARE PROGRAMS DEEMED TO BE IN SAFE HARBORS.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) Subject to such conditions as the Secretary may promulgate from time to time as necessary to prevent fraud and abuse, for purposes of paragraphs (1) and (2) and section 1128A(a), the following transfers shall not be treated as remuneration:

''(A) TRANSFERS BETWEEN INDIAN HEALTH PROGRAMS, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.—Transfers of anything of value between or among an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, that are made for the purpose of providing necessary health care items and services to any patient served by such Program, Tribe, or Organization and that consist of—

''(i) services in connection with the collection, transport, analysis, or interpretation of diagnostic specimens or test data;

''(ii) inventory or supplies;

''(iii) staff; or

''(iv) a waiver of all or part of premiums or cost sharing.

''(B) TRANSFERS BETWEEN INDIAN HEALTH PROGRAMS, INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS AND PATIENTS.—Transfers of anything of value between an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization and any patient served or eligible for service from an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, including any patient served or eligible for service pursuant to section 807 of the Indian Health Care Improvement Act, but only if such transfers—

''(i) consist of expenditures related to providing transportation for the patient for the provision of necessary health care items or services, provided that the provision of such transportation is not advertised, nor an incentive of which the value is disproportionately large in relationship to the value of the health care item or service (with respect to the value of the item or service itself or, for preventative items or services, the future health care costs reasonably expected to be avoided);

''(ii) consist of expenditures related to providing housing to the patient (including a pregnant patient) and immediate family members or an escort necessary to assuring the timely provision of health care items and services to the patient, provided that the provision of such housing is not advertised nor an incentive of which the value is disproportionately large in relationship to the value of the health care item or service (with respect to the value of the item or service itself or, for preventative items or services, the future health care costs reasonably expected to be avoided); or

''(iii) are for the purpose of paying premiums or cost sharing on behalf of such a patient, provided that the making of such payment is not subject to conditions other than conditions agreed to under a contract for the delivery of contract health services.

''(C) CONTRACT HEALTH SERVICES.—A transfer of anything of value negotiated as part of a contract entered into between an Indian Health Program, Indian Tribe, Tribal Organization, Urban Indian Organization, or the Indian Health Service and a contract care provider for the delivery of contract health services authorized by the Indian Health Service, provided that—

''(i) such a transfer is not tied to volume or value of referrals or other business generated by the parties; and

''(ii) any such transfer is limited to the fair market value of the health care items or services provided or, in the case of a transfer of items or services related to preventative care, the value of the future health care costs reasonably expected to be avoided.

''(D) OTHER TRANSFERS.—Any other transfer of anything of value involving an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, or a patient served or eligible for service from an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, that the Secretary, in consultation with the Attorney General, determines is appropriate, taking into account the special circumstances of such Indian Health Programs, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, and of patients served by such Programs, Tribes, and Organizations.''.

SEC. __28. RULES APPLICABLE UNDER MEDICAID AND SCHIP TO MANAGED CARE ENTITIES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS AND INDIAN MANAGED CARE ENTITIES.

(a) IN GENERAL.—Section 1932 of the Social Security Act (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

''(h) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—

''(1) ENROLLEE OPTION TO SELECT AN INDIAN HEALTH CARE PROVIDER AS PRIMARY CARE PROVIDER.—In the case of a non-Indian Medicaid managed care entity that—

''(A) has an Indian enrolled with the entity; and

''(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1903(m) or under section 1905(t)(3) shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

''(2) ASSURANCE OF PAYMENT TO INDIAN HEALTH CARE PROVIDERS FOR PROVISION OF COVERED SERVICES.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require any such entity that has a significant percentage of Indian enrollees (as determined by the Secretary), as a condition of receiving payment under such contract to satisfy the following requirements:

''(A) DEMONSTRATION OF PARTICIPATING INDIAN HEALTH CARE PROVIDERS OR APPLICATION OF ALTERNATIVE PAYMENT ARRANGEMENTS.—Subject to subparagraph (E), to—

''(i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those enrollees who are eligible to receive services from such providers; or

''(ii) agree to pay Indian health care providers who are not participating providers with the entity for covered Medicaid managed care services provided to those enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

''(B) PROMPT PAYMENT.—To agree to make prompt payment (in accordance with rules applicable to managed care entities) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (E) applies, that the entity is required to pay in accordance with that subparagraph.

''(C) SATISFACTION OF CLAIM REQUIREMENT.—To deem any requirement for the submission of a claim or other documentation for services covered under subparagraph (A) by the enrollee to be satisfied through the submission of a claim or other documentation by an Indian health care provider that is consistent with section 403(h) of the Indian Health Care Improvement Act.

''(D) COMPLIANCE WITH GENERALLY APPLICABLE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), as a condition of payment under subparagraph (A), an Indian health care provider shall comply with the generally applicable requirements of this title, the State plan, and such entity with respect to covered Medicaid managed care services provided by the Indian health care provider to the same extent that non-Indian providers participating with the entity must comply with such requirements.

''(ii) LIMITATIONS ON COMPLIANCE WITH MANAGED CARE ENTITY GENERALLY APPLICABLE REQUIREMENTS.—An Indian health care provider—

''(I) shall not be required to comply with a generally applicable requirement of a managed care entity described in clause (i) as a condition of payment under subparagraph (A) if such compliance would conflict with any other statutory or regulatory requirements applicable to the Indian health care provider; and

''(II) shall only need to comply with those generally applicable requirements of a managed care entity described in clause (i) as a condition of payment under subparagraph (A) that are necessary for the entity's compliance with the State plan, such as those related to care management, quality assurance, and utilization management.

''(E) APPLICATION OF SPECIAL PAYMENT REQUIREMENTS FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND ENCOUNTER RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—

''(i) FEDERALLY-QUALIFIED HEALTH CENTERS.—

''(I) MANAGED CARE ENTITY PAYMENT REQUIREMENT.—To agree to pay any Indian health care provider that is a Federally-qualified health center but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a Federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

''(II) CONTINUED APPLICATION OF STATE REQUIREMENT TO MAKE SUPPLEMENTAL PAYMENT.—Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1902(bb)(5) regarding the State plan requirement to make any supplemental payment due under such section to a Federally-qualified health center for services furnished by such center

to an enrollee of a managed care entity (regardless of whether the Federally-qualified health center is or is not a participating provider with the entity).

''(ii) CONTINUED APPLICATION OF ENCOUNTER RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—If the amount paid by a managed care entity to an Indian health care provider that is not a Federally-qualified health center and that has elected to receive payment under this title as an Indian Health Service provider under the July 11, 1996, Memorandum of Agreement between the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) and the Indian Health Service for services provided by such provider to an Indian enrollee with the managed care entity is less than the encounter rate that applies to the provision of such services under such memorandum, the State plan shall provide for payment to the Indian health care provider of the difference between the applicable encounter rate under such memorandum and the amount paid by the managed care entity to the provider for such services.

''(F) CONSTRUCTION.—Nothing in this paragraph shall be construed as waiving the application of section 1902(a)(30)(A) (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

''(3) OFFERING OF MANAGED CARE THROUGH INDIAN MEDICAID MANAGED CARE ENTITIES.—If—

''(A) a State elects to provide services through Medicaid managed care entities under its Medicaid managed care program; and

''(B) an Indian health care provider that is funded in whole or in part by the Indian Health Service, or a consortium composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Indian Health Service, has established an Indian Medicaid managed care entity in the State that meets generally applicable standards required of such an entity under such Medicaid managed care program,

the State shall offer to enter into an agreement with the entity to serve as a Medicaid managed care entity with respect to eligible Indians served by such entity under such program.

''(4) SPECIAL RULES FOR INDIAN MANAGED CARE ENTITIES.—The following are special rules regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities:

''(A) ENROLLMENT.—

''(i) LIMITATION TO INDIANS.—An Indian Medicaid managed care entity may restrict enrollment under such program to Indians and to members of specific Tribes in the same manner as Indian Health Programs may restrict the delivery of services to such Indians and tribal members.

''(ii) NO LESS CHOICE OF PLANS.—Under such program the State may not limit the choice of an Indian among Medicaid managed care entities only to Indian Medicaid managed care entities or to be more restrictive than the choice of managed care entities offered to individuals who are not Indians.

''(iii) DEFAULT ENROLLMENT.—

''(I) IN GENERAL.—If such program of a State requires the enrollment of Indians in a Medicaid managed care entity in order to receive benefits, the State, taking into consideration the criteria specified in subsection (a)(4)(D)(ii)(I), shall provide for the enrollment of Indians described in subclause (II) who are not otherwise enrolled with such an entity in an Indian Medicaid managed care entity described in such clause.

''(II) INDIAN DESCRIBED.—An Indian described in this subclause, with respect to an Indian Medicaid managed care entity, is an Indian who, based upon the service area and capacity of the entity, is eligible to be enrolled with the entity consistent with subparagraph (A).

''(iv) EXCEPTION TO STATE LOCK-IN.—A request by an Indian who is enrolled under such program with a non-Indian Medicaid managed care entity to change enrollment with that entity to enrollment with an Indian Medicaid managed care entity shall be considered cause for granting such request under procedures specified by the Secretary.

''(B) FLEXIBILITY IN APPLICATION OF SOLVENCY.—In applying section 1903(m)(1) to an Indian Medicaid managed care entity—

''(i) any reference to a 'State' in subparagraph (A)(ii) of that section shall be deemed to be a reference to the 'Secretary'; and

''(ii) the entity shall be deemed to be a public entity described in subparagraph (C)(ii) of that section.

''(C) EXCEPTIONS TO ADVANCE DIRECTIVES.—The Secretary may modify or waive the requirements of section 1902(w) (relating to provision of written materials on advance directives) insofar as the Secretary finds that the requirements otherwise imposed are not an appropriate or effective way of communicating the information to Indians.

''(D) FLEXIBILITY IN INFORMATION AND MARKETING.—

''(i) MATERIALS.—The Secretary may modify requirements under subsection (a)(5) to ensure that information described in that subsection is provided to enrollees and potential enrollees of Indian Medicaid managed care entities in a culturally appropriate and understandable manner that clearly communicates to such enrollees and potential enrollees their rights, protections, and benefits.

''(ii) DISTRIBUTION OF MARKETING MATERIALS.—The provisions of subsection (d)(2)(B) requiring the distribution of marketing materials to an entire service area shall be deemed satisfied in the case of an Indian Medicaid managed care entity that distributes appropriate materials only to those Indians who are potentially eligible to enroll with the entity in the service area.

''(5) MALPRACTICE INSURANCE.—Insofar as, under a Medicaid managed care program, a health care provider is required to have medical malpractice insurance coverage as a condition of contracting as a provider with a Medicaid managed care entity, an Indian health care provider that is—

''(A) a Federally-qualified health center that is covered under the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.);

''(B) providing health care services pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) that are covered under the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.); or

''(C) the Indian Health Service providing health care services that are covered under the Federal Tort Claims Act (28 U.S.C. 1346(b), 2671 et seq.);

are deemed to satisfy such requirement.

''(6) DEFINITIONS.—For purposes of this subsection:

''(A) INDIAN HEALTH CARE PROVIDER.—The term 'Indian health care provider' means an Indian Health Program or an Urban Indian Organization.

''(B) INDIAN; INDIAN HEALTH PROGRAM; SERVICE; TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian Health Program', 'Service', 'Tribe', 'tribal organization', 'Urban Indian Organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.

''(C) INDIAN MEDICAID MANAGED CARE ENTITY.—The term 'Indian Medicaid managed care entity' means a managed care entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C)) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

''(D) NON-INDIAN MEDICAID MANAGED CARE ENTITY.—The term 'non-Indian Medicaid managed care entity' means a managed care entity that is not an Indian Medicaid managed care entity.

''(E) COVERED MEDICAID MANAGED CARE SERVICES.—The term 'covered Medicaid managed care services' means, with respect to an individual enrolled with a managed care entity, items and services that are within the scope of items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

''(F) MEDICAID MANAGED CARE PROGRAM.—The term 'Medicaid managed care program' means a program under sections 1903(m) and 1932 and includes a managed care program operating under a waiver under section 1915(b) or 1115 or otherwise.''.

(b) APPLICATION TO SCHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by section __26(b)(2), is amended by adding at the end the following new subparagraph:

''(H) Subsections (a)(2)(C) and (h) of section 1932.''.

SEC. __29. 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 202, 205, and 206, 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, 2008, 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 section 1880(b), 1911(b) or otherwise) toward the achievement and maintenance of such compliance.

''(5) Such other information as the Secretary determines is appropriate.''.

SA 2535. Mr. ALLARD submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. TREATMENT OF UNBORN CHILDREN.

(a) CODIFICATION OF CURRENT REGULATIONS.—Section 2110(c)(1) (42 U.S.C. 1397jj(c)(1)) is amended by striking the period at the end and inserting the following: '', and includes, at the option of a State, an unborn child. For purposes of the previous sentence, the term 'unborn child' means a member of the species Homo sapiens, at any stage of development, who is carried in the womb.''.

(b) CLARIFICATIONS REGARDING COVERAGE OF MOTHERS.—Section 2103 (42 U.S.C. 1397cc) is amended by adding at the end the following new subsection:

''(g) CLARIFICATIONS REGARDING AUTHORITY TO PROVIDE POSTPARTUM SERVICES AND MATERNAL HEALTH CARE.—Any State that provides child health assistance to an unborn child under the option described in section 2110(c)(1) may—

''(1) continue to provide such assistance to the mother, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends; and

''(2) in the interest of the child to be born, have flexibility in defining and providing services to benefit either the mother or unborn child consistent with the health of both.''.

SA 2536. Mr. ALLARD submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

At the end of title I, add the following:

SEC. ___. STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.

(a) ELIGIBILITY BASED ON GROSS INCOME.—

(1) IN GENERAL.—Section 2110 (42 U.S.C. 1397jj) is amended by adding at the end the following new subsection:

''(d) STANDARDIZATION OF DETERMINATION OF FAMILY INCOME.—A State shall determine family income for purposes of determining income eligibility for child health assistance or other health benefits coverage under the State child health plan (or under a waiver of such plan under section 1115) solely on the basis of the gross income (as defined by the Secretary) of the family.''.

(2) PROHIBITION ON WAIVER OF REQUIREMENTS.—Section 2107(f) (42 U.S.C. 1397gg(f)), as amended by section 106(a)(2)(A), is amended by adding at the end the following new paragraph:

''(3) The Secretary may not approve a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2110(d) (relating to determining income eligibility on the basis of gross income) and regulations promulgated to carry out such requirements.''.

(b) REGULATIONS.—Not later than 90 days after the date of enactment of this Act, the Secretary shall promulgate interim final regulations defining gross income for purposes of section 2110(d) of the Social Security Act, as added by subsection (a)(1).

(c) APPLICATION TO CURRENT ENROLLEES.—The interim final regulations promulgated under subsection (b) shall not be used to determine the income eligibility of any individual enrolled in a State child health plan under title XXI of the Social Security Act on the date of enactment of this Act before the date on which such eligibility of the individual is required to be redetermined under the plan as in effect on such date. In the case of any individual enrolled in such plan on such date who, solely as a result of the application of subsection (d) of section 2110 of the Social Security Act (as added by subsection (a)(1))) and the regulations promulgated under subsection (b), is determined to be ineligible for child health assistance under the State child health plan, a State may elect, subject to substitution of the Federal medical assistance percentage for the enhanced FMAP under section 2105(a)(1) of the Social Security Act, to continue to provide the individual with such assistance for so long as the individual otherwise would be eligible for such assistance and the individual's family income, if determined under the income and resource standards and methodologies applicable under the State child health plan on September 30, 2007, would not exceed the income eligibility level applicable to the individual under the State child health plan.

SA 2537. Mr. KYL submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

SEC. ___. DELAY IN EFFECTIVE DATE.

Notwithstanding any other provision of this Act, this Act and the amendments made by this Act shall not take effect until the day after the date on which the Director of the Congressional Budget Office certifies that this Act and the amendments made by the Act, will not result in a reduction of private health insurance coverage greater than 20 percent.

SA 2538. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. __. DISEASE PREVENTION AND TREATMENT RESEARCH TRUST FUND.

(a) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

''SEC. 9511. DISEASE PREVENTION AND TREATMENT 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 'Disease Prevention and Treatment Research Trust Fund', consisting of such amounts as may be appropriated or credited to the Disease Prevention and Treatment Research Trust Fund.

''(b) TRANSFER TO DISEASE PREVENTION AND TREATMENT RESEARCH TRUST FUND OF AMOUNTS EQUIVALENT TO CERTAIN TAXES.—There are hereby appropriated to the Disease Prevention and Treatment Research Trust Fund amounts equivalent to the taxes received in the Treasury attributable to the amendments made by section 701 of the Children's Health Insurance Program Reauthorization Act of 2007.

''(c) EXPENDITURES FROM TRUST FUND.—

''(1) IN GENERAL.—Amounts in the Disease Prevention and Treatment Research Trust Fund shall be available, as provided by appropriation Acts, for the purposes of funding the disease prevention and treatment research activities of the National Institutes of Health. Amounts appropriated from the Disease Prevention and Treatment Research Trust Fund shall be in addition to any other funds provided by appropriation Acts for the National Institutes of Health.

''(2) DISEASE PREVENTION AND TREATMENT RESEARCH ACTIVITIES.—Disease prevention and treatment research activities shall include activities relating to:

''(A) CANCER.—Disease prevention and treatment research in this category shall include activities relating to pediatric, lung, breast, ovarian, uterine, prostate, colon, rectal, oral, skin, bone, kidney, liver, stomach, bladder, thyroid, pancreatic, brain and nervous system, and blood-related cancers, including leukemia and lymphoma. Priority in this category shall be given to disease prevention and treatment research into pediatric cancers.

''(B) RESPIRATORY DISEASES.—Disease prevention and treatment research in this category shall include activities relating to chronic obstructive pulmonary disease, tuberculosis, bronchitis, asthma, and emphysema.

''(C) CARDIOVASCULAR DISEASES.—Disease prevention and treatment research in this category shall include activities relating to peripheral arterial disease, heart disease, valve disease, stroke, and hypertension.

''(D) OTHER DISEASES, CONDITIONS, AND DISORDERS.—Disease prevention and treatment research in this category shall include activities relating to autism, diabetes (including type I diabetes, also known as juvenile diabetes, and type II diabetes), muscular dystrophy, Alzheimer's disease, Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis, cerebral palsy, cystic fibrosis, spinal muscular atrophy, osteoporosis, human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), depression and other mental health disorders, infertility, arthritis, anaphylaxis, lymphedema, psoriasis, eczema, lupus, cleft lip and palate, fibromyalgia, chronic fatigue and immune dysfunction syndrome, alopecia areata, and sepsis.''.

(b) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9511. Disease Prevention and Treatment Research Trust Fund.''.

SA 2539. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 106 and insert the following:

SEC. 106. ELIMINATION OF COVERAGE FOR NONPREGNANT ADULTS.

(a) ELIMINATION OF COVERAGE.—Title XXI (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following new section:

"SEC. 2111. ELIMINATION OF COVERAGE FOR NONPREGNANT ADULTS.

''(a) NO COVERAGE FOR NONPREGNANT CHILDLESS ADULTS AND NONPREGNANT PARENTS.—

''(1) TERMINATION OF COVERAGE UNDER APPLICABLE EXISTING WAIVERS.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided for any other adult other than a pregnant woman after September 30, 2007.

''(2) NO NEW WAIVERS.—Notwithstanding section 1115 or any other provision of this title the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for any other adult other than a pregnant woman.

''(b) INCREASED OUTREACH AND COVERAGE OF LOW-INCOME CHILDREN.—A State that, but for the application of subsections (a) and (b), would have expended funds for child health assistance or other health benefits coverage for an adult other than a pregnant woman after fiscal year 2007 shall use the funds that would have been expended for such assistance or coverage to conduct outreach to, and provide child health assistance for, low-income children who are eligible for such assistance under the State child health plan.

''(c) NONAPPLICATION.—Beginning with fiscal year 2008, this title shall be applied without regard to any provision of this title that would be contrary to the prohibition on providing child health assistance or health benefits coverage for an adult other than a pregnant woman established under this section.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 2107(f) (42 U.S.C. 1397gg(f)) is amended—

(A) by striking '', the Secretary'' and inserting '':

''(1) The Secretary'';

(B) in the first sentence, by inserting ''or a nonpregnant parent (as defined in section 2111(d)(2)) of a targeted low-income child'' before the period;

(C) by striking the second sentence; and

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

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2111.''.

(2) Section 6102(c) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 131) is amended by striking ''Nothing'' and inserting ''Subject to section 2111 of the Social Security Act, as added by section 106(a)(1) of the Children's Health Insurance Program Reauthorization Act of 2007, nothing''.

SA 2540. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 58, between lines 16 and 17, insert the following:

''(d) COVER KIDS FIRST IMPLEMENTATION REQUIREMENT.—Notwithstanding the preceding subsections of this section, no funds shall be available under this title for child health assistance or other health benefits coverage that is provided for any other adult other than a pregnant woman, and this title shall be applied with respect to a State without regard to such subsections, for each fiscal year quarter that begins prior to the date on which the State demonstrates to the Secretary that the State has enrolled in the State child health plan at least 95 percent of the targeted low-income children who reside in the State.''.

SA 2541. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, add the following:

SEC. 112. COVER LOW-INCOME KIDS FIRST.

Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 602, is amended by adding at the end the following new paragraph:

''(12) NO PAYMENTS FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE OR HEALTH BENEFITS COVERAGE FOR INDIVIDUALS WHOSE GROSS FAMILY INCOME EXCEEDS 200 PERCENT OF THE POVERTY LINE UNLESS AT LEAST 95 PERCENT OF ELIGIBLE LOW-INCOME CHILDREN ENROLLED.—Notwithstanding any other provision of this title, for fiscal years beginning with fiscal year 2008, no payments shall be made to a State under subsection (a)(1), or any other provision of this title, for any fiscal year quarter that begins prior to the date on which the State demonstrates to the Secretary that the State has enrolled in the State child health plan at least 95 percent of the low-income children who reside in the State and are eligible for child health assistance under this State child health plan with respect to any expenditures for providing child health assistance or health benefits coverage for any individual whose gross family income exceeds 200 percent of the poverty line.''.

SA 2542. Mr. ENSIGN submitted an amendment intended to be proposed to the amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, add the following:

SEC. 112. REMOVING THE INCENTIVE TO COVER CHILDREN AT HIGHER INCOME LEVELS RATHER THAN LOWER INCOME LEVELS.

(a) ELIMINATION OF ENHANCED FMAP.—Section 2105 (42 U.S.C. 1397ee) is amended—

(1) in subsection (a)(1), in the matter preceding subparagraph (A), by striking ''enhanced FMAP (or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)))'' and inserting ''Federal medical assistance percentage'';

(2) in subparagraph (A), by striking ''on the basis of an enhanced FMAP'';

(3) by striking subsection (b) and inserting the following:

''(b) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' has the meaning given such term in the first sentence of section 1905(b).'';

(4) in subsection (d)(B)(ii), by striking ''an enhanced FMAP'' and inserting ''payments''; and

(5) in subsection (g)(1)(B)(i), by striking ''the additional amount'' and all that follows through the period and inserting ''the Federal medical assistance percentage with respect to expenditures described in clause (ii).''.

(b) CONFORMING AMENDMENTS TO TITLE XIX.—Section 1905 (42 U.S.C. 1396d)) is amended—

(1) in subsection (b)—

(A) in the first sentence by striking ''and (4)'' and all that follows up to the period;

(B) in the last sentence—

(i) by inserting ''the Federal medical assistance percentage shall apply only'' after ''Notwithstanding the first sentence of this subsection,''; and

(ii) by striking ''section 2104'' and all that follows through the period and inserting ''section 2104.''; and

(2) in subsection (u)(4), by striking ''an enhanced FMAP described in section 2105(b)'' and inserting ''this subsection''.

(c) CONFORMING AMENDMENTS TO TITLE XXI AND THE AMENDMENTS MADE BY OTHER PROVISIONS OF THIS ACT.—

(1) Subsections (a)(2) and (b)(1) of section 2111, as added by section 106(a), are each amended by striking subparagraph (C).

(2) Section 2111(b)(2)(B), as so added, is amended—

(A) in clause (ii), by striking ''applicable percentage determined under clause (iii) or (iv) for'' and inserting ''Federal medical assistance percentage of'';

(B) by striking clauses (iii) and (iv); and

(C) by redesignating clauses (v) and (vi) as clauses (iii) and (iv), respectively.

(3) This Act shall be applied without regard to the amendment to section 2105(c) made by section 110.

(4) Section 2105(g)(4)(A), as added by section 111, is amended by striking ''the additional amount'' and all that follows through the period and inserting ''the Federal medical assistance percentage with respect to expenditures described in subparagraph (B).''.

(5) The amendment made by paragraph (1) of section 201(b) of this Act is amended to read as follows:

''(1) in the matter preceding subparagraph (A) (as amended by section 112(a)(1)(A)), by inserting '(or, in the case of expenditures described in subparagraph (D)(iv), 75 percent)' after 'Federal medical assistance percentage'; and''.

(6) Section 2105(c)(9), as added by section 301(c)(1), is amended by striking ''enhanced FMAP'' and inserting ''Federal medical assistance percentage''.

(7) Section 601(a)(2) of this Act is amended by striking '', rather than on the basis of an enhanced FMAP (as defined in section 2105(b) of such Act)''.

(8) Section 2105(c)(11), as added by section 602(a)(1), is amended by striking ''enhanced FMAP'' and inserting ''Federal medical assistance percentage''.

SA 2543. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other

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

At the end of title VI, add the following:

SEC. 610. PERSONAL EMPOWERMENT THROUGH INDIVIDUAL RESPONSIBILITY.

Section 2103(e) (42 U.S.C. 1397cc(e)) is amended by adding at the end the following new paragraph:

''(5) PERSONAL EMPOWERMENT THROUGH INDIVIDUAL RESPONSIBILITY.—Notwithstanding the preceding provisions of this subsection or any other provision of this title, for fiscal years beginning with fiscal year 2008, a State shall not be considered to have an approved State child health plan unless the State has submitted a State plan amendment to the Secretary specifying how the State will impose premiums, deductibles, coinsurance, and other cost-sharing under the State child health plan (regardless of whether such plan is implemented under this title, title XIX, or both) for populations of individuals whose family income exceeds the effective income eligibility level applicable under the State child health plan for that population on the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, in a manner that is consistent with the authority and limitations for imposed cost-sharing under section 1916A.''.

SA 2544. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 134, strike line 23 and all that follows through page 135, line 10, and insert the following:

(ii) INCLUSION OF HIGH DEDUCTIBLE HEALTH PLANS; EXCLUSION OF FLEXIBLE SPENDING ARRANGEMENTS.—Such term—

(I) includes coverage consisting of a high deductible health plan (as defined in section 223(c)(2) of such Code) purchased in conjunction with a health savings account (as defined under section 223(d) of such Code); but

(II) does not include coverage consisting of benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986).

SA 2545. Mr. ENSIGN (for himself and Mr. DEMINT) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. __. USE OF HEALTH SAVINGS ACCOUNTS FOR NON-GROUP HIGH DEDUCTIBLE HEALTH PLAN PREMIUMS.

(a) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 (relating to exceptions) 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 new clause:

''(v) a high deductible health plan, other than a group health plan (as defined in section 5000(b)(1)).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2007.

SA 2546. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, add the following:

SEC. _____. REPEAL OF EXCISE TAX ON TELEPHONE AND OTHER COMMUNICATIONS SERVICES.

(a) IN GENERAL.—Chapter 33 of the Internal Revenue Code of 1986 (relating to facilities and services) is amended by striking subchapter B.

(b) CONFORMING AMENDMENTS.—

(1) Section 4293 of such Code is amended by striking ''chapter 32 (other than the taxes imposed by sections 4064 and 4121) and subchapter B of chapter 33,'' and inserting ''and chapter 32 (other than the taxes imposed by sections 4064 and 4121),''.

(2)(A) Paragraph (1) of section 6302(e) of such Code is amended by striking ''section 4251 or''.

(B) Paragraph (2) of section 6302(e) of such Code is amended—

(i) by striking ''imposed by—'' and all that follows through ''with respect to'' and inserting ''imposed by section 4261 or 4271 with respect to'', and

(ii) by striking ''bills rendered or''.

(C) The subsection heading for section 6302(e) of such Code is amended by striking ''Communications Services and''.

(3) Section 6415 of such Code is amended by striking ''4251, 4261, or 4271'' each place it appears and inserting ''4261 or 4271''.

(4) Paragraph (2) of section 7871(a) of such Code is amended by inserting ''or'' at the end of subparagraph (B), by striking subparagraph (C), and by redesignating subparagraph (D) as subparagraph (C).

(5) The table of subchapters for chapter 33 of such Code is amended by striking the item relating to subchapter B.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid pursuant to bills first rendered more than 90 days after the date of the enactment of this Act.

SA 2547. Mr. BUNNING submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

Beginning on page 79, strike line 21 and all that follows through page 81, line 6, and insert the following:

(a) FMAP APPLIED TO EXPENDITURES.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATION ON MATCHING RATE FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE PROVIDED TO CHILDREN WHOSE EFFECTIVE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—For fiscal years beginning with fiscal year 2008, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

(c) APPLICATION OF SAVINGS TO GRANTS FOR OUTREACH AND ENROLLMENT.—

(1) IN GENERAL.—Notwithstanding the dollar amount specified in section 2113(g) of the Social Security Act, as added by section 201(a), the dollar amount specified in such section shall be increased by the amount appropriated under paragraph (2).

(2) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated such amount as the Secretary determines is equal to the amount of additional Federal expenditures for the period of fiscal years 2008 through 2012 that would have been made if the enhanced FMAP (as defined in section 2105(b) of the Social Security Act) applied to expenditures for providing child health assistance to targeted low-income children residing in a State that, on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, has an approved State plan amendment or waiver to provide, or has enacted a State law to submit a State plan amendment to provide, expenditures described in section 2105(c)(8) of such Act (as added by subsection (a)). The preceding sentence constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of such amount to States awarded grants under section 2113 of the Social Security Act.

SA 2548. Mr. BURR (for himself, Mr. CORKER, Mr. COBURN, Mr. MARTINEZ, and Mrs. DOLE) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other puuposes; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE ____—EVERY AMERICAN HEALTH INSURED

Subtitle A—Refundable and Advanceable Credit for Certain Health Insurance Coverage

SEC. ___00. REFERENCE.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. ___01. REFUNDABLE AND ADVANCEABLE CREDIT FOR CERTAIN HEALTH INSURANCE COVERAGE.

(a) ADVANCEABLE CREDIT.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by adding at the end the following new section:

''SEC. 25E. QUALIFIED HEALTH INSURANCE CREDIT.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a

credit against the tax imposed by this chapter for the taxable year the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer's spouse and dependents.

''(b) MONTHLY LIMITATION.—

''(1) IN GENERAL.—The monthly limitation for each month during the taxable year for an eligible individual is 1/12th of—

''(A) the applicable adult amount, in the case that the eligible individual is the taxpayer or the taxpayer's spouse,

''(B) the applicable adult amount, in the case that the eligible individual is an adult dependent, and

''(C) the applicable child amount, in the case that the eligible individual is a child dependent.

''(2) LIMITATION ON AGGREGATE AMOUNT.—Notwithstanding paragraph (1), the aggregate monthly limitations for the taxpayer and the taxpayer's spouse and dependents for any month shall not exceed 1/12th of the applicable aggregate amount.

''(3) APPLICABLE AMOUNT.—For purposes of this section—

''Calendar year	Applicable adult amount	Applicable child amount	Applicable aggregate amount
2009	$2,160	$1,620	$5,400
2010	$2,220	$1,670	$5,550
2011	$2,290	$1,710	$5,710
2012	$2,350	$1,760	$5,880
2013	$2,420	$1,810	$6,050
2014	$2,490	$1,870	$6,220
2015	$2,560	$1,920	$6,400
2016	$2,640	$1,980	$6,590
2017	$2,710	$2,030	$6,780

''(4) NO CREDIT FOR INELIGIBLE MONTHS.—With respect to any individual, the monthly limitation shall be zero for any month for which such individual is not an eligible individual.

''(c) LIMITATION BASED ON AMOUNT OF TAX.—In the case of a taxable year to which section 26(a)(2) does not apply, the credit allowed under subsection (a) for the taxable year shall not exceed the excess of—

''(1) the sum of the regular tax liability (as defined in section 26(b)) plus the tax imposed by section 55, over

''(2) the sum of the credits allowable under this subpart (other than this section) and section 27 for the taxable year.

''(d) EXCESS CREDIT REFUNDABLE TO CERTAIN TAX-FAVORED ACCOUNTS.—If—

''(1) the credit which would be allowable under subsection (a) if only qualified refund eligible health insurance were taken into account under this section, exceeds

''(2) the limitation imposed by section 26 or subsection (c) for the taxable year,

such excess shall be paid by the Secretary into the designated account of the taxpayer.

''(e) ELIGIBLE INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible individual' means, with respect to any month, an individual who—

''(A) is the taxpayer, the taxpayer's spouse, or the taxpayer's dependent, and

''(B) is covered under qualified health insurance as of the 1st day of such month.

''(2) COVERAGE UNDER MEDICARE, MEDICAID, SCHIP, MILITARY COVERAGE.—The term 'eligible individual' shall not include any individual who for any month is—

''(A) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, and the individual is not a participant or beneficiary in a group health plan or large group health plan that is a primary plan (as defined in section 1862(b)(2)(A) of such Act),

''(B) enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act), or

''(C) entitled to benefits under chapter 55 of title 10, United States Code, including under the TRICARE program (as defined in section 1072(7) of such title).

''(3) IDENTIFICATION REQUIREMENTS.—The term 'eligible individual' shall not include any individual for any month unless the policy number associated with the qualified health insurance and the TIN of each eligible individual covered under such health insurance for such month are included on the return of tax for the taxable year in which such month occurs.

''(4) PRISONERS.—The term 'eligible individual' shall not include any individual for a month if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

''(5) ALIENS.—The term 'eligible individual' shall not include any alien individual who is not a lawful permanent resident of the United States.

''(f) HEALTH INSURANCE.—For purposes of this section—

''(1) QUALIFIED HEALTH INSURANCE.—The term 'qualified health insurance' means any insurance constituting medical care which (as determined under regulations prescribed by the Secretary)—

''(A) has a reasonable annual and lifetime benefit maximum, and

''(B) provides coverage for inpatient and outpatient care, emergency benefits, and physician care.

Such term does not include any insurance substantially all of the coverage of which is coverage described in section 223(c)(1)(B).

''(2) QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.—The term 'qualified refund eligible health insurance' means any qualified health insurance which is—

''(A) coverage under a group health plan (as defined in section 5000(b)(1)), or

''(B) coverage offered in a State which has been deemed by the Secretary of Health and Human Services to meet the refundability requirements of section 2201 of the Social Security Act.

''(g) DESIGNATED ACCOUNTS.—

''(1) DESIGNATED ACCOUNT.—For purposes of this section, the term 'designated account' means any specified account established and maintained by the provider of the taxpayer's qualified refund eligible health insurance—

''(A) which is designated by the taxpayer (in such form and manner as the Secretary may provide) on the return of tax for the taxable year, and

''(B) which, under the terms of the account, accepts the payment described in subparagraph (A) on behalf of the taxpayer.

''(2) SPECIFIED ACCOUNT.—For purposes of this paragraph, the term 'specified account' means—

''(A) any health savings account under section 223 or Archer MSA under section 220, or

''(B) any health insurance reserve account.

''(3) HEALTH INSURANCE RESERVE ACCOUNT.—For purposes of this subsection, the term 'health insurance reserve account' means a trust created or organized in the United States as a health insurance reserve account exclusively for the purpose of paying the qualified medical expenses (within the meaning of section 223(d)(2)) of the account beneficiary (as defined in section 223(d)(3)), but only if the written governing instrument creating the trust meets the requirements described in subparagraphs (B), (C), (D), and (E) of section 223(d)(1). Rules similar to the rules under subsections (g) and (h) of section 408 shall apply for purposes of this subparagraph.

''(4) TREATMENT OF PAYMENT.—Any payment under subsection (d) to a designated account shall—

''(A) not be taken into account with respect to any dollar limitation which applies with respect to contributions to such account (or to tax benefits with respect to such contributions),

''(B) be includible in the gross income of the taxpayer for the taxable year in which the payment is made (except as provided in subparagraph (C)), and

''(C) be taken into account in determining any deduction or exclusion from gross income in the same manner as if such contribution were made by the taxpayer.

''(h) OTHER DEFINITIONS.—For purposes of this section—

''(1) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof). An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the custodial parent for a coverage month unless the custodial and noncustodial parent provide otherwise.

''(2) ADULT.—The term 'adult' means an individual who is not a child.

''(3) CHILD.—The term 'child' means a qualifying child (as defined in section 152(c).

''(i) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a credit under section 35 or as a deduction under section 213(a).

''(2) MEDICAL AND HEALTH SAVINGS ACCOUNTS.—The credit allowed under subsection (a) for any taxable year shall be reduced by the aggregate amount distributed from Archer MSAs (as defined in section 220(d)) and health savings accounts (as defined in section 223(d)) which are excludable from gross income for such taxable years by reason of being used to pay premiums for coverage of an eligible individual under qualified health insurance for any month.

''(3) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(4) MARRIED COUPLES MUST FILE JOINT RETURN.—

''(A) IN GENERAL.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and his spouse file a joint return for the taxable year.

''(B) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this paragraph.

''(5) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section with respect to any individual unless such individual's coverage (and such related information as the Secretary may require) is verified in such manner as the Secretary may prescribe.

''(6) INSURANCE WHICH COVERS OTHER INDIVIDUALS; TREATMENT OF PAYMENTS.—Rules similar to the rules of paragraphs (7) and (8) of section 35(g) shall apply for purposes of this section.

''(j) COORDINATION WITH ADVANCE PAYMENTS.—

''(1) REDUCTION IN CREDIT FOR ADVANCE PAYMENTS.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

''(2) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If the aggregate amount paid on behalf of the taxpayer under section 7527A for months beginning in the taxable year exceeds the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer's spouse and dependents for such months, then the tax imposed by this chapter for such taxable year shall be increased by the sum of—

''(A) such excess, plus

''(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the payment under section 7527A to the date such excess is paid.

For purposes of subparagraph (B), an equal part of the aggregate amount of the excess shall be deemed to be attributable to payments made under section 7527A on the first day of each month beginning in such taxable year, unless the taxpayer establishes the date on which each such payment giving rise to such excess occurred, in which case subparagraph (B) shall be applied with respect to each date so established.

''(k) COST-OF-LIVING ADJUSTMENTS.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2017, each of the dollar amounts contained in the last row of the table under subsection (b)(3) shall be increased by an amount equal to such dollar amount multiplied by the blended cost-of-living adjustment.

''(2) BLENDED COST-OF-LIVING ADJUSTMENT.—For purposes of paragraph (1), the blended cost-of-living adjustment means one-half of the sum of—

''(A) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins by substituting 'calendar year 2016' for 'calendar year 1992' in subparagraph (B) thereof, plus

''(B) the cost-of-living adjustment determined under section 213(d)(10)(B)(ii) for the calendar year in which the taxable year begins by substituting '2016' for '1996' in subclause (II) thereof.

''(3) ROUNDING.—Any increase determined under paragraph (2) shall be rounded to the nearest multiple of $10.''.

(b) ADVANCE PAYMENT OF CREDIT.—Chapter 77 (relating to miscellaneous provisions) is amended by inserting after section 7527 the following new section:

''SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

''(a) IN GENERAL.—The Secretary shall establish a program for making payments on behalf of individuals to providers of qualified refund eligible health insurance (as defined in section 25E(f)(2)) for such individuals.

''(b) LIMITATION.—The Secretary may make payments under subsection (a) only to the extent that the Secretary determines that the amount of such payments made on behalf of any taxpayer for any month does not exceed the sum of the monthly limitations determined under section 25E(b) for the taxpayer and taxpayer's spouse and dependents for such month.''.

(c) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by inserting after section 6050V the following new section:

''SEC. 6050W. RETURNS RELATING TO CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

''(a) REQUIREMENT OF REPORTING.—Every person who is entitled to receive payments for any month of any calendar year under section 7527A (relating to advance payment of credit for qualified refund eligible health insurance) with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each 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, with respect to each individual referred to in subsection (a)—

''(A) the name, address, and TIN of each such individual,

''(B) the months for which amounts payments under section 7527A were received,

''(C) the amount of each such payment,

''(D) the type of insurance coverage provide by such person with respect to such individual and the policy number associated with such coverage,

''(E) the name, address, and TIN of the spouse and each dependent covered under such coverage, and

''(F) such other information as the Secretary may prescribe.

''(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 individual 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) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) (relating to definitions) is amended by redesignating clauses (xv) through (xxi) as clauses (xvi) through (xxii), respectively, and by inserting after clause (xiv) the following new clause:

''(xv) section 6050W (relating to returns relating to credit for qualified refund eligible health insurance),''.

(B) Paragraph (2) of section 6724(d) is amended by striking the period at the end of subparagraph (CC) and inserting '', or'' and by inserting after subparagraph (CC) the following new subparagraph:

''(DD) section 6050W (relating to returns relating to credit for qualified refund eligible health insurance).''.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''or 25E'' after ''section 35''.

(2)(A) Section 23(b)(4)(B) is amended by inserting ''and section 25D'' after ''this section''.

(B) Section 24(b)(3)(B) is amended by striking ''and 25B'' and inserting '', 25B, and 25D''.

(C) Section 25B(g)(2) is amended by striking ''section 23'' and inserting ''sections 23 and 25D''.

(D) Section 26(a)(1) is amended by striking ''and 25B'' and inserting ''25B, and 25D''.

(3) The table of sections for subpart A of part IV of subchapter A of chapter 1 is amended by inserting after the item relating to section 25D the following new item:

''Sec. 25E. Qualified health insurance credit.''.

(4) The table of sections for chapter 77 is amended by inserting after the item relating to section 7527 the following new item:

''Sec. 7527A. Advance payment of credit for qualified refund eligible health insurance.''.

(5) 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. 6050W. Returns relating to credit for qualified refund eligible health insurance.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.

SEC. ___02. CHANGES TO EXISTING TAX PREFERENCES FOR MEDICAL COVERAGE, ETC., FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT OR STANDARD DEDUCTION.

(a) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.—

(1) IN GENERAL.—Section 106 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

''(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.—Subsection (a) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month. The amount includible in gross income by reason of this subsection shall be determined under rules similar to the rules of section 4980B(f)(4).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 106(b)(1) is amended—

(i) by inserting ''gross income does not include'' before ''amounts contributed'', and

(ii) by striking ''shall be treated as employer-provided coverage for medical expenses under an accident or health plan''.

(B) Section 106(d)(1) is amended—

(i) by inserting ''gross income does not include'' before ''amounts contributed'', and

(ii) by striking ''shall be treated as employer-provided coverage for medical expenses under an accident or health plan''.

(b) AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH PLANS.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(f) NO EXCLUSION FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDIT.—Subsection (b) shall not apply with respect to any employer-provided coverage under an accident or health plan for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

(c) SPECIAL RULES FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by adding at the end the following new paragraph:

''(6) NO DEDUCTION TO INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE.—Paragraph (1) shall not apply for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

(d) EARNED INCOME CREDIT UNAFFECTED BY REPEALED EXCLUSIONS.—Subparagraph (B) of section 32(c)(2) is amended by redesignating clauses (v) and (vi) as clauses (vi) and (vii), respectively, and by inserting after clause (iv) the following new clause:

''(v) the earned income of an individual shall be computed without regard to sections 105(f) and 106(f),''.

(e) MODIFICATION OF DEDUCTION FOR MEDICAL EXPENSES.—Subsection (d) of section 213 is amended by adding at the end the following new paragraph:

''(12) PREMIUMS FOR QUALIFIED HEALTH INSURANCE.—The term 'medical care' does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) under qualified health insurance (as defined in section 25E(f)) for any month.''.

(f) DEFINITION OF WAGES FOR EMPLOYMENT TAX PURPOSES.—

(1) FEDERAL INSURANCE CONTRIBUTIONS ACT.—Subsection (a) of section 3121 is amended—

(A) by striking ''sickness or'' each place it appears in paragraph (2), and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) any payment made to or for the benefit of an employee 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 104, 105, or 106;''.

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended—

(A) by striking ''sickness or'' each place it appears in paragraph (1), and

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

''(13) The term 'compensation' shall not include any payment made to or for the benefit of an employee 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 104, 105, or 106.''.

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended—

(A) by striking ''sickness or'' each place it appears in paragraph (2), and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) any payment made to or for the benefit of an employee 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 104, 105, or 106;''.

(g) REPORTING REQUIREMENT.—Subsection (a) of section 6051 is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ''and'', and by inserting after paragraph (13) the following new paragraph:

''(14) the total amount of employer-provided coverage under an accident or health plan which is includible in gross income by reason of sections 105(f) and 106(f).''.

(h) RETIRED PUBLIC SAFETY OFFICERS.—Section 402(l)(4)(D) is amended by adding at the end the following: ''Such term shall not include any premium for coverage by an accident or health insurance plan for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.''.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2008.

Subtitle B—Improving Private Health Insurance Access and Affordability

SEC. ___11. IMPROVING PRIVATE HEALTH INSURANCE ACCESS AND AFFORDABILITY.

The Social Security Act is amended by adding at the end the following new title:

''TITLE XXII—REFUNDABILITY DEEMING; STATE HEALTH INSURANCE EXCHANGES

''Subtitle A—Refundability Deeming

''SEC. 2201. REFUNDABILITY DEEMING.

''(a) IN GENERAL.—For purposes of section 25E of the Internal Revenue Code of 1986, the Secretary shall deem whether a State (as defined for purposes of title XIX) has taken efforts to provide its citizens with greater access to affordable private health insurance. Those efforts may include, but are not limited to, the following initiatives:

''(1) The establishment of a State health insurance exchange.

''(2) The establishment of a high risk solution, such as a high risk pool, reinsurance mechanism, or other State-designed high risk solution.

''(3) The availability of affordable coverage (as defined in section 2212(b)(2), determined without regard to whether such coverage is qualified exchange-based health insurance coverage (as defined in section 2214).

''(b) MORE INDIVIDUALS COVERED.—A State shall demonstrate to the Secretary that an initiative under subsection (a) is reasonably designed to operate in a manner so as to result, in combination with the qualified health insurance tax credit, in a reduction in the number of eligible individuals (as defined in section 2213) in the State who do not have health insurance coverage, as measured by the Secretary based upon information obtained in the Current Population Survey.

''(c) REFERENCE TO REFUNDABILITY REQUIREMENT FOR APPLICATION OF REFUNDABILITY OF QUALIFIED HEALTH INSURANCE TAX CREDIT.—For rules relating to limitations on the refundability of the qualified health insurance credit under section 25E of the Internal Revenue Code of 1986 in relation to initiatives described in subsection (a), see section 25E(d). In this title, the term 'qualified health insurance tax credit' means the tax credit provided under such section.

''Subtitle B—State Health Insurance Exchanges

''SEC. 2211. STATE HEALTH INSURANCE EXCHANGES.

''(a) IN GENERAL.—The Secretary shall provide a process for the review and certification of applications of each State of a State-based program as a certified health insurance exchange for the State (each in this subtitle referred to as a 'certified State health insurance exchange' or an 'exchange'). A program shall not be treated as a certified State health insurance exchange unless the Secretary, in consultation with the Secretary of the Treasury, determines that the program meets the requirements for an exchange under this subtitle.

''(b) CONTINUED CERTIFICATION.—Upon certification of a program under subsection (a), the program shall remain so certified unless the Secretary determines that the program has failed to meet any of the requirements for an exchange under this subtitle.

''SEC. 2212. REQUIREMENTS FOR EXCHANGE CERTIFICATION.

''(a) GENERAL REQUIREMENTS.—

''(1) IN GENERAL.—The exchange shall be a means to pool individual consumers purchasing private health insurance, to provide them with greater negotiating leverage, and to provide a market where private health insurance plans can compete to offer coverage for these individuals.

''(2) ADMINISTRATION.—Nothing in this subtitle shall prohibit a State from either directly contracting with the health insurance plans participating in the exchange or a third party administrator to operate the exchange.

''(3) PLAN PARTICIPATION.—No State may restrict or otherwise limit the ability of health insurance plans to participate in and offer health insurance products through an exchange, so long as the providers of these plans are duly licensed under State insurance laws applicable to all health insurance providers in the State and comply with the requirements under this subtitle.

''(4) BENEFITS.—A State shall not impose requirements that health insurance plans participating in the exchange provide any benefits, beyond those requirements that the State imposes upon all licensed health insurance providers operating in the State.

''(5) PRICING.—A State shall not set prices for any products offered through the exchange.

''(6) PREMIUMS COLLECTION METHOD.—A State shall ensure the existence of an effective and efficient method for the collection of premiums owed for qualified exchange-based health insurance coverage.

''(7) MULTI-STATE POOLING ARRANGEMENTS.—Nothing in this subtitle shall prohibit State health insurance exchanges from organizing into a multi-state pooling arrangement.

''(b) OFFERING OF AFFORDABLE QUALIFIED EXCHANGE-BASED HEALTH INSURANCE COVERAGE TO ELIGIBLE INDIVIDUALS.—

''(1) AFFORDABLE AND BENCHMARK COVERAGE.—The exchange must have one or more health insurance plans participating in the offering to each eligible individual (as defined in section 2213(a)) of qualified exchange-based health insurance coverage (as defined in section 2214)—

''(A) at least one of which is affordable as determined under paragraph (2); and

''(B) at least one of which provides benchmark benefits coverage described in section 2113(b).

Private health insurance providers, duly licensed in the State, may enter into agreements with the exchange to provide qualified exchange-based health insurance coverage and increase the choices available to eligible individuals.

''(2) AFFORDABLE COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), a State through an exchange shall meet the requirement under paragraph (1)(A) in a year by using its funds to supplement the premiums of the lowest cost plan participating in the exchange (as determined by a methodology to be specified by the Secretary), so that the average premium for individuals enrolling in the plan will not exceed 6 percent of the State's median income.

''(B) EXCEPTION.—A State is not required under subparagraph (A) to provide any supplemental payments if there is at least one plan available in all areas of the State with average premiums that are below 6 percent of the State's median income.

''(C) NO USE OF PRICE FIXING.—The implementation of this paragraph shall comply with subsection (a)(5).

''(D) APPLICATION.—

''(i) DISREGARDING LATE ENROLLMENT PENALTIES AND RELATED PREMIUM DISINCENTIVES.—The amount of premium under subparagraph (A) shall not take into account any increase in premium resulting from the State's application of methods permitted under subsection (a)(6).

''(ii) APPLICATION TO SUB-STATE AREAS.—A State may apply subparagraph (A) separately for different areas within the State.

''(c) ENROLLMENT OF ELIGIBLE INDIVIDUALS.—

''(1) ENROLLMENT MECHANISMS.—Health insurance plans participating in the exchange in State shall have uniform mechanisms designed to encourage and facilitate the enrollment of all eligible individuals in qualified exchange-based health insurance coverage.

''(2) ENROLLMENT OPPORTUNITIES.—

''(A) IN GENERAL.—Health insurance plans participating in the exchange in a State shall permit the enrollment and changes of enrollment of individuals at the time they become eligible individuals in the State, such as through loss of group-based qualifying health insurance coverage, changes in residency or family composition, and other circumstances specified by the Secretary.

''(B) ANNUAL OPEN ENROLLMENT PERIODS.—Health insurance plans participating in the

exchange in a State shall permit eligible individuals to change enrollment among such plans in an annual manner, subject to subparagraph (A).

''(3) LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.—Qualified exchange-based health insurance coverage shall meet the requirements of section 9801 of the Internal Revenue Code of 1986 in the same manner as if it were a group health plan.

''(d) PATHWAY FOR ENROLLMENT BY MEDICAID AND SCHIP BENEFICIARIES.—A State through an exchange shall include a pathway for eligible individuals who are enrolled (or eligible to enroll) under title XIX or XXI in such State to enroll in qualified exchange-based health insurance coverage. A State may use the program under section 1938 in developing such a pathway.

''(e) METHODS TO REDUCE ADVERSE SELECTION.—Health insurance plans participating in the exchange in a State shall have a mechanism to reduce adverse selection in the enrollment of eligible individuals. This mechanism shall be uniform for all such plans and may include waiting periods and premium surcharges for late enrollees (or individuals who otherwise do not have periods of creditable coverage before enrolling through the exchange) and other devices reasonably designed to reduce adverse selection in the enrollment of eligible individuals consistent with the requirements of subpart 1 of part B of title XXVII of the Public Health Service Act (relating to portability, access, and renewability requirements for health insurance coverage in the individual market).

''(f) REINSURANCE OR OTHER RISK REDISTRIBUTION MECHANISM.—Health insurance plans participating in the exchange in a State may have a uniform mechanism that protects entities offering qualified exchange-based health insurance coverage to manage risk. Such a mechanism may include reinsurance, a high risk pool, or other mechanism approved by the Secretary.

''(g) DISSEMINATION OF COVERAGE INFORMATION.—Health insurance plans participating in the exchange in a State shall ensure that there is wide dissemination of information about health insurance coverage options, including the plans offered and premiums and benefits for such plans, to eligible individuals and to employers that provide financial assistance in purchasing such coverage.

''(h) INFORMATION COORDINATION.—Health insurance plans participating in the exchange in a State shall report to the Secretary of the Treasury such information as is required under the Internal Revenue Code of 1986 to carry out the qualified health insurance tax credit.

''SEC. 2213. ELIGIBLE INDIVIDUAL.

''(a) ELIGIBLE INDIVIDUAL.—In this subtitle—

''(1) IN GENERAL.—The term 'eligible individual' means, with respect to a State and a month, an individual who, as of the first day of the month—

''(A) is a resident of the State (as determined in accordance with guidelines specified by the Secretary);

''(B) is citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence or otherwise residing in the United States under color of law, or an alien otherwise lawfully residing in the United States under color of law for such period as the Secretary shall specify; and

''(C) is not covered under group-based qualifying health insurance coverage.

''(2) GROUP-BASED QUALIFYING HEALTH INSURANCE COVERAGE.—The term 'group-based qualifying health insurance coverage' means any of the following::

''(A) GROUP HEALTH PLAN COVERAGE.—

''(i) IN GENERAL.—Subject to clause (ii), coverage under a group health plan (as defined in section 9832(a) of the Internal Revenue Code of 1986).

''(ii) EXCEPTION.—Clause (i) shall not include—

''(I) a health plan if substantially all of its coverage is coverage described in section 223(c)(1)(B) of the Internal Revenue Code of 1986; or

''(II) coverage under a group health plan insofar as the plan benefits consist (other than coverage described in subclause (I)) of contribution towards a qualified exchange-based health insurance coverage.

''(B) MEDICARE.—

''(i) IN GENERAL.—Subject to clause (ii), coverage under any part of the Medicare program under title XVIII.

''(ii) EXCEPTION.—Clause (i) shall not apply if all the coverage under Medicare is, through the direct or indirect application of section 1862(b), secondary to coverage under a group health plan.

''(C) MILITARY HEALTH CARE.—Coverage under the military health program under chapter 55 of title 10, United States Code, including under the TRICARE program (as defined in section 1072(7) of such title).

''(D) FEHBP.—Coverage under the Federal employees health benefit program under chapter 89 of title 5, United States Code.

''(E) FULL VETERANS COVERAGE.—Coverage through the Department of Veterans Affairs if such coverage is based on enrollment of an individual who is described in paragraph (1) of section 1705(a) of title 38, United States Code (relating to veterans with service-connected disabilities rated 50 percent or greater).

''(b) RELATION TO MEDICAID/SCHIP.—Except as a State may otherwise provide, an individual is not disqualified from being an eligible individual merely because the individual is enrolled under title XIX or XXI.

''SEC. 2214. QUALIFIED EXCHANGE-BASED HEALTH INSURANCE COVERAGE.

''In this subtitle, the term 'qualified exchange-based health insurance coverage' means qualified health insurance (as defined in section 25E(f)(1) of the Internal Revenue Code of 1986) offered by a private entity through an exchange.

''SEC. 2215. FLEXIBILITY IN APPLICATION TO LOWER-INCOME INDIVIDUALS.

''(a) STATE SUPPLEMENTATION.—Nothing in this subtitle shall be construed as preventing a State from providing, under a certified State health insurance exchange and at the State's own expense, additional assistance to eligible individuals with respect to subsidizing premium and cost-sharing costs for qualified exchange-based health insurance coverage.

''(b) TREATMENT OF CERTAIN MEDICAID AND SCHIP BENEFICIARIES.—Nothing in this subtitle shall be construed as preventing a State Medicaid or children's health insurance program under title XIX or XXI from permitting individuals eligible for medical assistance or child health assistance under the respective titles from obtaining such assistance through enrollment in qualified exchange-based health insurance coverage.''.

SEC. ___12. EXPANSION OF MEDICAID HEALTH OPPORTUNITY ACCOUNTS TO ALL STATES.

Section 1938 of the Social Security Act (42 U.S.C. 1396u–8) is amended—

(1) in subsection (a)—

(A) by striking paragraph (1) and inserting the following:

''(1) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary shall establish a program under which States may provide under their State plans under this title (including such a plan operating under a statewide waiver under section 1115) in accordance with this section for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a 'State health opportunity accounts program'.''; and

(B) in paragraph (2)—

(i) by striking the paragraph heading and inserting ''IMPLEMENTATION.—'';

(ii) by striking subparagraph (A) and inserting the following:

''(A) IN GENERAL.—The program established under this section shall begin on January 1, 2008.''; and

(iii) in subparagraph (B)—

(I) by striking clause (i) and inserting the following:

''(i) IN GENERAL.—Not later than March 31, 2013, the Comptroller General of the United States shall submit a report to Congress evaluating the programs conducted under this section .''; and

(II) in clause (ii), by striking ''2010'' and inserting ''2013''; and

(C) in paragraph (3)(E), by inserting ''that include plan comparison information in language that is easily understood'' before the period;

(2) in subsection (b)—

(A) in paragraph (1) , by striking ''consistent with paragraphs (2) and (3)'';

(B) by striking paragraphs (2) through (4) and inserting the following:

''(2) LIMITATION ON ENROLLEES IN MEDICAID MANAGED CARE ORGANIZATIONS.—Insofar as the State provides for eligibility of individuals who are enrolled in Medicaid managed care organizations, such individuals may participate in the State health opportunity account program only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

''(A) In no case may the number of such individuals enrolled in the organization who participate in the program exceed 5 percent of the total number of individuals enrolled in such organization.

''(B) The proportion of enrollees in the organization who so participate is not significantly disproportionate to the proportion of such enrollees in other such organizations who participate.

''(C) The State has provided for an appropriate adjustment in the per capita payments to the organization to account for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.''; and

(C) by redesignating paragraphs (5) and (6) as paragraphs (3) and (4), respectively;

(3) in subsection (d)—

(A) in paragraph (2)(C)(i)—

(i) in subclause (II), by striking ''and'' at the end;

(ii) in subclause (III), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(IV) shall provide contributions into such an account on a sliding-scale based on income.''; and

(B) in paragraph (3)(B)(ii)—

(i) in subclause (I), by striking ''and'' at the end;

(ii) by redesignating subclause (II) as subclause (III); and

(iii) by inserting after subclause (I), the following:

''(II) may be transferred into a health savings account established under section 223 of the Internal Revenue Code of 1986 and such transfer shall be treated as a rollover contribution described in section 223(f) of the Internal Revenue Code of 1986; and''; and

(4) by striking ''State demonstration program'' each place it appears and inserting ''State health opportunity accounts program''.

SA 2549. Mr. LOTT submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. 61__. ESTIMATED TAX SAFE HARBOR FOR ALTERNATIVE MINIMUM TAX LIABILITY.

(a) IN GENERAL.—Section 6654 of the Internal Revenue Code of 1986 (relating to failure by individual to pay estimated income tax) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

''(m) SAFE HARBOR FOR CERTAIN ALTERNATIVE MINIMUM TAX PAYERS.—In the case of any individual with respect to whom there was no liability for the tax imposed under section 55 for the preceding taxable year—

''(1) any required payment calculated under subsection (d)(1)(B)(i) shall be determined without regard to any tax imposed under section 55,

''(2) any annualized income installment calculated under subsection (d)(2)(B) shall determined without regard to alternative minimum taxable income, and

''(3) the determination of the amount of the tax for the taxable year for purposes of subsection (e)(1) shall not include the amount of any tax imposed under section 55.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SA 2550. Mr. LOTT submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, add the following:

SEC. _____. PERMANENT REPEAL OF ALTERNATIVE MINIMUM TAX.

(a) IN GENERAL.—Section 55(a) of the Internal Revenue Code of 1986 (relating to alternative minimum tax imposed) is amended by adding at the end the following new flush sentence:

''For purposes of this title, the tentative minimum tax on any taxpayer for any taxable year beginning after December 31, 2006, shall be zero.''.

(b) MODIFICATION OF LIMITATION ON USE OF CREDIT FOR PRIOR YEAR MINIMUM TAX LIABILITY.—Subsection (c) of section 53 of the Internal Revenue Code of 1986 (relating to credit for prior year minimum tax liability) is amended to read as follows:

''(c) LIMITATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the credit allowable under subsection (a) for any taxable year shall not exceed the excess (if any) of—

''(A) the regular tax liability of the taxpayer for such taxable year reduced by the sum of the credits allowable under subparts A, B, D, E, and F of this part, over

''(B) the tentative minimum tax for the taxable year.

''(2) TAXABLE YEARS BEGINNING AFTER 2006.—In the case of any taxable year beginning after December 31, 2006, the credit allowable under subsection (a) to a taxpayer other than a corporation for any taxable year shall not exceed 90 percent of the regular tax liability of the taxpayer for such taxable year reduced by the sum of the credits allowable under subparts A, B, D, E, and F of this part.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2006.

SA 2551. Mr. BROWN (for himself and Mr. VOINOVICH) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITING TO CLASS II NARCOTICS THE REQUIRED USE OF TAMPER-RESISTANT PRESCRIPTION PADS UNDER MEDICAID.

(a) IN GENERAL.—Effective as if included in the enactment of section 1903(i)(23) (42 U.S.C. 1396b(i)(23)), as added by section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110–28), such section is amended by inserting ''which are narcotic drugs included in schedule II of section 202 of the Controlled Substances Act (21 U.S.C. 812) and'' after ''1927(k)(2))''.

(b) DELAY IN EFFECTIVE DATE FOR REQUIREMENT.—Effective as if included in the enactment of section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110–28), paragraph (2) of such section is amended by striking ''September 30, 2007'' and inserting ''March 31, 2009''.

SA 2552. Mr. SMITH (for himself and Mr. KOHL) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end, insert the following:

(__) SSI EXTENSIONS FOR HUMANITARIAN IMMIGRANTS; COLLECTION OF UNEMPLOYMENT COMPENSATION DEBTS RESULTING FROM FRAUD.—

(1) SSI EXTENSIONS FOR HUMANITARIAN IMMIGRANTS.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(M) SSI EXTENSIONS THROUGH FISCAL YEAR 2010.—

''(i) TWO-YEAR EXTENSION.—

''(I) IN GENERAL.—Except as provided in clause (ii), with respect to eligibility for benefits for the specified Federal program described in paragraph (3)(A), the 7-year period described in subparagraph (A) shall be deemed to be a 9-year period during fiscal years 2008 through 2010.

''(II) ALIENS WHOSE BENEFITS CEASED IN PRIOR FISCAL YEARS.—

''(aa) IN GENERAL.—Beginning on the date of the enactment of the SSI Extension for Elderly and Disabled Refugees Act, any qualified alien rendered ineligible for the specified Federal program described in paragraph (3)(A) during fiscal years prior to fiscal year 2008 solely by reason of the termination of the 7-year period described in subparagraph (A) shall be eligible for such program for an additional 2-year period in accordance with this clause, if such alien meets all other eligibility factors under title XVI of the Social Security Act.

''(bb) PAYMENT OF BENEFITS.—Benefits paid under item (aa) shall be paid prospectively over the duration of the qualified alien's renewed eligibility.

''(ii) PENDING NATURALIZATION APPLICATION.—With respect to eligibility for benefits for the specified program described in paragraph (3)(A), subsection (a)(1) shall not apply during fiscal years 2008 through 2010 to an alien described in one of clauses (i) through (v) of subparagraph (A), if the alien has submitted an application for naturalization that is pending before the Secretary of Homeland Security, and such submission is verified by the Commissioner of Social Security either by receiving a receipt number from the alien for such submitted application or by receiving confirmation from the Secretary of Homeland Security.''.

(2) COLLECTION OF UNEMPLOYMENT COMPENSATION DEBTS RESULTING FROM FRAUD.—

(A) IN GENERAL.—Section 6402 of the Internal Revenue Code (relating to authority to make credits or refunds) is amended by redesignating subsections (f) through (k) as subsections (g) through (l), respectively, and by inserting after subsection (e) the following new subsection:

''(f) COLLECTION OF UNEMPLOYMENT COMPENSATION DEBTS RESULTING FROM FRAUD.—

''(1) IN GENERAL.—Upon receiving notice from any State that a named person owes a covered unemployment compensation debt to such State, the Secretary shall, under such conditions as may be prescribed by the Secretary—

''(A) reduce the amount of any overpayment payable to such person by the amount of such covered unemployment compensation debt;

''(B) pay the amount by which such overpayment is reduced under subparagraph (A) to such State and notify such State of such person's name, taxpayer identification number, address, and the amount collected; and

''(C) notify the person making such overpayment that the overpayment has been reduced by an amount necessary to satisfy a covered unemployment compensation debt.

If an offset is made pursuant to a joint return, the notice under subparagraph (B) shall include the names, taxpayer identification numbers, and addresses of each person filing such return and the notice under subparagraph (C) shall include information related to the rights of a spouse of a person subject to such an offset.

''(2) PRIORITIES FOR OFFSET.—Any overpayment by a person shall be reduced pursuant to this subsection—

''(A) after such overpayment is reduced pursuant to—

''(i) subsection (a) with respect to any liability for any internal revenue tax on the part of the person who made the overpayment;

''(ii) subsection (c) with respect to past-due support; and

''(iii) subsection (d) with respect to any past-due, legally enforceable debt owed to a Federal agency; and

''(B) before such overpayment is credited to the future liability for any Federal internal revenue tax of such person pursuant to subsection (b).

If the Secretary receives notice from a State or States of more than one debt subject to paragraph (1) or subsection (e) that is owed by a person to such State or States, any overpayment by such person shall be applied against such debts in the order in which such debts accrued.

''(3) NOTICE; CONSIDERATION OF EVIDENCE.—No State may take action under this subsection until such State—

''(A) notifies the person owing the covered unemployment compensation debt that the State proposes to take action pursuant to this section;

''(B) provides such person at least 60 days to present evidence that all or part of such liability is not legally enforceable or due to fraud;

''(C) considers any evidence presented by such person and determines that an amount of such debt is legally enforceable and due to fraud; and

''(D) satisfies such other conditions as the Secretary may prescribe to ensure that the determination made under subparagraph (C) is valid and that the State has made reasonable efforts to obtain payment of such covered unemployment compensation debt.

''(4) COVERED UNEMPLOYMENT COMPENSATION DEBT.—For purposes of this subsection, the term 'covered unemployment compensation debt' means—

''(A) a past-due debt for erroneous payment of unemployment compensation due to fraud which has become final under the law of a State certified by the Secretary of Labor pursuant to section 3304 and which remains uncollected;

''(B) contributions due to the unemployment fund of a State for which the State has determined the person to be liable due to fraud; and

''(C) any penalties and interest assessed on such debt.

''(5) REGULATIONS.—

''(A) IN GENERAL.—The Secretary may issue regulations prescribing the time and manner in which States must submit notices of covered unemployment compensation debt and the necessary information that must be contained in or accompany such notices. The regulations may specify the minimum amount of debt to which the reduction procedure established by paragraph (1) may be applied.

''(B) FEE PAYABLE TO SECRETARY.—The regulations may require States to pay a fee to the Secretary, which may be deducted from amounts collected, to reimburse the Secretary for the cost of applying such procedure. Any fee paid to the Secretary pursuant to the preceding sentence shall be used to reimburse appropriations which bore all or part of the cost of applying such procedure.

''(C) SUBMISSION OF NOTICES THROUGH SECRETARY OF LABOR.—The regulations may include a requirement that States submit notices of covered unemployment compensation debt to the Secretary via the Secretary of Labor in accordance with procedures established by the Secretary of Labor. Such procedures may require States to pay a fee to the Secretary of Labor to reimburse the Secretary of Labor for the costs of applying this subsection. Any such fee shall be established in consultation with the Secretary of the Treasury. Any fee paid to the Secretary of Labor may be deducted from amounts collected and shall be used to reimburse the appropriation account which bore all or part of the cost of applying this subsection.

''(6) ERRONEOUS PAYMENT TO STATE.—Any State receiving notice from the Secretary that an erroneous payment has been made to such State under paragraph (1) shall pay promptly to the Secretary, in accordance with such regulations as the Secretary may prescribe, an amount equal to the amount of such erroneous payment (without regard to whether any other amounts payable to such State under such paragraph have been paid to such State).''.

(B) DISCLOSURE OF CERTAIN INFORMATION TO STATES REQUESTING REFUND OFFSETS FOR LEGALLY ENFORCEABLE STATE UNEMPLOYMENT COMPENSATION DEBT RESULTING FROM FRAUD.—

(i) GENERAL RULE.—Paragraph (3) of section 6103(a) of such Code is amended by inserting ''(10),'' after ''(6),''.

(ii) DISCLOSURE TO DEPARTMENT OF LABOR AND ITS AGENT.—Paragraph (10) of section 6103(l) of such Code is amended—

(I) by striking ''(c), (d), or (e)'' each place it appears in the heading and text and inserting ''(c), (d), (e), or (f)'',

(II) in subparagraph (A) by inserting '', to officers and employees of the Department of Labor and its agent for purposes of facilitating the exchange of data in connection with a request made under subsection (f)(5) of section 6402,'' after ''section 6402'', and

(III) in subparagraph (B) by inserting '', and any agents of the Department of Labor,'' after ''agency'' the first place it appears.

(iii) SAFEGUARDS.—Paragraph (4) of section 6103(p) of such Code is amended—

(I) in the matter preceding subparagraph (A), by striking ''(l)(16),'' and inserting ''(l)(10), (16),'';

(II) in subparagraph (F)(i), by striking ''(l)(16),'' and inserting ''(l)(10), (16),''; and

(III) in the matter following subparagraph (F)(iii)—

(aa) in each of the first two places it appears, by striking ''(l)(16),'' and inserting ''(l)(10), (16),'';

(bb) by inserting ''(10),'' after ''paragraph (6)(A),''; and

(cc) in each of the last two places it appears, by striking ''(l)(16)'' and inserting ''(l)(10) or (16)''.

(C) EXPENDITURES FROM STATE FUND.—Section 3304(a)(4) of such Code is amended—

(i) in subparagraph (E), by striking ''and'' after the semicolon;

(ii) in subparagraph (F), by inserting ''and'' after the semicolon; and

(iii) by adding at the end the following new subparagraph:

''(G) with respect to amounts of covered unemployment compensation debt (as defined in section 6402(f)(4)) collected under section 6402(f)—

''(i) amounts may be deducted to pay any fees authorized under such section; and

''(ii) the penalties and interest described in section 6402(f)(4)(B) may be transferred to the appropriate State fund into which the State would have deposited such amounts had the person owing the debt paid such amounts directly to the State;''.

(D) CONFORMING AMENDMENTS.—

(i) Subsection (a) of section 6402 of such Code is amended by striking ''(c), (d), and (e),'' and inserting ''(c), (d), (e), and (f)''.

(ii) Paragraph (2) of section 6402(d) of such Code is amended by striking ''and before such overpayment is reduced pursuant to subsection (e)'' and inserting ''and before such overpayment is reduced pursuant to subsections (e) and (f)''.

(iii) Paragraph (3) of section 6402(e) of such Code is amended in the last sentence by inserting ''or subsection (f)'' after ''paragraph (1)''.

(iv) Subsection (g) of section 6402 of such Code, as redesignated by subsection (a), is amended by striking ''(c), (d), or (e)'' and inserting ''(c), (d), (e), or (f)''.

(v) Subsection (i) of section 6402 of such Code, as redesignated by subsection (a), is amended by striking ''subsection (c) or (e)'' and inserting ''subsection (c), (e), or (f)''.

(E) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to refunds payable under section 6402 of the Internal Revenue Code of 1986 on or after the date of enactment of this Act.

SA 2553. Mr. SMITH submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. __. MODIFICATIONS TO SOCIAL SECURITY ACT TO ENCOURAGE THE INCLUSION OF INDIVIDUALS WITH DISABILITIES IN WORK PROGRAMS.

(a) AUTHORIZATION OF MODIFIED EMPLOYABILITY PLAN FOR INDIVIDUALS WITH DISABILITIES.—

(1) IN GENERAL.—Section 407(c)(2) of the Social Security Act (42 U.S.C. 607(c)(2)) is amended by adding at the end the following new subparagraph:

''(E) INDIVIDUALS WITH DISABILITIES COMPLYING WITH A MODIFIED EMPLOYABILITY PLAN DEEMED TO BE MEETING WORK PARTICIPATION REQUIREMENTS.—

''(i) MODIFIED EMPLOYABILITY PLAN.—A State may develop a modified employability plan for an adult or minor child head of household recipient of assistance who has been determined by a qualified medical, mental health, addiction, or social services professional (as determined by the State) to have a disability, or who is caring for a family member with a disability (as so determined). The modified employability plan shall—

''(I) include a determination that, because of the disability of the recipient or the individual for whom the recipient is caring, reasonable modification of work activities, hourly participation requirements, or both, is needed in order for the recipient to participate in work activities;

''(II) set forth the modified work activities in which the recipient is required to participate;

''(III) set forth the number of hours per week for which the recipient is required to participate in such modified work activities based on the State's evaluation of the family's circumstances;

''(IV) set forth the services, supports, and modifications that the State will provide to the recipient or the recipient's family;

''(V) be developed in cooperation with the recipient; and

''(VI) be reviewed not less than every 6 months.

''(ii) INCLUSION IN MONTHLY PARTICIPATION RATES.—For the purpose of determining monthly participation rates under subsection (b)(1)(B)(i), and notwithstanding paragraphs (1), (2)(A), (2)(B), (2)(C), and (2)(D) of this subsection and subsection (d) of this section, a recipient is deemed to be engaged in work for a month in a fiscal year if—

''(I) the State has determined that the recipient is in substantial compliance with activities and hourly participation requirements set forth in a modified employability plan that meets the requirements set forth in clause (i); and

''(II) the State complies with the reporting requirement set forth in clause (iii) for the fiscal year in which the month occurs.

''(iii) REPORTS.—

''(I) REPORT BY STATE.—With respect to any fiscal year for which a State counts a recipient as engaged in work pursuant to a modified employability plan, the State shall submit a report entitled 'Annual State Report on TANF Recipients Participating in Work Activities Pursuant to Modified Employability Plans Due to Disability' to the Secretary not later than March 31 of the succeeding fiscal year. The report shall provide the following information:

''(aa) The aggregate number of recipients with modified employability plans due to a disability.

''(bb) The percentage of all recipients with modified employability plans who substantially complied with activities set forth in the plans each month of the fiscal year.

''(cc) Information regarding the most prevalent types of physical and mental impairments that provided the basis for the disability determinations.

''(dd) The percentage of cases with a modified employability plan in which the recipient had a disability, was caring for a child with a disability, or was caring for another family member with a disability.

''(ee) A description of the most prevalent types of modification in work activities or hours of participation that were included in the modified employability plans.

''(ff) A description of the qualifications of the staff who determined whether individuals had a disability, of the staff who determined that individuals needed modifications to their work requirements, and of the staff who developed the modified employability plans.

''(II) REPORT BY SECRETARY.—The Secretary shall submit an annual report to Congress entitled 'Efforts in State TANF Programs to Promote and Support Employment for Individuals with Disabilities' not later than July 31 of each fiscal year that includes information on State efforts to engage individuals with disabilities in work activities for the preceding fiscal year. The report shall include the following:

''(aa) The number of individuals for whom each State has developed a modified employability plan.

''(bb) The types of physical and mental impairments that provided the basis for the disability determination, and whether the individual with the disability was an adult recipient or minor child head of household, a child, or a non-recipient family member.

''(cc) The types of modifications that States have included in modified employability plans.

''(dd) The extent to which individuals with a modified employability plan are participating in work activities.

''(ee) An analysis of the extent to which the option to establish such modified employability plans was a factor in States' achieving or not achieving the minimum participation rates under subsection (a) for the fiscal year.

''(iv) DEFINITIONS.—

''(I) DISABILITY.—For purposes of this subparagraph, the term 'disability' means a mental or physical impairment, including substance abuse or addiction, that—

''(aa) constitutes or results in a substantial impediment to employment; or

''(bb) substantially limits 1 or more major life activities.

''(II) MODIFIED WORK ACTIVITIES.—For purposes of this subparagraph, the term 'modified work activities' means activities the State has determined will help the recipient become employable and which are not subject to and do not count against the limitations and requirements under the preceding provisions of this subsection and of subsection (d).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on October 1, 2007.

(b) STATE OPTION TO EXCLUDE SSI APPLICANTS IN WORK PARTICIPATION RATE.—

(1) IN GENERAL.—Section 407(b)(5) of the Social Security Act (42 U.S.C. 607(b)(5)) is amended by striking ''at its option, not require an individual'' and all that follows and inserting ''at its option—

''(A) not require an individual who is a single custodial parent caring for a child who has not attained 12 months of age to engage in work, and may disregard such an individual in determining the participation rates under subsection (a) of this section for not more than 12 months;

''(B) disregard for purposes of determining such rates for any month, on a case-by-case basis, an individual who is an applicant for or a recipient of supplemental security income benefits under title XVI or of social security disability insurance benefits under title II, if—

''(i) the State has determined that an application for such benefits has been filed by or on behalf of the individual;

''(ii) the State has determined that there is a reasonable basis to conclude that the individual meets the disability or blindness criteria applied under title II or XVI;

''(iii) there has been no final decision (including a decision for which no appeal is pending at the administrative or judicial level or for which the time period for filing such an appeal has expired) denying benefits; and

''(iv) not less than every 6 months, the State reviews the status of such application and determines that there is a reasonable basis to conclude that the individual continues to meet the disability or blindness criteria under title II or XVI; and

''(C) disregard for purposes of determining such rates for any month, on a case-by-case basis, an individual who the State has determined would meet the disability criteria for supplemental security income benefits under title XVI or social security disability insurance benefits under title II but for the requirement that the disability has lasted or is expected to last for a continuous period of not less than 12 months.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on October 1, 2007.

SA 2554. Mrs. DOLE submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, add the following:

SEC. ___. BUDGET POINT OF ORDER AGAINST LEGISLATION THAT RAISES EXCISE TAX RATES.

Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''POINT OF ORDER AGAINST RAISES IN EXCISE TAX RATES

''SEC. 316. (a) IN GENERAL.—It shall not be in order in the Senate to consider any bill, resolution, amendment, amendment between Houses, motion, or conference report that includes a Federal excise tax rate increase which disproportionately affects taxpayers with earned income of less than 200 percent of the Federal poverty level, as determined by the Joint Committee on Taxation. In this subsection, the term 'Federal excise tax rate increase' means any amendment to any section in subtitle D or E of the Internal Revenue Code of 1986, that imposes a new percentage or amount as a rate of tax and thereby increases the amount of tax imposed by any such section.

''(b) SUPERMAJORITY WAIVER AND APPEAL.—

''(1) WAIVER.—This section may be waived or suspended in the Senate only by an affirmative vote of three-fifths of the Members, duly chosen and sworn.

''(2) APPEAL.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.''.

SA 2555. Mrs. DOLE submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. 61_. CREDIT FOR TRANSPORTATION OF FOOD FOR CHARITABLE PURPOSES.

(a) IN GENERAL.—Subpart B of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 30D. CREDIT FOR TRANSPORTATION OF FOOD FOR CHARITABLE PURPOSES.

''(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to 25 cents for each mile for which the taxpayer uses a qualified truck for a qualified charitable purpose during the taxable year.

''(b) QUALIFIED CHARITABLE PURPOSE.—For purposes of this section, the term 'qualified charitable purpose' means the transportation of food in connection with the hunger relief efforts of an organization which is described in section 501(c)(3) and is exempt from taxation under section 501(a) (other than a private foundation, as defined in section 509(a), which is not an operating foundation, as defined in section 4942(j)(3)).

''(c) QUALIFIED TRUCK.—For purposes of this section, the term 'qualified truck' means a truck which—

''(1) has a capacity of not less than 1,760 cubic square feet,

''(2) is owned, leased, or operated by the taxpayer, and

''(3) is ordinarily used for hauling property in the course of a business.

''(d) OTHER RULES.—

''(1) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under this section with respect to any amount for which a deduction is allowed under any other provision of this chapter.

''(2) NO CREDIT WHERE TAXPAYER IS COMPENSATED.—No credit shall be allowed under this section if the taxpayer receives compensation in connection with the use of the qualified truck for the qualified charitable purpose.

''(3) CAPACITY REQUIREMENT.—No credit shall be allowed under this section unless at least 50 percent of the hauling capacity of the qualified truck (measured in cubic square feet) is used for the qualified charitable purpose.''.

(b) CONFORMING AMENDMENT.—The table of sections for subpart B of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 30D. Credit for transportation of food for charitable purposes.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2007.

SA 2556. Mrs. CLINTON (for herself, Mrs. DOLE, Ms. MIKULSKI, Mr. GRAHAM, Mr. BROWN, and Mrs. BOXER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. MILITARY FAMILY AND MEDICAL LEAVE ACT.

(a) SHORT TITLE.—This section may be cited as the ''Military Family and Medical Leave Act''.

(b) DEFINITIONS.—Section 101 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) is amended by adding at the end the following:

''(14) ACTIVE DUTY.—The term 'active duty' means duty under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code.

''(15) COVERED SERVICEMEMBER.—The term 'covered servicemember' means a member of the Armed Forces, including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy, or is otherwise in medical hold or medical holdover status, for a serious injury or illness.

''(16) MEDICAL HOLD OR MEDICAL HOLDOVER STATUS.—The term 'medical hold or medical holdover status' means—

''(A) the status of a member of the Armed Forces, including a member of the National Guard or a Reserve, assigned or attached to a military hospital for medical care; and

''(B) the status of a member of a reserve component of the Armed Forces who is separated, whether pre-deployment or post-deployment, from the member's unit while in need of health care based on a medical condition identified while the member is on active duty in the Armed Forces.

''(17) SERIOUS INJURY OR ILLNESS.—The term 'serious injury or illness', in the case of a member of the Armed Forces, means an injury or illness incurred by the member in line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.''.

(c) MILITARY FAMILY AND MEDICAL LEAVE.—

(1) ENTITLEMENT TO LEAVE.—Section 102(a) of such Act (29 U.S.C. 2612(a)) is amended by adding at the end the following:

''(3) MILITARY FAMILY AND MEDICAL LEAVE.—Subject to section 103, an eligible employee shall be entitled to a total of 26 workweeks of leave during a 12-month period to care for a covered servicemember who is the spouse, son, daughter, or parent of the employee. The leave described in this paragraph shall only be available during a single 12-month period.

''(4) COMBINED LEAVE TOTAL.—During the single 12-month period described in paragraph (3), an eligible employee shall be entitled to a combined total of 26 workweeks of leave under paragraphs (1) and (3). Nothing in this paragraph shall be construed to limit the availability of leave under paragraph (1) during any other 12-month period.''.

(2) SCHEDULE.—Section 102(b) of such Act (29 U.S.C. 2612(b)) is amended—

(A) in paragraph (1), in the second sentence—

(i) by striking ''section 103(b)(5)'' and inserting ''subsection (b)(5) or (f) (as appropriate) of section 103''; and

(ii) by inserting ''or under subsection (a)(3)'' after ''subsection (a)(1)''; and

(B) in paragraph (2), by inserting ''or under subsection (a)(3)'' after ''subsection (a)(1)''.

(3) SUBSTITUTION OF PAID LEAVE.—Section 102(d) of such Act (29 U.S.C. 2612(d)) is amended—

(A) in paragraph (1)—

(i) by inserting ''(or 26 workweeks in the case of leave provided under subsection (a)(3))'' after ''12 workweeks'' the first place it appears; and

(ii) by inserting ''(or 26 workweeks, as appropriate)'' after ''12 workweeks'' the second place it appears; and

(B) in paragraph (2)—

(i) in subparagraph (A), by adding at the end the following: ''An eligible employee may elect, or an employer may require the employee, to substitute any of the accrued paid vacation leave, personal leave, or family leave of the employee for leave provided under subsection (a)(3) for any part of the 26-week period of such leave under such subsection.''; and

(ii) in subparagraph (B), by adding at the end the following: ''An eligible employee may elect, or an employer may require the employee, to substitute any of the accrued paid vacation leave, personal leave, or medical or sick leave of the employee for leave provided under subsection (a)(3) for any part of the 26-week period of such leave under such subsection.''.

(4) NOTICE.—Section 102(e)(2) of such Act (29 U.S.C. 2612(e)(2)) is amended by inserting ''or under subsection (a)(3)'' after ''subsection (a)(1)''.

(5) SPOUSES EMPLOYED BY SAME EMPLOYER.—Section 102(f) of such Act (29 U.S.C. 2612(f)) is amended—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), and aligning the margins of the subparagraphs with the margins of section 102(e)(2)(A);

(B) by striking ''In any'' and inserting the following:

''(1) IN GENERAL.—In any''; and

(C) by adding at the end the following:

''(2) MILITARY FAMILY AND MEDICAL LEAVE.—

''(A) IN GENERAL.—The aggregate number of workweeks of leave to which both that husband and wife may be entitled under subsection (a) may be limited to 26 workweeks during the single 12-month period described in subsection (a)(3) if the leave is—

''(i) leave under subsection (a)(3); or

''(ii) a combination of leave under subsection (a)(3) and leave described in paragraph (1).

''(B) BOTH LIMITATIONS APPLICABLE.—If the leave taken by the husband and wife includes leave described in paragraph (1), the limitation in paragraph (1) shall apply to the leave described in paragraph (1).''.

(d) CERTIFICATION.—Section 103 of such Act (29 U.S.C. 2613) is amended by adding at the end the following:

''(f) CERTIFICATION FOR MILITARY FAMILY AND MEDICAL LEAVE.—An employer may require that a request for leave under section 102(a)(3) be supported by a certification issued at such time and in such manner as the Secretary may by regulation prescribe.''.

(e) FAILURE TO RETURN.—Section 104(c) of such Act (29 U.S.C. 2614(c)) is amended—

(1) in paragraph (2)(B)(i), by inserting ''or under section 102(a)(3)'' before the semicolon; and

(2) in paragraph (3)(A)—

(A) in clause (i), by striking ''or'' at the end;

(B) in clause (ii), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(iii) a certification issued by the health care provider of the son, daughter, spouse, or parent of the employee, as appropriate, in the case of an employee unable to return to work because of a condition specified in section 102(a)(3).''.

(f) ENFORCEMENT.—Section 107 of such Act (29 U.S.C. 2617) is amended, in subsection (a)(1)(A)(i)(II), by inserting ''(or 26 weeks, in a case involving leave under section 102(a)(3))'' after ''12 weeks''.

(g) INSTRUCTIONAL EMPLOYEES.—Section 108 of such Act (29 U.S.C. 2618) is amended, in subsections (c)(1), (d)(2), and (d)(3), by inserting ''or under section 102(a)(3)'' after ''section 102(a)(1)''.

SA 2557. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. 61__. REDUCTION IN RATE OF TENTATIVE MINIMUM TAX FOR NONCORPORATE TAXPAYERS.

(a) IN GENERAL.—Clause (i) of section 55(b)(1)(A) of the Internal Revenue Code of 1986 (relating to noncorporate taxpayers) is amended to read as follows:

''(i) IN GENERAL.—In the case of a taxpayer other than a corporation, the tentative minimum tax for the taxable year is—

''(I) 24 percent of the taxable excess, reduced by

''(II) the alternative minimum tax foreign tax credit for the taxable year.''.

(b) CONFORMING AMENDMENT.—Subparagraph (A) of section 55(b)(1) of such Code is amended by striking clause (iii).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2006.

SA 2558. Mr. GRAHAM submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 218, strike line 5 and all that follows through page 220, line 2, and insert the following:

(a) CIGARS.—Section 5701(a) of the Internal Revenue Code of 1986 is amended—

(1) by striking ''($1.594 cents per thousand on cigars removed during 2000 or 2001)'' in paragraph (1) and inserting ''($50.00 per thousand on cigars removed after December 31, 2007, and before October 1, 2012)'',

(2) by striking ''(18.063 percent on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''(53.13 percent on cigars removed after December 31, 2007, and before October 1, 2012)'', and

(3) by striking ''($42.50 per thousand on cigars removed during 2000 or 2001)'' in paragraph (2) and inserting ''($10.00 per thousand on cigars removed after December 31, 2007, and before October 1, 2012)''.

(b) CIGARETTES.—Section 5701(b) of such Code is amended—

(1) by striking ''($17 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (1) and inserting ''($50.00 per thousand on cigarettes removed after December 31, 2007, and before October 1, 2012)'', and

(2) by striking ''($35.70 per thousand on cigarettes removed during 2000 or 2001)'' in paragraph (2) and inserting ''($104.9999 per thousand on cigarettes removed after December 31, 2007, and before October 1, 2012)''.

(c) CIGARETTE PAPERS.—Section 5701(c) of such Code is amended by striking ''(1.06 cents on cigarette papers removed during 2000 or 2001)'' and inserting ''(3.13 cents on cigarette papers removed after December 31, 2007, and before October 1, 2012)''.

(d) CIGARETTE TUBES.—Section 5701(d) of such Code is amended by striking ''(2.13 cents on cigarette tubes removed during 2000 or 2001)'' and inserting ''(6.26 cents on cigarette tubes removed after December 31, 2007, and before October 1, 2012)''.

(e) SMOKELESS TOBACCO.—Section 5701(e) of such Code is amended—

(1) by striking ''(51 cents on snuff removed during 2000 or 2001)'' in paragraph (1) and inserting ''($1.50 on snuff removed after December 31, 2007, and before October 1, 2012)'', and

(2) by striking ''(17 cents on chewing tobacco removed during 2000 or 2001)'' in paragraph (2) and inserting ''(50 cents on chewing tobacco removed after December 31, 2007, and before October 1, 2012)''.

(f) PIPE TOBACCO.—Section 5701(f) of such Code is amended by striking ''(95.67 cents on pipe tobacco removed during 2000 or 2001)'' and inserting ''($2.8126 on pipe tobacco removed after December 31, 2007, and before October 1, 2012)''.

(g) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking ''(95.67 cents on roll-your-own tobacco removed during 2000 or 2001)'' and inserting ''($8.8889 on roll-your-own tobacco removed after December 31, 2007, and before October 1, 2012)''.

SA 2559. Mr. GRAHAM submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. ____. EXTENSION OF ELECTION TO INCLUDE COMBAT PAY AS INCOME FOR PURPOSES OF THE EARNED INCOME TAX CREDIT.

Paragraph (2)(B)(vi) of section 32(c) of the Internal Revenue Code of 1986 (relating to earned income) is amended by striking ''ending—'' and all that follows through the period and inserting ''ending after the date of the enactment of this clause, a taxpayer may elect to treat amounts excluded from gross income by reason of section 112 as earned income.''.

SA 2560. Mr. DODD submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. 610. FAMILY LEAVE FOR CAREGIVERS OF MEMBERS OF THE ARMED FORCES WITH COMBAT-RELATED INJURIES.

(a) SERVICEMEMBER FAMILY LEAVE.—

(1) DEFINITIONS.—Section 101 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) is amended by adding at the end the following:

''(14) COMBAT-RELATED INJURY.—The term 'combat-related injury' means an injury or illness that was incurred (as determined under criteria prescribed by the Secretary of Defense)—

''(A) as a direct result of armed conflict;

''(B) while an individual was engaged in hazardous service;

''(C) in the performance of duty under conditions simulating war; or

''(D) through an instrumentality of war.

''(15) SERVICEMEMBER.—The term 'servicemember' means a member of the Armed Forces.''.

(2) ENTITLEMENT TO LEAVE.—Section 102(a) of such Act (29 U.S.C. 2612(a)) is amended by adding at the end the following:

''(3) SERVICEMEMBER FAMILY LEAVE.—Subject to section 103, an eligible employee who is the primary caregiver for a servicemember with a combat-related injury shall be entitled to a total of 26 workweeks of leave during any 12-month period to care for the servicemember.

''(4) COMBINED LEAVE TOTAL.—An eligible employee shall be entitled to a combined total of 26 workweeks of leave under paragraphs (1) and (3).''.

(3) REQUIREMENTS RELATING TO LEAVE.—

(A) SCHEDULE.—Section 102(b) of such Act (29 U.S.C. 2612(b)) is amended—

(i) in paragraph (1), by inserting after the second sentence the following: ''Subject to paragraph (2), leave under subsection (a)(3) may be taken intermittently or on a reduced leave schedule''; and

(ii) in paragraph (2), by inserting ''or subsection (a)(3)'' after ''subsection (a)(1)''.

(B) SUBSTITUTION OF PAID LEAVE.—Section 102(d) of such Act (29 U.S.C. 2612(d)) is amended—

(i) in paragraph (1)—

(I) by inserting ''(or 26 workweeks in the case of leave provided under subsection (a)(3))'' after ''12 workweeks'' the first place it appears; and

(II) by inserting ''(or 26 workweeks, as appropriate)'' after ''12 workweeks'' the second place it appears; and

(ii) in paragraph (2)(B), by adding at the end the following: ''An eligible employee may elect, or an employer may require the employee, to substitute any of the accrued paid vacation leave, personal leave, family leave, or medical or sick leave of the employee for leave provided under subsection (a)(3) for any part of the 26-week period of such leave under such subsection.''.

(C) NOTICE.—Section 102(e) of such Act (29 U.S.C. 2612(e)) is amended by adding at the end the following:

''(3) NOTICE FOR SERVICEMEMBER FAMILY LEAVE.—In any case in which an employee seeks leave under subsection (a)(3), the employee shall provide such notice as is practicable.''.

(D) CERTIFICATION.—Section 103 of such Act (29 U.S.C. 2613) is amended by adding at the end the following:

''(f) CERTIFICATION FOR SERVICEMEMBER FAMILY LEAVE.—An employer may require that a request for leave under section 102(a)(3) be supported by a certification issued at such time and in such manner as the Secretary may by regulation prescribe.''.

(E) FAILURE TO RETURN.—Section 104(c) of such Act (29 U.S.C. 2614(c)) is amended—

(i) in paragraph (2)(B)(i), by inserting ''or section 102(a)(3)'' before the semicolon; and

(ii) in paragraph (3)(A)—

(I) in clause (i), by striking ''or'' at the end;

(II) in clause (ii), by striking the period and inserting ''; or''; and

(III) by adding at the end the following:

''(iii) a certification issued by the health care provider of the person for whom the employee is the primary caregiver, in the case of an employee unable to return to work because of a condition specified in section 102(a)(3).''.

(F) ENFORCEMENT.—Section 107 of such Act (29 U.S.C. 2617) is amended, in subsection (a)(1)(A)(i)(II), by inserting ''(or 26 weeks, in a case involving leave under section 102(a)(3))'' after ''12 weeks''.

(G) INSTRUCTIONAL EMPLOYEES.—Section 108 of such Act (29 U.S.C. 2618) is amended, in subsections (c)(1), (d)(2), and (d)(3), by inserting ''or section 102(a)(3)'' after ''section 102(a)(1)''.

(b) SERVICEMEMBER FAMILY LEAVE FOR CIVIL SERVICE EMPLOYEES.—

(1) DEFINITIONS.—Section 6381 of title 5, United States Code, is amended—

(A) in paragraph (5), by striking ''and'' at the end;

(B) in paragraph (6), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(7) the term 'combat-related injury' means an injury or illness that was incurred (as determined under criteria prescribed by the Secretary of Defense)—

''(A) as a direct result of armed conflict;

''(B) while an individual was engaged in hazardous service;

''(C) in the performance of duty under conditions simulating war; or

''(D) through an instrumentality of war; and

''(8) the term 'servicemember' means a member of the Armed Forces.''.

(2) ENTITLEMENT TO LEAVE.—Section 6382(a) of such title is amended by adding at the end the following:

''(3) Subject to section 6383, an employee who is the primary caregiver for a servicemember with a combat-related injury shall be entitled to a total of 26 administrative workweeks of leave during any 12-month period to care for the servicemember.

''(4) An employee shall be entitled to a combined total of 26 administrative workweeks of leave under paragraphs (1) and (3).''.

(3) REQUIREMENTS RELATING TO LEAVE.—

(A) SCHEDULE.—Section 6382(b) of such title is amended—

(i) in paragraph (1), by inserting after the second sentence the following: ''Subject to paragraph (2), leave under subsection (a)(3) may be taken intermittently or on a reduced leave schedule.''; and

(ii) in paragraph (2), by inserting ''or subsection (a)(3)'' after ''subsection (a)(1)''.

(B) SUBSTITUTION OF PAID LEAVE.—Section 6382(d) of such title is amended by adding at the end the following: ''An employee may elect to substitute for leave under subsection (a)(3) any of the employee's accrued or accumulated annual or sick leave under subchapter I for any part of the 26-week period of leave under such subsection.''.

(C) NOTICE.—Section 6382(e) of such title is amended by adding at the end the following:

''(3) In any case in which an employee seeks leave under subsection (a)(3), the employee shall provide such notice as is practicable.''.

(D) CERTIFICATION.—Section 6383 of such title is amended by adding at the end the following:

''(f) An employing agency may require that a request for leave under section 6382(a)(3) be supported by a certification issued at such time and in such manner as the Office of Personnel Management may by regulation prescribe.''.

SA 2561. Mr. SMITH (for himself and Mrs. CLINTON) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. DEMONSTRATION PROJECT REGARDING MEDICAID COVERAGE OF LOW-INCOME HIV-INFECTED INDIVIDUALS.

(a) REQUIREMENT TO CONDUCT DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration project under which a State may apply under section 1115 of the Social Security Act (42 U.S.C. 1315) to provide medical assistance under a State medicaid program to HIV-infected individuals described in subsection (b) in accordance with the provisions of this section.

(2) LIMITATION ON NUMBER OF APPROVED APPLICATIONS.—The Secretary shall only approve as many State applications to provide medical assistance in accordance with this section as will not exceed the limitation on aggregate payments under subsection (d)(2)(A).

(3) AUTHORITY TO WAIVE RESTRICTIONS ON PAYMENTS TO TERRITORIES.—The Secretary shall waive the limitations on payment under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) in the case of a State that is subject to such limitations and submits an approved application to provide medical assistance in accordance with this section.

(b) HIV-INFECTED INDIVIDUALS DESCRIBED.—For purposes of subsection (a), HIV-infected individuals described in this subsection are individuals who are not described in section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i))—

(1) who have HIV infection;

(2) whose income (as determined under the State Medicaid plan with respect to disabled individuals) does not exceed 200 percent of the poverty line (as defined in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)); and

(3) whose resources (as determined under the State Medicaid plan with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in section 1902(a)(10)(A)(i) of such Act may have and obtain medical assistance under such plan.

(c) LENGTH OF PERIOD FOR PROVISION OF MEDICAL ASSISTANCE.—A State shall not be approved to provide medical assistance to an HIV-infected individual in accordance with the demonstration project established under this section for a period of more than 5 consecutive years.

(d) 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, $500,000,000 for the period of fiscal years 2008 through 2012.

(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) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $500,000,000; or

(B) payments be provided by the Secretary under this section after September 30, 2012.

(3) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to States with approved applications under this section based on their applications and the availability of funds.

(4) PAYMENTS TO STATES.—The Secretary shall pay to each State, from its allocation under paragraph (3), an amount each quarter equal to the enhanced FMAP described in section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) of expenditures in the quarter for medical assistance provided to HIV-infected individuals who are eligible for such assistance under a State Medicaid program in accordance with the demonstration project established under this section.

(e) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration project established under this section. Such evaluation shall include an analysis of the cost-effectiveness of the project and the impact of the project on the Medicare, Medicaid, and Supplemental Security Income programs established under titles XVIII, XIX, and XVI, respectively, of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq., 1381 et seq.).

(2) REPORT TO CONGRESS.—Not later than December 31, 2012, the Secretary shall submit a report to Congress on the results of the evaluation of the demonstration project established under this section.

SA 2562. Mr. KYL submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. 61__. EXTENSION AND MODIFICATION OF 15-YEAR STRAIGHT-LINE COST RECOVERY FOR QUALIFIED LEASEHOLD IMPROVEMENTS AND QUALIFIED RESTAURANT IMPROVEMENTS; 15-YEAR STRAIGHT-LINE COST RECOVERY FOR CERTAIN IMPROVEMENTS TO RETAIL SPACE.

(a) EXTENSION OF LEASEHOLD AND RESTAURANT IMPROVEMENTS.—

(1) IN GENERAL.—Clauses (iv) and (v) of section 168(e)(3)(E) of the Internal Revenue Code of 1986 (relating to 15-year property) are each amended by striking ''January 1, 2008'' and inserting ''January 1, 2009''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to property placed in service after December 31, 2007.

(b) MODIFICATION OF TREATMENT OF QUALIFIED RESTAURANT PROPERTY AS 15-YEAR PROPERTY FOR PURPOSES OF DEPRECIATION DEDUCTION.—

(1) TREATMENT TO INCLUDE NEW CONSTRUCTION.—Paragraph (7) of section 168(e) of the Internal Revenue Code of 1986 (relating to classification of property) is amended to read as follows:

''(7) QUALIFIED RESTAURANT PROPERTY.—The term 'qualified restaurant property' means any section 1250 property which is a building (or its structural components) or an improvement to such building if more than 50 percent of such building's square footage is devoted to preparation of, and seating for on-premises consumption of, prepared meals.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to any property placed in service after the date of the enactment of this Act, the original use of which begins with the taxpayer after such date.

(c) RECOVERY PERIOD FOR DEPRECIATION OF CERTAIN IMPROVEMENTS TO RETAIL SPACE.—

(1) 15-YEAR RECOVERY PERIOD.—Section 168(e)(3)(E) of the Internal Revenue Code of 1986 (relating to 15-year property) is amended by striking ''and'' at the end of clause (vii), by striking the period at the end of clause (viii) and inserting '', and'', and by adding at the end the following new clause:

''(ix) any qualified retail improvement property placed in service before January 1, 2009.''.

(2) QUALIFIED RETAIL IMPROVEMENT PROPERTY.—Section 168(e) of such Code is amended by adding at the end the following new paragraph:

''(8) QUALIFIED RETAIL IMPROVEMENT PROPERTY.—

''(A) IN GENERAL.—The term 'qualified retail improvement property' means any improvement to an interior portion of a building which is nonresidential real property if—

''(i) such portion is open to the general public and is used in the retail trade or business of selling tangible personal property to the general public, and

''(ii) such improvement is placed in service more than 3 years after the date the building was first placed in service.

''(B) IMPROVEMENTS MADE BY OWNER.—In the case of an improvement made by the owner of such improvement, such improvement shall be qualified retail improvement property (if at all) only so long as such improvement is held by such owner. Rules similar to the rules under paragraph (6)(B) shall apply for purposes of the preceding sentence.

''(C) CERTAIN IMPROVEMENTS NOT INCLUDED.—Such term shall not include any improvement for which the expenditure is attributable to—

''(i) the enlargement of the building,

''(ii) any elevator or escalator,

''(iii) any structural component benefitting a common area, or

''(iv) the internal structural framework of the building.''.

(3) REQUIREMENT TO USE STRAIGHT LINE METHOD.—Section 168(b)(3) of such Code is amended by adding at the end the following new subparagraph:

''(I) Qualified retail improvement property described in subsection (e)(8).''.

(4) ALTERNATIVE SYSTEM.—The table contained in section 168(g)(3)(B) of such Code is amended by inserting after the item relating to subparagraph (E)(viii) the following new item:

(E)(ix) ..... 39''.

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to property placed in service after the date of the enactment of this Act.

SA 2563. Mr. KYL submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, add the following:

SEC. _____. PERMANENT EXTENSION OF EXPENSING FOR SMALL BUSINESSES.

(a) DOLLAR LIMITATION.—Paragraph (1) of section 179(b) of the Internal Revenue Code

of 1986 is amended by striking ''$25,000 ($125,000 in the case of taxable years beginning after 2006 and before 2011)'' and inserting ''$125,000''.

(b) REDUCTION IN LIMITATION.—Paragraph (2) of section 179(b) of the Internal Revenue Code of 1986 is amended by striking ''$200,000 ($500,000 in the case of taxable years beginning after 2006 and before 2011)'' and inserting ''$500,000''.

(c) INFLATION ADJUSTMENTS.—Subparagraph (A) of section 179(b)(5) of the Internal Revenue Code of 1986 is amended by striking ''and before 2011''.

(d) ELECTION.—Paragraph (2) of section 179(c) of the Internal Revenue Code of 1986 is amended by striking ''and before 2011''.

(e) COMPUTER SOFTWARE.—Clause (ii) of section 179(d)(1)(A) of the Internal Revenue Code of 1986 is amended by striking ''and before 2011''.

SA 2564. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 196, between lines 18 and 19, insert the following:

(c) GAO STUDY AND REPORT ON ACCESS TO ORAL HEALTH CARE, INCLUDING PREVENTIVE AND RESTORATIVE SERVICES.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of children's access to oral health care, including preventive and restorative services, under Medicaid and CHIP, including—

(A) the extent to which providers are willing to treat children eligible for such programs;

(B) information on such children's access to networks of care;

(C) geographic availability of oral health care, including preventive and restorative services, under such programs; and

(D) as appropriate, information on the degree of availability of oral health care, including preventive and restorative services, for children under such programs.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the appropriate committees of Congress on the study conducted under paragraph (1) that includes recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are necessary to address any barriers to access to oral health care, including preventive and restorative services, under Medicaid and CHIP that may exist.

SA 2565. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 85, between lines 2 and 3, insert the following:

''(3) FIVE PERCENT SET ASIDE FOR OUTREACH TO AND ENROLLMENT OF CHILDREN IN UNDESERVED COMMUNITIES.—An amount equal to 5 percent of the funds appropriated under subsection (g) shall be used by the Secretary to award grants to school-based health centers for outreach to and enrollment of children in undeserved communities.

SA 2566. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 168, line 22, insert ''dental care,'' after ''health services,''.

SA 2567. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title II, add the following:

SEC. _____. ESTABLISHMENT OF STATE TELEPHONE HOTLINES FOR ACCESS TO DENTAL PROVIDERS.

The Secretary shall work with States to establish telephone hotlines for individuals enrolled in a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act, or any waiver of such plans, who have dental coverage under such a plan or waiver in order to identify participating dental providers who are willing to accept such individuals as patients under such a plan or waiver.

SA 2568. Mr. AKAKA (for himself, Mr. ALEXANDER, Mr. INOUYE, and Mr. CORKER) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. MEDICAID DSH ALLOTMENTS FOR TENNESSEE AND HAWAII.

(a) TENNESSEE.—The DSH allotments for Tennessee for each fiscal year beginning with fiscal year 2008 under subsection (f)(3) of section 1923 of the Social Security Act (42 U.S.C. 13961396r–4) are deemed to be $30,000,000. The Secretary of Health and Human Services may impose a limitation on the total amount of payments made to hospitals under the TennCare Section 1115 waiver only to the extent that such limitation is necessary to ensure that a hospital does not receive payment in excess of the amounts described in subsection (f) of such section or as necessary to ensure that the waiver remains budget neutral.

(b) HAWAII.—Section 1923(f)(6) (42 U.S.C. 1396r–4(f)(6)) is amended—

(1) in the paragraph heading, by striking ''FOR FISCAL YEAR 2007''; and

(2) in subparagraph (B)—

(A) in clause (i), by striking ''Only with respect to fiscal year 2007'' and inserting ''With respect to each of fiscal years 2007 and 2008'';

(B) by redesignating clause (ii) as clause (iv); and

(C) by inserting after clause (i), the following new clauses:

''(ii) TREATMENT AS A LOW-DSH STATE.—With respect to fiscal year 2009 and each fiscal year thereafter, notwithstanding the table set forth in paragraph (2), the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clauses (ii) and (iii) of paragraph (5)(B).

''(iii) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this section do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.''.

SA 2569. Mr. MENENDEZ submitted an amendment intended to be proposed to amendment SA 2547 submitted by Mr. BUNNING to the amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of the matter proposed to be inserted, add the following:

(d) EXCLUSION OF FEDERALLY ELECTED OFFICIALS WITH INCOMES OVER 300 PERCENT OF THE FEDERAL POVERTY LINE FROM BENEFITS UNDER FEHBP.—Notwithstanding any other provision of law, on and after October 1, 2007, any federally elected official, including a Member of Congress and the President, whose income exceeds 300 percent of the Federal poverty line shall not be eligible for benefits under the Federal Employees Health Benefits Program (FEHBP) under chapter 89 of title 5, United States Code.

SA 2570. Mr. WYDEN submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 39, line 8, after the period, insert the following: ''In addition, States may use up to 1 percent of any payments received from the Incentive Pool to fund voluntary incentive programs to promote children's receipt of relevant screenings and improvements in healthy eating and physical activity with the aim of reducing the incidence of type 2 diabetes. Such programs may involve reductions in cost-sharing or premiums when children receive regular screening and reach certain benchmarks in healthy eating and physical activity. Under such programs, a State may also provide financial bonuses for partnerships with entities, such as schools, which increase their education and efforts with respect to reducing the incidence of type 2 diabetes and childhood obesity and may also devise incentives for providers

serving children covered under this title and title XIX to perform relevant screening and counseling regarding healthy eating and physical activity.''.

On page 195, between lines 15 and 16, insert the following new paragraph:

''(7) To the extent applicable, a description of any efforts to address type 2 diabetes and childhood obesity that are funded under the program under this title (and the program under title XIX, as appropriate).''.

SA 2571. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, insert the following:

SEC. ___. INCENTIVE PROGRAM FOR STATE HEALTH ACCESS INNOVATIONS.

Section 2104, as amended by section 108, is amended by adding at the end the following new subsection:

''(l) INCENTIVE PROGRAM FOR STATE HEALTH ACCESS INNOVATIONS.—

''(1) ESTABLISHMENT OF STATE HEALTH ACCESS INNOVATIONS INCENTIVE POOL.—

''(A) IN GENERAL.—There is hereby established in the Treasury of the United States a fund which shall be known as the 'CHIP State Health Access Innovations Pool' (in this subsection referred to as the 'SHAI Pool''). Amounts in the SHAI Pool are authorized to be appropriated for payments under this subsection and shall remain available until expended.

''(B) TRANSFER OF FUNDS.—Notwithstanding subsection (j)(1)(B)(i), from the amount appropriated for fiscal year 2008 under such subsection, $250,000,000 of such amount is hereby transferred to the SHAI Pool and made available for expenditure from such pool for the period of fiscal years 2008 through 2012.

''(2) AWARD OF GRANTS.—

''(A) IN GENERAL.—The Secretary shall award grants to eligible States from amounts in the SHAI Pool in accordance with this subsection.

''(B) ELIGIBLE STATE.—For purposes of this subsection, an eligible State is a State—

''(i) for which the percentage of low-income children without health insurance (as determined by the Secretary on the basis of the most recent data available) is less than 10 percent; and

''(ii) that submits an application for a grant from the SHAI Pool for the purpose of carrying out programs and activities that are designed to expand access to health providers and health services for low-income children who are eligible for medical assistance under the State plan under title XIX (or a waiver of such plan) or child health assistance under the State child health plan under this title.

''(3) REQUIREMENTS.—

''(A) PRIORITY IN AWARDING OF GRANTS.—In awarding grants under this subsection, the Secretary shall give preference to grant applications that—

''(i) propose innovative approaches to increasing the availability of health care providers and services;

''(ii) create longer-term improvements in health care infrastructure;

''(iii) have potential application in other States;

''(iv) seek to remedy shortages of health care providers; or

''(v) result in the direct provision of health services.

''(B) PROHIBITIONS.—The Secretary shall not—

''(i) award a grant to carry out programs or activities which the Secretary determines would substitute for services or funds provided by a State or the Federal Government; or

''(ii) disapprove any grant application on the basis that programs or activities to be conducted with funds provided under the grant would be provided through or by an entity that otherwise receives Federal or State funding, such as a Federally-qualified health center.

''(C) TERM, AMOUNT, AND NUMBER OF GRANTS PER ELIGIBLE STATES.—

''(i) TERM.—A grant awarded under this subsection may be renewed each year for a period of up to 5 years, but in no case later than fiscal year 2012.

''(ii) AMOUNT.—No grant awarded under this subsection may exceed $2,000,000 for any fiscal year.

''(iii) NO LIMIT ON NUMBER OF GRANTS PER STATE.—Nothing in this subsection shall be construed as limiting the number of grants that an eligible State may be awarded under this subsection.

''(D) ANNUAL AGGREGATE LIMIT.—The aggregate amount of all grants awarded from the SHAI pool shall not exceed—

''(i) $50,000,000 in fiscal year 2008;

''(ii) $100,000,000 in fiscal year 2009;

''(iii) $150,000,000 in fiscal year 2010;

''(iv) $200,000,000 in fiscal year 2011; and

''(v) $250,000,000 in fiscal year 2012.''.

SA 2572. Mr. SANDERS submitted an amendment intended to be proposed to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end appropriate place, add the following:

SEC. _____. IMPROVMENTS TO MEDICARE COVERAGE OF AND PAYMENT FOR FQHC SERVICES.

(a) COVERAGE FOR FQHC AMBULATORY SERVICES.—Section 1861(aa)(3) of the Social Security Act (42 U.S.C. 1395x(aa)(3)) is amended to read as follows:

''(3) The term 'Federally qualified health center services' means—

''(A) services of the type described in subparagraphs (A) through (C) of paragraph (1), and such other services furnished by a Federally qualified health center for which payment may otherwise be made under this title if such services were furnished by a health care provider or health care professional other than a Federally qualified health center; and

''(B) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act; when furnished to an individual as a patient of a Federally qualified health center.''.

(b) PER VISIT PAYMENT REQUIREMENTS FOR FQHCS.—Section 1833(a)(3)(A) of the Social Security Act (42 U.S.C. 1395l(a)(3)(A)), is amended by adding ''(which regulations may not limit the per visit payment amount, or a component of such amount, for services described in section 1832(a)(2)(D)(ii))'' after ''the Secretary may prescribe in regulations''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 2008.

SA 2573. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. _____. SENSE OF THE SENATE REGARDING MEDICARE PAYMENT FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.

It is the sense of the Senate that title XVIII of the Social Security Act, regarding per visit Medicare payment requirements for Federally qualified health centers (FQHCs), should be amended by adding that regulations may not limit the per visit payment amount or a component of such amount.

SA 2574. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PREVENTING THE CARRYING OUT OF A PROPOSED RULE.

The Secretary shall not take any action to finalize (or otherwise implement) provisions contained in the proposed rule published on May 3, 2007, on pages 24680 through 25135 of volume 72, Federal Register, insofar as such provisions propose—

(1) to alter payments for services under the hospital inpatient prospective payment system under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) based on use of a Medicare severity diagnosis related group (MS-DRG) system; or

(2) to implement a prospective behavioral offset in response to the implementation of such a Medicare Severity Diagnosis Related Group (MS-DRG) system for purposes of such hospital inpatient prospective payment system.

SA 2575. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. SENSE OF THE SENATE.

It is the sense of the Senate that the Secretary should not take any action to finalize (or otherwise implement) provisions contained in the proposed rule published on May 3, 2007, on pages 24680 through 25135 of volume 72, Federal Register, insofar as such provisions propose—

(1) to alter payments for services under the hospital inpatient prospective payment system under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) based on use of a Medicare severity diagnosis related group (MS-DRG) system; or

(2) to implement a prospective behavioral offset in response to the implementation of such a Medicare Severity Diagnosis Related Group (MS-DRG) system for purposes of such hospital inpatient prospective payment system.

SA 2576. Mr. DEMINT submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

On page 217, after line 25, insert the following:

SEC. __. REPEAL OF MEDICINE AND DRUGS LIMITATION ON DEDUCTION FOR MEDICAL CARE.

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended by striking subsection (b).

(b) CONFORMING AMENDMENT.—Section 213(d) of such Code is amended by striking paragraph (3).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SA 2577. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—HEALTH CARE CHOICE

SEC. __01. SHORT TITLE.

This title may be cited as ''Health Care Choice Act of 2007''.

SEC. __02. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This title is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. __03. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insurance across State lines, as the acts establishing those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. __04. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(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.—The term 'covered laws' means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

''(A) individual health insurance coverage issued by a health insurance issuer;

''(B) the offer, sale, and issuance of individual health insurance coverage to an individual; and

''(C) the provision to an individual in relation to individual health insurance coverage of—

''(i) health care and insurance related services;

''(ii) management, operations, and investment activities of a health insurance issuer; and

''(iii) loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

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

''(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.

''(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, 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; or

''(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9));

''(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 individual 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, except that a State many 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 by, or operation of, a health insurance issuer that is in hazardous financial condition.

''(i) 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.

''(j) STATES' AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

''(k) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

''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 primary State does not meet the following requirements:

''(1) The State insurance commissioner must use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

''(2) The State must have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage unless the issuer provides an independent review mechanism functionally equivalent (as determined by the primary State insurance commissioner or official) 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.

''SEC. 2798. 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 of the enactment of this Act.

SEC. __05. SEVERABILITY.

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

SA 2578. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. _____. TREATMENT OF CERTAIN HOSPITALS IN DETERMINING THE APPROVED FTE RESIDENT AMOUNT FOR PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS UNDER THE MEDICARE PROGRAM.

(a) TREATMENT.—

(1) IN GENERAL.—For purposes of subparagraph (F) of section 1886(h)(2) of the Social Security Act (42 U.S.C. 1395ww(h)(2)), and any regulations implementing such section, in the case of an eligible hospital, the approved FTE resident amount for the hospital's first cost reporting period for which it has an approved medical residency training program and is participating under title XVIII of such Act, subject to paragraph (2), shall be based on the hospital's actual costs incurred in connection with the Graduate Medical Education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(2) LIMIT.—The approved FTE resident amount for such first cost reporting period may not exceed 140 percent of the locality adjusted national average per resident amount computed under subparagraph (E) of such section 1886(h)(2) for the area in which the hospital is located and for the period.

(b) ELIGIBLE HOSPITAL DEFINED.—In this section, the term ''eligible hospital'' means a hospital that—

(1) did not have an approved medical residency training program (as defined in section 1886(h)(5)(A) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(A)) in 1984;

(2) began such a program in a cost reporting period beginning on or after July 1, 2005 and ending before September 30, 2011; and

(3) is located within 150 miles of the Medical Center of Louisiana at New Orleans.

SA 2579. Mr. THUNE (for himself, Mr. LOTT, Mr. CORNYN, and Mr. DEMINT) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. _____. EXCLUSION OF INDIVIDUALS WITH ALTERNATIVE MINIMUM TAX LIABILITY FROM ELIGIBILITY FOR SCHIP COVERAGE.

(a) IN GENERAL.—Section 2102(b), as amended by this Act, is amended by adding at the end the following new paragraph:

''(6) EXCLUSION OF INDIVIDUALS WITH ALTERNATIVE MINIMUM TAX LIABILITY.—Notwithstanding any other provision of this title, no individual whose income is subject to tax liability imposed under section 55 of the Internal Revenue Code of 1986 for the taxable year shall be eligible for assistance under a State plan under this title for the fiscal year following such taxable year.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SA 2580. Mr. BINGAMAN (for himself, Mr. LEVIN, Ms. STABENOW, and Mr. FEINGOLD) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, add the following:

SEC. ____. ONE-YEAR DELAY IN PROVISIONS RELATING TO PHASE-OUT FOR COVERAGE OF NONPREGNANT CHILDLESS ADULTS.

(a) ONE-YEAR DELAY.—Notwithstanding section 2111(a) of the Social Security Act (as added by section 106), or any other provision of title XXI of such Act, as amended by this Act, each date specified in such section and title relating to the phase-out for coverage of nonpregnant childless adults under an applicable existing waiver (as defined in section 2111(c) of such Act) shall be applied as if such date were 1 year later.

(b) INCREASE IN BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c) (42 U.S.C. 1396r–8(c)) is amended—

(A) in paragraph (1)(B)(i)—

(i) in subclause (IV), by striking ''and'' after the semicolon;

(ii) in subclause (V)—

(I) by inserting ''and before January 1, 2008,'' after ''1995,''; and

(II) by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(VI) after December 31, 2007, is 20.1 percent.''; and

(B) in paragraph (3)(B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii)—

(I) by inserting ''and before January 1, 2008,'' after ''1993,''; and

(II) by striking the period and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(iii) after December 31, 2007, is 16 percent.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

(c) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking ''and'' at the end;

(B) in clause (xii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(xiii) such contract provides that (I) payment for covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall allow the entity to collect such rebates from manufacturers, and (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates.''.

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (d)—

(i) in paragraph (1), by adding at the end the following:

''(C) Notwithstanding subparagraphs (A) and (B)—

''(i) a medicaid managed care organization with a contract under section 1903(m) may exclude or otherwise restrict coverage of a covered outpatient drug on the basis of policies or practices of the organization, such as those affecting utilization management, formulary adherence, and cost sharing or dispute resolution, in lieu of any State policies or practices relating to the exclusion or restriction of coverage of such drugs; and

''(ii) nothing in this section or paragraph (2)(A)(xiii) of section 1903(m) shall be construed as requiring a medicaid managed care organization with a contract under such section to maintain the same such polices and practices as those established by the State for purposes of individuals who receive medical assistance for covered outpatient drugs on a fee-for service basis.''; and

(ii) in paragraph (4), by inserting after subparagraph (E) the following:

''(F) Notwithstanding the preceding subparagraphs of this paragraph, any formulary established by medicaid managed care organization with a contract under section 1903(m) may be based on positive inclusion of drugs selected by a formulary committee consisting of physicians, pharmacists, and other individuals with appropriate clinical experience as long as drugs excluded from the formulary are available through prior authorization, as described in paragraph (5).''; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatients drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by a health maintenance organization other than a medicaid managed care organization with a contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

SA 2581. Mr. BINGAMAN (for himself, Mr. KERRY, and Mr. JOHNSON) submitted an amendment intended to be

proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. INCLUDING COSTS INCURRED BY THE INDIAN HEALTH SERVICE, A FEDERALLY QUALIFIED HEALTH CENTER, AN AIDS DRUG ASSISTANCE PROGRAM, CERTAIN HOSPITALS, OR A PHARMACEUTICAL MANUFACTURER PATIENT ASSISTANCE PROGRAM IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT OF POCKET THRESHOLD UNDER PART D.

(a) INCLUDING COSTS INCURRED.—

(1) IN GENERAL.—Section 1860D–2(b)(4)(C) (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii)—

(i) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred if'';

(ii) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program'';

(iii) by striking ''(other than under such section or such a Program)''; and

(iv) by striking the period at the end and inserting ''; and''; and

(C) 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);

''(IV) by a Federally qualified health center (as defined in section 1861(aa)(4));

''(V) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act;

''(VI) by a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that meets the requirements of clauses (i) and (ii) of section 340B(a)(4)(L) of the Public Health Service Act; or

''(VII) by a pharmaceutical manufacturer patient assistance program, either directly or through the distribution or donation of covered part D drugs, which shall be valued at the negotiated price of such covered part D drug under the enrollee's prescription drug plan or MA–PD plan as of the date that the drug was distributed or donated.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to costs incurred on or after January 1, 2008.

(b) INCREASE IN BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c) (42 U.S.C. 1396r–8(c)) is amended—

(A) in paragraph (1)(B)(i)—

(i) in subclause (IV), by striking ''and'' after the semicolon;

(ii) in subclause (V)—

(I) by inserting ''and before January 1, 2008,'' after ''1995,''; and

(II) by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(VI) after December 31, 2007, is 20.1 percent.''; and

(B) in paragraph (3)(B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii)—

(I) by inserting ''and before January 1, 2008,'' after ''1993,''; and

(II) by striking the period and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(iii) after December 31, 2007, is 16 percent.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

SA 2582. Mr. BINGAMAN (for himself, Mr. KERRY, and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. EXTENSION OF MORATORIUM ON SECRETARIAL AUTHORITY.

(a) EXTENSION.—Effective as if included in the enactment of section 7002 of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110–28), subsection (a)(1) of such section is amended, in the matter preceding subparagraph (A), by striking ''1 year'' and inserting ''2 years''.

(b) INCREASE IN BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c) (42 U.S.C. 1396r–8(c)) is amended—

(A) in paragraph (1)(B)(i)—

(i) in subclause (IV), by striking ''and'' after the semicolon;

(ii) in subclause (V)—

(I) by inserting ''and before January 1, 2008,'' after ''1995,''; and

(II) by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(VI) after December 31, 2007, is 20.1 percent.''; and

(B) in paragraph (3) (B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii)—

(I) by inserting ''and before January 1, 2008,'' after ''1993,''; and

(II) by striking the period and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(iii) after December 31, 2007, is 16 percent.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

SA 2583. Mr. BINGAMAN (for himself and Mr. KERRY) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself and Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. _____. IMPROVEMENTS TO THE MEDICARE SAVINGS PROGRAM.

(a) INCREASING SLMB ELIGIBILITY INCOME LEVEL TO 135 PERCENT OF POVERTY.—Section 1902(a)(10)(E)(iii) (42 U.S.C. 1396a(a)(10)(E)(iii)) is amended by striking ''and 120 percent in 1995 and years thereafter'' and inserting '', 120 percent in 1995 through 2007, and 135 percent in 2008 and years thereafter''.

(b) IMPROVING THE ASSETS TEST FOR THE MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) (42 U.S.C. 1396d(p)(1)(C)) is amended to read as follows:

''(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed—

''(i) for years before 2008, twice the maximum amount of resources that an individual may have and obtain benefits under that program; and

''(ii) for 2008 and subsequent years, the resource limitation established under this clause (or clause (i)) 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.''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to eligibility determinations for medicare cost-sharing furnished for periods beginning on or after January 1, 2008.

(d) INCREASE IN BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c) (42 U.S.C. 1396r–8(c)) is amended—

(A) in paragraph (1)(B)(i)—

(i) in subclause (IV), by striking ''and'' after the semicolon;

(ii) in subclause (V)—

(I) by inserting ''and before January 1, 2008,'' after ''1995,''; and

(II) by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(VI) after December 31, 2007, is 20.1 percent.''; and

(B) in paragraph (3) (B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii)—

(I) by inserting ''and before January 1, 2008,'' after ''1993,''; and

(II) by striking the period and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(iii) after December 31, 2007, is 16 percent.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

(e) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking ''and'' at the end;

(B) in clause (xii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(xiii) such contract provides that (I) payment for covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall allow the entity to collect such rebates from manufacturers, and (II) capitation rates paid to the entity shall be based on actual

cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates.''.

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (d)—

(i) in paragraph (1), by adding at the end the following:

''(C) Notwithstanding subparagraphs (A) and (B)—

''(i) a medicaid managed care organization with a contract under section 1903(m) may exclude or otherwise restrict coverage of a covered outpatient drug on the basis of policies or practices of the organization, such as those affecting utilization management, formulary adherence, and cost sharing or dispute resolution, in lieu of any State policies or practices relating to the exclusion or restriction of coverage of such drugs; and

''(ii) nothing in this section or paragraph (2)(A)(xiii) of section 1903(m) shall be construed as requiring a medicaid managed care organization with a contract under such section to maintain the same such polices and practices as those established by the State for purposes of individuals who receive medical assistance for covered outpatient drugs on a fee-for service basis.''; and

(ii) in paragraph (4), by inserting after subparagraph (E) the following:

''(F) Notwithstanding the preceding subparagraphs of this paragraph, any formulary established by medicaid managed care organization with a contract under section 1903(m) may be based on positive inclusion of drugs selected by a formulary committee consisting of physicians, pharmacists, and other individuals with appropriate clinical experience as long as drugs excluded from the formulary are available through prior authorization, as described in paragraph (5).''; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatients drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by a health maintenance organization other than a medicaid managed care organization with a contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

SA 2584. Mr. BINGAMAN (for himself, Mr. KERRY and Mr. FEINGOLD) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself and Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 301 and insert the following:

SEC. 301. STATE OPTION TO REQUIRE CERTAIN INDIVIDUALS TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID.

(a) STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(46) (42 U.S.C. 1396a(a)(46)) is amended—

(A) by inserting ''(A)'' after ''(46)'';

(B) by adding ''and'' after the semicolon; and

(C) by adding at the end the following new subparagraph:

''(B) at the option of the State and subject to section 1903(x), require that, with respect to an individual (other than an individual described in section 1903(x)(1)) who declares to be a citizen or national of the United States for purposes of establishing initial eligibility for medical assistance under this title (or, at State option, for purposes of renewing or redetermining such eligibility to the extent that such satisfactory documentary evidence of citizenship or nationality has not yet been presented), there is presented satisfactory documentary evidence of citizenship or nationality of the individual (using criteria determined by the State, which shall be no more restrictive than the criteria used by the Social Security Administration to determine citizenship, and which shall accept as such evidence a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood, and, with respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) that the Secretary, after consulting with such tribes, determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subparagraph));''.

(2) LIMITATION ON WAIVER AUTHORITY.—Notwithstanding any provision of section 1115 of the Social Security Act (42 U.S.C. 1315), or any other provision of law, the Secretary of Health and Human Services may not waive the requirements of section 1902(a)(46)(B) of such Act (42 U.S.C. 1396a(a)(46)(B)) with respect to a State.

(3) CONFORMING AMENDMENTS.—Section 1903 (42 U.S.C. 1396b) is amended—

(A) in subsection (i)—

(i) in paragraph (20), by adding ''or'' after the semicolon;

(ii) in paragraph (21), by striking ''; or'' and inserting a period; and

(iii) by striking paragraph (22); and

(B) in subsection (x) (as amended by section 405(c)(1)(A) of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432))—

(i) by striking paragraphs (1) and (3);

(ii) by redesignating paragraph (2) as paragraph (1);

(iii) in paragraph (1), as so redesignated, by striking ''paragraph (1)'' and inserting ''section 1902(a)(46)(B)''; and

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

''(2) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.''.

(b) CLARIFICATION OF RULES FOR CHILDREN BORN IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MEDICAID.—Section 1903(x) (42 U.S.C. 1396b(x)), as amended by subsection a(3)(B), is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking ''or'' at the end;

(B) by redesignating subparagraph (D) as subparagraph (E); and

(C) by inserting after subparagraph (C) the following new subparagraph:

''(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or''; and

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

''(3) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.''.

(c) EFFECTIVE DATE.—

(1) RETROACTIVE APPLICATION.—The amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 4).

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on the date of enactment of this Act, was determined to be ineligible for medical assistance under a State Medicaid program solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by subsections (a) and (b), had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

(d) INCREASE IN BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c) (42 U.S.C. 1396r–8(c)) is amended—

(A) in paragraph (1)(B)(i)—

(i) in subclause (IV), by striking ''and'' after the semicolon;

(ii) in subclause (V)—

(I) by inserting ''and before January 1, 2008,'' after ''1995,''; and

(II) by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(VI) after December 31, 2007, is 20.1 percent.''; and

(B) in paragraph (3)(B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii)—

(I) by inserting ''and before January 1, 2008,'' after ''1993,''; and

(II) by striking the period and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(iii) after December 31, 2007, is 16 percent.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

(e) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking ''and'' at the end;

(B) in clause (xii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(xiii) such contract provides that (I) payment for covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall allow the entity to collect such rebates from manufacturers, and (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates.''.

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (d)—

(i) in paragraph (1), by adding at the end the following:

''(C) Notwithstanding subparagraphs (A) and (B)—

''(i) a medicaid managed care organization with a contract under section 1903(m) may exclude or otherwise restrict coverage of a covered outpatient drug on the basis of policies or practices of the organization, such as those affecting utilization management, formulary adherence, and cost sharing or dispute resolution, in lieu of any State policies or practices relating to the exclusion or restriction of coverage of such drugs; and

''(ii) nothing in this section or paragraph (2)(A)(xiii) of section 1903(m) shall be construed as requiring a medicaid managed care organization with a contract under such section to maintain the same such polices and practices as those established by the State for purposes of individuals who receive medical assistance for covered outpatient drugs on a fee-for service basis.''; and

(ii) in paragraph (4), by inserting after subparagraph (E) the following:

''(F) Notwithstanding the preceding subparagraphs of this paragraph, any formulary established by medicaid managed care organization with a contract under section 1903(m) may be based on positive inclusion of drugs selected by a formulary committee consisting of physicians, pharmacists, and other individuals with appropriate clinical experience as long as drugs excluded from the formulary are available through prior authorization, as described in paragraph (5).''; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatients drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by a health maintenance organization other than a medicaid managed care organization with a contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

SA 2585. Mr. BINGAMAN (for himself and Mr. LEVIN, Mr. KERRY, Mr. FEINGOLD, Mr. DURBIN, and Mrs. LINCOLN) submitted an amendment intended to be proposed by him to the bill H.R. 976, to to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. INSTITUTE OF MEDICINE STUDY AND REPORT RELATING TO CHIP COVERAGE OF ADULT POPULATIONS.

Not later than July 1, 2009, the Institute of Medicine shall conduct a study and submit a report to Congress regarding coverage of adult populations in CHIP. Such study and report shall include the following:

(1) Quantification of the total Federal and State expenditures made for providing coverage of adult populations under—

(A) section 1115 waivers approved before the date of enactment of this Act with respect to the provision of such coverage under State child health plans; and

(B) the amendments made by this Act.

(2) An analysis of the impact of providing coverage for parents under CHIP on the access of children to health insurance and the access of children to health services.

(3) An analysis of the overall cost of providing coverage to pregnant women enrolled in State child health plans under CHIP. Such analysis shall include the long-term cost-savings to Federal and State governments associated with the provision of prenatal care, including the increase in Federal and State health care expenditures that would be associated with the mother and newborn child (over the mother's lifetime and the child's lifetime) if such prenatal care had not been provided.

SA 2586. Mr. BINGAMAN (for himself and Mr. KERRY) submitted an amendment intended to be proposed by him to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ____. EXPEDITING LOW-INCOME SUBSIDIES AND REVISING THE RESOURCE STANDARDS UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM.

(a) EXPEDITING LOW-INCOME SUBSIDIES.—

(1) IN GENERAL.—Section 1860D–14 (42 U.S.C. 1395w–114) is amended by adding at the end the following new subsection:

''(e) EXPEDITED APPLICATION AND ELIGIBILITY PROCESS.—

''(1) EXPEDITED PROCESS.—

''(A) IN GENERAL.—The Commissioner of Social Security shall provide for an expedited process under this subsection for the qualification for low-income assistance under this section through a request to the Secretary of the Treasury as provided in subparagraphs (B) and (C) for information described in section 6103(l)(21) of the Internal Revenue Code of 1986. Such process shall be conducted in cooperation with the Secretary.

''(B) OPT IN FOR NEWLY ELIGIBLE INDIVIDUALS.—Not later than 60 days after the date of the enactment of this subsection, the Secretary shall ensure that, as part of the Medicare enrollment process, enrolling individuals—

''(i) receive information describing the low-income subsidy provided under this section; and

''(ii) are provided the opportunity to opt-in to the expedited process described in this subsection by requesting that the Commissioner of Social Security screen the individual involved for eligibility for such subsidy through a request to the Secretary of the Treasury under section 6103(l)(21) of the Internal Revenue Code of 1986.

''(C) CURRENTLY ELIGIBLE INDIVIDUALS.—The Commissioner of Social Security shall, as soon as practicable after implementation of subparagraph (A), screen any part D eligible individual to which subparagraph (B) did not apply at the time of such individual's enrollment for eligibility for the low-income subsidy provided under this section through a request to the Secretary of the Treasury under section 6103(l)(21) of the Internal Revenue Code of 1986.

''(2) NOTIFICATION OF POTENTIALLY ELIGIBLE INDIVIDUALS.—Under such process, in the case of each individual identified under paragraph (1) who has not otherwise applied for, or been determined eligible for, benefits under this section (or who has applied for and been determined ineligible for such benefits based only on excess resources), the Commissioner of Social Security shall send a notification that the individual is likely eligible for low-income subsidies under this section. Such notification shall include the following:

''(A) APPLICATION INFORMATION.—Information on how to apply for such low-income subsidies.

''(B) DESCRIPTION OF THE LIS BENEFIT.—A description of the low-income subsidies available under this section.

''(C) INFORMATION ON STATE HEALTH INSURANCE PROGRAMS.—Information on—

''(i) the State Health Insurance Assistance Program for the State in which the individual is located; and

''(ii) how the individual may contact such Program in order to obtain assistance regarding enrollment and benefits under this part.

''(D) ATTESTATION.—An application form that provides for a signed attestation, under penalty of law, as to the amount of income and assets of the individual and constitutes an application for the low-income subsidies under this section. Such form—

''(i) shall not require the submittal of additional documentation regarding income or assets;

''(ii) shall permit the appointment of a personal representative described in paragraph (4); and

''(iii) shall allow for the specification of a language (other than English) that is preferred by the individual for subsequent communications with respect to the individual under this part.

If a State is doing its own outreach to low-income seniors regarding enrollment and low-income subsidies under this part, such process shall be coordinated with the State's outreach effort.

''(3) HOLD-HARMLESS.—Under such process, if an individual in good faith and in the absence of fraud executes an attestation described in paragraph (2)(D) and is provided low-income subsidies under this section on the basis of such attestation, if the individual is subsequently found not eligible for such subsidies, there shall be no recovery made against the individual because of such subsidies improperly paid.

''(4) USE OF AUTHORIZED REPRESENTATIVE.—Under such process, with proper authorization (which may be part of the attestation form described in paragraph (2)(D)), an individual may authorize another individual to act as the individual's personal representative with respect to communications under this part and the enrollment of the individual under a prescription drug plan (or MA–PD plan) and for low-income subsidies under this section.

''(5) USE OF PREFERRED LANGUAGE IN SUBSEQUENT COMMUNICATIONS.—In the case where an attestation described in paragraph (2)(D) is completed and in which a language other than English is specified under clause (iii) of

such paragraph, the Commissioner of Social Security shall provide that subsequent communications to the individual under this part shall be in such language.

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed as precluding the Commissioner of Social Security or the Secretary from taking additional outreach efforts to enroll eligible individuals under this part and to provide low-income subsidies to eligible individuals.''.

(2) PRESCRIPTION DRUG PLANS REQUIRED TO PROVIDE EXPEDITED LOW-INCOME SUBSIDY OPT-IN AS PART OF APPLICATIONS.—

(A) IN GENERAL.—Section 1860D–1(b)(1)(B)(vi) (42 U.S.C. 1395w–101(b)(1)(B)(vi)) is amended by inserting before the period at the end the following: '', except that any application form distributed by a sponsor of a prescription drug plan, or an organization offering an MA–PD plan, shall contain an option for a part D eligible individual to opt-in to the expedited process under section 1860D–14(e) for low-income assistance subsidies under such section by requesting that the individual be screened for eligibility for such subsidy through a request to the Secretary of the Treasury under section 6103(l)(21) of the Internal Revenue Code of 1986''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to application forms for plan years beginning with 2008.

(3) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF DETERMINING INDIVIDUALS ELIGIBLE FOR SUBSIDIES UNDER MEDICARE PART D.—

(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 MEDICARE PART D SUBSIDIES.—

''(A) IN GENERAL.—The Secretary shall, upon written request from the Commissioner of Social Security under section 1860D–14(e)(1) of the Social Security Act, disclose to officers and employees of the Social Security Administration return information of a taxpayer who (according to the records of the Secretary) may be eligible for a subsidy under section 1860D–14 of the Social Security 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 gross income of such taxpayer,

''(iv) such other information relating to the liability of the taxpayer as is prescribed by the Secretary by regulation as might indicate the eligibility of such taxpayer for a subsidy under section 1860D–14 of the Social Security Act, and

''(v) the taxable year with respect to which the preceding information relates.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used by officers and employees of the Social Security Administration only for the purposes of identifying eligible individuals for, and, if applicable, administering—

''(i) low-income subsidies under section 1860D–14 of the Social Security Act, and

''(ii) the Medicare Savings Program implemented under clauses (i), (iii), and (iv) of section 1902(a)(10)(E) of such Act.

''(C) TERMINATION.—Return information may not be disclosed under this paragraph after the date that is one year after the date of the enactment of this paragraph.''.

(B) CONFORMING AMENDMENTS.—Paragraph (4) of section 6103(p) of the Internal Revenue Code of 1986 is amended—

(i) by striking ''(14) or (17)'' in the matter preceding subparagraph (A) and inserting ''(14), (17), or (21)''; and

(ii) by striking ''(15) or (17)'' in subparagraph (F)(ii) and inserting ''(15), (17), or (21)''.

(b) MODIFICATION OF RESOURCE STANDARDS FOR DETERMINATION OF ELIGIBILITY FOR LOW-INCOME SUBSIDY.—

(1) INCREASING THE RESOURCE STANDARD APPLIED TO FULL LOW-INCOME SUBSIDY.—Subparagraph (D) of section 1860D–14(a)(3) (42 U.S.C. 1395w–114(a)(3)) is amended—

(A) in the heading, by striking ''THREE TIMES'';

(B) in clause (i), by striking ''and'' at the end;

(C) in clause (ii)—

(i) by striking ''a subsequent year'' and inserting ''2007'';

(ii) by striking ''this clause for the previous year'' and inserting ''clause (i) for 2006''; and

(iii) by inserting ''(or clause (i))'' after ''this clause''; and

(iv) by striking the period at the end and inserting a semicolon;

(D) by adding at the end the following new clauses:

''(iii) for 2008, six times the maximum amount of resources that an individual may have and obtain benefits under such supplemental security income program; and

''(iv) for a subsequent year the resource limitation established under this clause (or clause (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 ''clause (ii)''.

(2) INCREASING THE ALTERNATE RESOURCE STANDARD.—Subparagraph (E)(i) of such section is amended—

(A) by striking ''and'' at the end of subclause (I);

(B) in subclause (II)—

(i) by striking ''a subsequent year'' and inserting ''2007'';

(ii) by striking ''in this subclause (or subclause (I)) for the previous year'' and inserting ''in subclause (I) for 2006''; and

(iii) by striking the period at the end and inserting a semicolon;

(C) by inserting after subclause (II) the following new subclauses:

''(III) for 2008, $27,500 (or $55,000 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

(D) in the last sentence, by inserting ''or (IV)'' after ''subclause (II)''.

(3) EXEMPTIONS FROM RESOURCES.—Section 1860D–14(a)(3) (42 U.S.C. 1395w–114(a)(3)) is amended—

(A) in subparagraph (D), in the matter preceding clause (i), by inserting '', subject to the additional exclusions provided under subparagraph (G)'' before ''(''';

(B) in subparagraph (E)(i), in the matter preceding subclause (I), by inserting ''subject to the additional exclusions provided under subparagraph (G)'' before ''(''''; and

(C) by adding at the end the following new subparagraph:

''(G) ADDITIONAL EXCLUSIONS.—In determining the resources of an individual (and their eligible spouse, if any) under section 1613 for purposes of subparagraphs (D) and (E) the following additional exclusions shall apply:

''(i) LIFE INSURANCE POLICY.—No part of the value of any life insurance policy shall be taken into account.

''(ii) IN-KIND CONTRIBUTIONS.—No in-kind contribution shall be taken into account.

''(iii) PENSION OR RETIREMENT PLAN.—No balance in any pension or retirement plan shall be taken into account.''.

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

(c) INDEXING DEDUCTIBLE AND COST-SHARING ABOVE ANNUAL OUT-OF-POCKET THRESHOLD FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—

(1) INDEXING DEDUCTIBLE.—Section 1860D–14(a)(4)(B) (42 U.S.C. 1395w–114(a)(4)(B)) is amended—

(A) in clause (i), by striking ''or'';

(B) in clause (ii)—

(i) by striking ''a subsequent year'' and inserting ''2008'';

(ii) by striking ''this clause (or clause (i)) for the previous year'' and inserting ''clause (i) for 2007''; and

(iii) by striking ''involved.'' and inserting ''involved; and'';

(C) by adding after clause (ii) the following new clause:

''(iii) for 2008 and each succeeding year, the amount determined under this subparagraph 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

(D) in the flush sentence at the end, by striking ''clause (i) or (ii)'' and inserting ''clause (i), (ii), or (iii)''.

(2) INDEXING COST-SHARING.—Section 1860D–14(a) (42 U.S.C. 1395w–114(a)) is amended–

(A) in paragraph (1)(D)(iii), by striking ''exceed the copayment amount'' and all that follows through the period at the end and inserting ''exceed—

''(I) for 2006 and 2007, the copayment amount specified under section 1860D–2(b)(4)(A)(i)(I) for the drug and year involved; and

''(II) for 2008 and each succeeding year, the amount determined under this subparagraph 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

(B) in paragraph (2)(E), by striking ''exceed the copayment or coinsurance amount'' and all that follows through the period at the end and inserting ''exceed—

''(i) for 2006 and 2007, the copayment or coinsurance amount specified under section 1860D–2(b)(4)(A)(i)(I) for the drug and year involved; and

''(ii) for 2008 and each succeeding year, the amount determined under this clause 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.''.

(d) NO IMPACT ON ELIGIBILITY FOR BENEFITS UNDER OTHER PROGRAMS.—

(1) IN GENERAL.—Section 1860D–14(a)(3) (42 U.S.C. 1395w–114(a)(3)), as amended by subsection b(3), is amended—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ''subparagraph (F)'' and inserting ''subparagraphs (F) and (H)''; and

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

''(H) NO IMPACT ON ELIGIBILITY FOR BENEFITS UNDER OTHER PROGRAMS.—The availability of premium and cost-sharing subsidies under this section shall not be treated as benefits or otherwise taken into account in determining an individual's eligibility for, or the amount of benefits under, any other Federal program.''.

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

(e) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking ''and'' at the end;

(B) in clause (xii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(xiii) such contract provides that (I) payment for covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall allow the entity to collect such rebates from manufacturers, and (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates.''.

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (d)—

(i) in paragraph (1), by adding at the end the following:

''(C) Notwithstanding subparagraphs (A) and (B)—

''(i) a medicaid managed care organization with a contract under section 1903(m) may exclude or otherwise restrict coverage of a covered outpatient drug on the basis of policies or practices of the organization, such as those affecting utilization management, formulary adherence, and cost sharing or dispute resolution, in lieu of any State policies or practices relating to the exclusion or restriction of coverage of such drugs; and

''(ii) nothing in this section or paragraph (2)(A)(xiii) of section 1903(m) shall be construed as requiring a medicaid managed care organization with a contract under such section to maintain the same such polices and practices as those established by the State for purposes of individuals who receive medical assistance for covered outpatient drugs on a fee-for service basis.''; and

(ii) in paragraph (4), by inserting after subparagraph (E) the following:

''(F) Notwithstanding the preceding subparagraphs of this paragraph, any formulary established by medicaid managed care organization with a contract under section 1903(m) may be based on positive inclusion of drugs selected by a formulary committee consisting of physicians, pharmacists, and other individuals with appropriate clinical experience as long as drugs excluded from the formulary are available through prior authorization, as described in paragraph (5).''; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatients drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by a health maintenance organization other than a medicaid managed care organization with a contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

(f) INCREASE IN BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(1) IN GENERAL.—Section 1927(c) (42 U.S.C. 1396r–8(c)) is amended—

(A) in paragraph (1)(B)(i)—

(i) in subclause (IV), by striking ''and'' after the semicolon;

(ii) in subclause (V)—

(I) by inserting ''and before January 1, 2008,'' after ''1995,''; and

(II) by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(VI) after December 31, 2007, is 20.1 percent.''; and

(B) in paragraph (3) (B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii)—

(I) by inserting ''and before January 1, 2008,'' after ''1993,''; and

(II) by striking the period and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(iii) after December 31, 2007, is 16 percent.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to rebate agreements entered into or renewed under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

SA 2587. Mr. GREGG proposed an amendment to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; as follows:

Beginning on page 42, strike line 4 and all that follows through page 66, line 25, and insert the following:

SEC. 106. LIMITATIONS ON MATCHING RATES FOR POPULATIONS OTHER THAN LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.

(a) LIMITATION ON PAYMENTS.—Section 2105(c) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

''(8) LIMITATIONS ON MATCHING RATE FOR POPULATIONS OTHER THAN TARGETED LOW-INCOME CHILDREN OR PREGNANT WOMEN COVERED THROUGH A SECTION 1115 WAIVER.—For child health assistance or health benefits coverage furnished in any fiscal year beginning with fiscal year 2008:

''(A) FMAP APPLIED TO PAYMENTS ONLY FOR NONPREGNANT CHILDLESS ADULTS AND PARENTS AND CARETAKER RELATIVES ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—The Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to payments for child health assistance or health benefits coverage provided under the State child health plan for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES ENROLLED UNDER A WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(ii) NONPREGNANT CHILDLESS ADULTS ENROLLED UNDER A WAIVER ON SUCH DATE.—A nonpregnant childless adult enrolled in the State child health plan under a waiver, experimental, pilot, or demonstration project described in section 6102(c)(3) of the Deficit Reduction Act of 2005 (42 U.S.C. 1397gg note) on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 and whose family income does not exceed the income eligibility applied under such waiver with respect to that population on such date.

''(iii) NO REPLACEMENT ENROLLEES.—Nothing in clauses (i) or (ii) shall be construed as authorizing a State to provide child health assistance or health benefits coverage under a waiver described in either such clause to a nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child, or a nonpregnant childless adult, who is not enrolled under the waiver on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

''(B) NO FEDERAL PAYMENT FOR ANY NEW NONPREGNANT ADULT ENROLLEES OR FOR SUCH ENROLLEES WHO NO LONGER SATISFY INCOME ELIGIBILITY REQUIREMENTS.—Payment shall not be made under this section for child health assistance or other health benefits coverage provided under the State child health plan or under a waiver under section 1115 for any of the following:

''(i) PARENTS OR CARETAKER RELATIVES UNDER A SECTION 1115 WAIVER APPROVED AFTER THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—A nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child under a waiver, experimental, pilot, or demonstration project that is approved on or after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

''(ii) PARENTS, CARETAKER RELATIVES, AND NONPREGNANT CHILDLESS ADULTS WHOSE FAMILY INCOME EXCEEDS THE INCOME ELIGIBILITY LEVEL SPECIFIED UNDER A SECTION 1115 WAIVER APPROVED PRIOR TO THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child whose family income exceeds the income eligibility level referred to in subparagraph (B)(i), and any nonpregnant childless adult whose family income exceeds the income eligibility level referred to in subparagraph (B)(ii).

''(iii) NONPREGNANT CHILDLESS ADULTS, PARENTS, OR CARETAKER RELATIVES NOT ENROLLED UNDER A SECTION 1115 WAIVER ON THE DATE OF ENACTMENT OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION OF 2007.—Any nonpregnant parent or a nonpregnant caretaker relative of a targeted low-income child who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(i) on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, and any nonpregnant childless adult who is not enrolled in the State child health plan under a section 1115 waiver, experimental, pilot, or demonstration project referred to in subparagraph (B)(ii)(I) on such date.

''(C) DEFINITION OF CARETAKER RELATIVE.—In this subparagraph, the term 'caretaker relative' has the meaning given that term for purposes of carrying out section 1931.

''(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as implying that payments for coverage of populations for which the Federal medical assistance percentage (as so determined) is to be substituted for the enhanced FMAP under subsection (a)(1) in accordance with this paragraph are to be made from funds other

than the allotments determined for a State under section 2104.''.

(b) CONFORMING AMENDMENT.—Section 2105(a)(1) (42 U.S.C. 1397dd(a)(1)) is amended, in the matter preceding subparagraph (A), by inserting ''or subsection (c)(8)'' after ''subparagraph (B)''.

(c) NONAPPLICATION OF CERTAIN REFERENCES.—Subsections (e), (i), (j), and (k) of section 2104 (42 U.S.C. 1397dd), as added by this Act, shall be applied without regard to any reference to section 2111.

SEC. 107. PROHIBITION ON NEW SECTION 1115 WAIVERS FOR COVERAGE OF ADULTS OTHER THAN PREGNANT WOMEN.

(a) IN GENERAL.—Section 2107(f) (42 U.S.C. 1397gg(f)) is amended—

(1) by striking '', the Secretary'' and inserting '':

''(1) The Secretary''; and

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

''(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for any other adult other than a pregnant woman whose family income does not exceed the income eligibility level specified for a targeted low-income child in that State under a waiver or project approved as of such date.

''(3) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2105(c)(8).''.

(b) CLARIFICATION OF AUTHORITY FOR COVERAGE OF PREGNANT WOMEN.—Section 2106 (42 U.S.C. 1397ff) is amended by adding at the end the following new subsection:

''(f) NO AUTHORITY TO COVER PREGNANT WOMEN THROUGH STATE PLAN.—For purposes of this title, a State may provide assistance to a pregnant woman under the State child health plan only—

''(1) by virtue of a waiver under section 1115; or

''(2) through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.''.

(c) ASSURANCE OF NOTICE TO AFFECTED ENROLLEES.—The Secretary of Health and Human Services shall establish procedures to ensure that States provide adequate public notice for parents, caretaker relatives, and nonpregnant childless adults whose eligibility for child health assistance or health benefits coverage under a waiver under section 1115 of the Social Security Act will be terminated as a result of the amendments made by subsection (a), and that States otherwise adhere to regulations of the Secretary relating to procedures for terminating waivers under section 1115 of the Social Security Act.

SA 2588. Mr. OBAMA (for himself, Mrs. MCCASKILL, Mr. HARKIN, Mr. KERRY, and Ms. LANDRIEU) submitted an amendment intended to be proposed to amendment SA 2530 proposed by Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. ROCKEFELLER, and Mr. HATCH) to the bill H.R. 976, to amend the Internal Revenue Code of 1986 to provide tax relief for small businesses, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. _____. MILITARY FAMILY JOB PROTECTION.

(a) SHORT TITLE.—This section may be cited as the ''Military Family Job Protection Act''.

(b) PROHIBITION ON DISCRIMINATION IN EMPLOYMENT AGAINST CERTAIN FAMILY MEMBERS CARING FOR RECOVERING MEMBERS OF THE ARMED FORCES.—A family member of a recovering servicemember described in subsection (c) shall not be denied retention in employment, promotion, or any benefit of employment by an employer on the basis of the family member's absence from employment as described in that subsection, for a period of not more than 52 workweeks.

(c) COVERED FAMILY MEMBERS.—A family member described in this subsection is a family member of a recovering servicemember who is—

(1) on invitational orders while caring for the recovering servicemember;

(2) a non-medical attendee caring for the recovering servicemember; or

(3) receiving per diem payments from the Department of Defense while caring for the recovering servicemember.

(d) TREATMENT OF ACTIONS.—An employer shall be considered to have engaged in an action prohibited by subsection (b) with respect to a person described in that subsection if the absence from employment of the person as described in that subsection is a motivating factor in the employer's action, unless the employer can prove that the action would have been taken in the absence of the absence of employment of the person.

(e) DEFINITIONS.—In this section:

(1) BENEFIT OF EMPLOYMENT.—The term ''benefit of employment'' has the meaning given such term in section 4303 of title 38, United States Code.

(2) CARING FOR.—The term ''caring for'', used with respect to a recovering servicemember, means providing personal, medical, or convalescent care to the recovering servicemember, under circumstances that substantially interfere with an employee's ability to work.

(3) EMPLOYER.—The term ''employer'' has the meaning given such term in section 4303 of title 38, United States Code, except that the term does not include any person who is not considered to be an employer under title I of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611 et seq.) because the person does not meet the requirements of section 101(4)(A)(i) of such Act (29 U.S.C. 2611(4)(A)(i)).

(4) FAMILY MEMBER.—The term ''family member'', with respect to a recovering servicemember, has the meaning given that term in section 411h(b) of title 37, United States Code.

(5) RECOVERING SERVICEMEMBER.—The term ''recovering servicemember'' means a member of the Armed Forces, including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy, or is otherwise in medical hold or medical holdover status, for an injury, illness, or disease incurred or aggravated while on active duty in the Armed Forces.

SA 2589. Mr. REID proposed an amendment to the bill S. 1, to provide greater transparency in the legislative process; as follows:

At the end of the amendment add the following:

This section shall take effect 3 days after date of enactment.

SA 2590. Mr. REID proposed an amendment to amendment SA 2589 proposed by Mr. REID to the bill S. 1, to provide greater transparency in the legislative process; as follows:

In the amendment strike 3 and insert 1.

SA 2591. Mr. TESTER (for Mr. BIDEN) proposed an amendment to the resolution S. Res. 276, calling for the urgent deployment of a robust and effective multinational peacekeeping mission with sufficient size, resources, leadership, and mandate to protect civilians in Darfur, Sudan, and for efforts to strengthen the renewal of a just and inclusive peace process; as follows:

On page 8, line 9, strike ''and'',

On page 8, between lines 9 and 10, insert the following:

(5) urges all participants in the conflict in Darfur, including the leaders of rebel movements that were not signatories to the Darfur Peace Agreement, to participate fully in all meetings, conferences, and discussions within a political process led by the United Nations and African Union in order to return peace and security to the people of Darfur;

(6) regards failure to participate in such meetings, conferences, and discussions, as requested by the African Union and United Nations, as an obstruction of the political process and its goals that may be worthy of international sanctions; and

On page 8, line 10, strike ''(5)'' and insert ''(7)''.

SA 2592. Mr. TESTER (for Mr. BIDEN) proposed an amendment to the resolution S. Res. 276, calling for the urgent deployment of a robust and effective multinational peacekeeping mission with sufficient size, resources, leadership, and mandate to protect civilians in Darfur, Sudan, and for efforts to strengthen the renewal of a just and inclusive peace process; as follows:

In the twelfth whereas clause, insert ''and members of his administration'' after ''al-Bashir''.

Strike the seventeenth whereas clause and insert the following:

Whereas the United Nations and African Union have invited leaders of the rebel movements in Darfur to participate in a political process led by the United Nations and African Union to return peace and stability to the people of Darfur;

Whereas deliberately targeting civilians and people providing humanitarian assistance during an armed conflict is a flagrant violation of international humanitarian law, and those who commit such violations must be held accountable; and

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AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on July 31, 2007, at 9:30 a.m., in open session (and possibly closed session) to consider the following nominations:

Admiral Michael G. Mullen, USN for reappointment to the grade of Admiral and to be Chairman of the Joint Chiefs of Staff; and General James E. Cartwright, USMC for reappointment to the grade of General and to be Vice Chairman of the Joint Chiefs of Staff.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on July 31, 2007, at 9:30 a.m., to conduct a hearing entitled ''The State of the Securities Markets.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to hold a hearing during the session of the Senate on Tuesday, July 31, 2007, at 10 a.m., in room 253 of the Russell Senate Office Building.

The hearing is on the nominations of Vice Admiral Thomas J. Barrett, USCG (Ret.), to be Deputy Secretary, U.S. Department of Transportation, Mr. Ronald Spoehel, to be Chief Financial Officer, National Aeronautics and Space Administration, Rear Admiral William G. Sutton, Jr., USN (Ret.), to be Assistant Secretary of Commerce, U.S. Department of Commerce, and Mr. Paul R. Brubaker, to be Administrator of the Research and Innovative Technology Administration, U.S. Department of Transportation.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to hold a hearing during the session of the Senate on Tuesday, July 31, 2007, at 2:30 p.m., in room 253 of the Russell Senate Office Building.

The purpose of this hearing is to examine three major consumer protection and fraud prevention issues under the jurisdiction of the Federal Trade Commission: 1. The effectiveness of the national Do-Not-Call registry and current legislative proposals to improve the Do-Not-Call Implementation Act of 2003; 2. The effectiveness of CROA and possible legislative initiatives to clarify the language of the act; and 3. Telemarketing fraud, particularly against older Americans.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATIONAL RESOURCES

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to hold a hearing during the session of the Senate on Tuesday, July 31, 2007, at 2:30 p.m. in room SD–366 of the Dirksen Senate Office Building. The purpose of this hearing is to receive testimony on renewable fuels infrastructure.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works be authorized to meet during the session of the Senate on Tuesday, July 31, 2007, at 9:30 a.m. in room 406 of the Dirksen Senate Office Building, in order to conduct a business meeting.

The meeting will consider the following agenda:

Bill to reauthorize the provision of technical assistance to small public water systems, S. 1429; Ban Asbestos in America Act, S. 742; Toxic Right to Know Protection Act, S. 595; California waiver decision deadline bill, S. 1785; National Infrastructure Improvement Act, S. 775; The Multinational Species Conservation Funds reauthorizations, HR 5O and HR 465; The Captive Primate Safety Act, S. 1498; U.S. Army Corps of Engineers Resolutions; Nomination of Robert Lyle Laverty to be Assistant Secretary for Fish, Wildlife, and Parks, U.S. Department of the Interior; Nomination of Robert Lance Boldrey nominee for reappointment to the Board of Trustees for the Morris K. Udall Scholarship and Excellence in National Environmental Policy Foundation.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on Tuesday, July 31, 2007, at 10 a.m., in room 215 of the Dirksen Senate Office Building, to hear testimony on ''Carried Interest, Part II.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Tuesday, July 31, 2007, at 9:30 a.m. in order to hold a hearing on nuclear energy and nonproliferation challenges.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet in order to conduct a hearing entitled ''Evaluating the Propriety and Adequacy of the Oxycontin Criminal Settlement'' on Tuesday, July 31, 2007, at 2:30 p.m. in the Dirksen Senate Office Building room 226.

Witness list:

Panel I: John L. Brownlee, United States Attorney, Western District of Virginia, Roanoke, VA;

Panel II: Marianne Skolek, LPN, Myrtle Beach, SC; Vikramaditya Khanna, Professor of Law, University of Michigan Law School, Ann Arbor, MI; Sidney M. Wolfe, M.D., Director, Public Citizen's Health Research Group, Washington, DC; Virginia Pagano, Police Officer, Philadelphia Police Department, Narcotics Bureau, Philadelphia, PA; Jay P. McCloskey, Former U.S. Attorney, Maine, McCloskey, Mina, Cunniff & Dilworth, LLC, Portland, ME; James Campbell, M.D., Professor of Neurosurgery, Johns Hopkins Hospital, Baltimore, MD.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON VETERANS' AFFAIRS

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on Tuesday, July 31, to conduct a hearing on DoD/VA collaboration and cooperation and the education needs of returning service members. The committee will meet in Dirksen 562, at 9:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. WYDEN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on July 31, 2007 at 2:30 p.m. to hold a closed hearing.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON ANTITRUST, COMPETITION POLICY, AND CONSUMER RIGHTS

Mr. WYDEN. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights be authorized to meet on Tuesday, July 31, 2007 at 10 a.m. in order to conduct a hearing entitled ''The Leegin Decision: the end of the consumer discounts or good antitrust policy'' in room 226 of the Dirksen Senate Office Building.

Witness list: Pamela Jones Harbour, Commissioner, Federal Trade Commission Washington, DC; Robert Pitofsky, Sheehy Professor of Antitrust Law and Regulation, Georgetown University Law School, Washington, DC; Marcy Syms, Chief Executive Officer, SYMS, Secaucus, NJ; Stephan Bolerjack, Attorney at Law, Dykema Gossett PLLC, Representing the National Association of Manufacturers, Detroit, MI; and Janet L. McDavid, Attorney at Law, Hogan & Hartson, Washington, DC.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. GRASSLEY. Mr. President, I ask unanimous consent that Emily Wieneke and Molly Gallentine be granted floor privileges during the debate on H.R. 976.

The PRESIDING OFFICER. Without objection, it is so ordered.

TEMPORARY EXTENSION OF PROGRAMS UNDER THE SMALL BUSINESS ACT AND THE SMALL BUSINESS INVESTMENT ACT

Mr. TESTER. Mr. President, I ask unanimous consent that the Senate

proceed to the immediate consideration of H.R. 3206, which was received from the House and is at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 3206) to provide for an additional temporary extension of programs under the Small Business Act and the Small Business Investment Act of 1958 through December 15, 2007, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. TESTER. Mr. President, I ask unanimous consent that the bill be read three times, passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD, without intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 3206) was ordered to a third reading, was read the third time, and passed.

PROVIDING FOR THE REAPPOINTMENT OF ROGER W. SANT

Mr. TESTER. Mr. President, I ask unanimous consent that the Rules Committee be discharged from further consideration of S.J. Res. 7 and that the Senate then proceed to its consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the joint resolution by title.

The legislative clerk read as follows:

A joint resolution (S.J. Res. 7) providing for the reappointment of Roger W. Sant as a citizen regent of the Board of Regents of the Smithsonian Institution.

There being no objection, the Senate proceeded to consider the joint resolution.

Mr. TESTER. Mr. President, I ask unanimous consent that the joint resolution be read three times, passed, and the motion to reconsider be laid upon the table; that any statements relating to the joint resolution be printed in the RECORD.

The joint resolution (S.J. Res. 7) was ordered to be engrossed for a third reading, was read the third time, and passed, as follows:

S.J. RES. 7

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That, in accordance with section 5581 of the Revised Statutes (20 U.S.C. 43), the vacancy on the Board of Regents of the Smithsonian Institution, in the class other than Members of Congress, occurring because of the expiration of the term of Roger W. Sant of Washington, D.C., as filled by the reappointment of Roger W. Sant, for a term of 6 years, effective October 25, 2007.

PROVIDING FOR THE REAPPOINTMENT OF PATRICIA Q. STONESIFER

Mr. TESTER. Mr. President, I ask unanimous consent that the Rules Committee be discharged from further consideration of S.J. Res. 8 and that the Senate then proceed to its consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the joint resolution by title.

The legislative clerk read as follows:

A joint resolution (S.J. Res. 8) providing for the reappointment of Patricia Q. Stonesifer as a citizen regent of the Board of Regents of the Smithsonian Institution.

There being no objection, the Senate proceeded to consider the joint resolution.

Mr. TESTER. Mr. President, I ask unanimous consent that the joint resolution be read three times, passed, and the motion to reconsider be laid upon the table; that any statements relating to the joint resolution be printed in the RECORD.

The joint resolution (S.J. Res. 8) was ordered to be engrossed for a third reading, was read the third time, and passed, as follows:

S.J. RES. 8

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That, in accordance with section 5581 of the Revised Statutes (20 U.S.C. 43), the vacancy on the Board of Regents of the Smithsonian Institution, in the class other than Members of Congress, occurring because of the expiration of the term of Patricia Q. Stonesifer of Washington, is filled by the reappointment of Patricia Q. Stonesifer, for a term of 6 years, effective December 22, 2007.

PEACEKEEPING MISSION IN DARFUR, SUDAN

Mr. TESTER. Mr. President, I ask unanimous consent the Foreign Relations Committee be discharged from further consideration of S. Res. 276, and that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 276) calling for the urgent deployment of a robust and effective multinational peacekeeping mission with sufficient size, resources, leadership and mandate to protect civilians in Darfur, Sudan, and efforts to strengthen renewal of a just and conclusive peace process.

There being no objection, the Senate proceeded to consider the resolution.

Mr. TESTER. I ask unanimous consent the amendment to the resolution be agreed to, the resolution, as amended, be agreed to, the amendment to the preamble, which is at the desk, be considered and agreed to, the preamble, as amended, be agreed to, the motions to reconsider be laid on the table en bloc, and that any statements related thereto be printed in the RECORD, without intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2591) was agreed to, as follows:

On page 8, line 9, strike ''and''.

On page 8, between lines 9 and 10, insert the following:

(5) urges all participants in the conflict in Darfur, including the leaders of rebel movements that were not signatories to the Darfur Peace Agreement, to participate fully in all meetings, conferences, and discussions within a political process led by the United Nations and African Union in order to return peace and security to the people of Darfur;

(6) regards failure to participate in such meetings, conferences, and discussions, as requested by the African Union and United Nations, as an obstruction of the political process and its goals that may be worthy of international sanctions; and

On page 8, line 10, strike ''(5)'' and insert ''(7)''.

The resolution (S. Res. 276), as amended, was agreed to.

The amendment to the preamble (No. 2592) was agreed to, as follows:

Purpose: (To urge all participants in the conflict in Darfur to engage in a political process led by the United Nations and African Union, to express disapproval of failure to participate in such political process, and for other purposes)

In the twelfth whereas clause, insert ''and members of his administration'' after ''al-Bashir''.

Strike the seventeenth whereas clause and insert the following:

Whereas the United Nations and African Union have invited leaders of the rebel movements in Darfur to participate in a political process led by the United Nations and African Union to return peace and stability to the people of Darfur;

Whereas deliberately targeting civilians and people providing humanitarian assistance during an armed conflict is a flagrant violation of international humanitarian law, and those who commit such violations must be held accountable; and

The preamble, as amended, was agreed to.

The resolution, as amended, with its preamble, as amended, reads as follows:

(The resolution will be printed in a future edition of the RECORD.)

NATIONAL FETAL ALCOHOL SPECTRUM DISORDERS AWARENESS DAY

Mr. TESTER. I ask unanimous consent the Senate now proceed to consideration of S. Res. 285, which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 285) designating September 9, 2007, as ''National Fetal Alcohol Spectrum Disorders Awareness Day.''

There being no objection, the Senate proceeded to consider the resolution.

Mr. TESTER. I ask unanimous consent the resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid on the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 285) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 285

Whereas the term ''fetal alcohol spectrum disorders'' includes a broader range of conditions and therefore has replaced the term ''fetal alcohol syndrome'' as the umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy;

Whereas fetal alcohol spectrum disorders are the leading cause of cognitive disability in western civilization, including the United States, and are 100 percent preventable;

Whereas fetal alcohol spectrum disorders are a major cause of numerous social disorders, including learning disabilities, school failure, juvenile delinquency, homelessness, unemployment, mental illness, and crime;

Whereas the incidence rate of fetal alcohol syndrome is estimated at 1 out of 500 live births and the incidence rate of fetal alcohol spectrum disorders is estimated at 1 out of every 100 live births;

Whereas, although the economic costs of fetal alcohol spectrum disorders are difficult to estimate, the cost of fetal alcohol syndrome alone in the United States was $5,400,000,000 in 2003 and it is estimated that each individual with fetal alcohol syndrome will cost taxpayers of the United States between $1,500,000 and $3,000,000 in his or her lifetime;

Whereas, in February 1999, a small group of parents of children who suffer from fetal alcohol spectrum disorders came together with the hope that in 1 magic moment the world could be made aware of the devastating consequences of alcohol consumption during pregnancy;

Whereas the first International Fetal Alcohol Syndrome Awareness Day was observed on September 9, 1999;

Whereas Bonnie Buxton of Toronto, Canada, the co-founder of the first International Fetal Alcohol Syndrome Awareness Day, asked ''What if . . . a world full of FAS/E [Fetal Alcohol Syndrome/Effect] parents all got together on the ninth hour of the ninth day of the ninth month of the year and asked the world to remember that during the 9 months of pregnancy a woman should not consume alcohol . . . would the rest of the world listen?''; and

Whereas on the ninth day of the ninth month of each year since 1999, communities around the world have observed International Fetal Alcohol Syndrome Awareness Day: Now, therefore, be it

Resolved, That the Senate—

(1) designates September 9, 2007, as ''National Fetal Alcohol Spectrum Disorders Awareness Day''; and

(2) calls upon the people of the United States—

(A) to observe National Fetal Alcohol Spectrum Disorders Awareness Day with appropriate ceremonies—

(i) to promote awareness of the effects of prenatal exposure to alcohol;

(ii) to increase compassion for individuals affected by prenatal exposure to alcohol;

(iii) to minimize further effects of prenatal exposure to alcohol; and

(iv) to ensure healthier communities across the United States; and

(B) to observe a moment of reflection on the ninth hour of September 9, 2007, to remember that during the 9 months of pregnancy a woman should not consume alcohol.

RECOGNIZING THE HEROIC EFFORTS OF FIREFIGHTERS

Mr. TESTER. Mr. President, I ask unanimous consent the Senate now proceed to the consideration of S. Res. 286, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 286) recognizing the heroic efforts of firefighters to contain numerous wildfires throughout the Western United States.

There being no objection, the Senate proceeded to consider the resolution.

Mr. HATCH. Mr. President, I rise today to honor of the thousands of firefighters who, in recent weeks, have literally put themselves in the line of fire to protect our communities and rural economies from countless wildfires throughout the western United States.

For the second year in a row, western States have been plagued by continuous wildfires that far exceed those of average years. While July and August are typically considered the peak months for western wildfires, this year's fire season has been exacerbated by continued drought, record-high temperatures, widespread dry lightning storms, and high winds. As of July 23, more than 55,000 wildfires had been reported this year, burning over 4 million acres. That represents an increase of more than 8,000 fires and 1 million acres over the 10-year average.

My home State of Utah alone has reported nearly 700 separate wildfires that have burned nearly 700,000 acres. This includes the fire at the Milford Flats Complex, which burned more than 360,000 acres, easily making it Utah's largest wildfire on record and one of the largest of this year's fire season. Idaho is the only State that has been hit harder than Utah this fire season, reporting more than 700 fires that have burned more than 800,000 acres.

Utah and Idaho have not been alone in this recent spike of wildfire activity. The Milford Flats fire was ignited during a 3-day period that lasted from July 6th through July 8th, at time period in which more than 1,200 wildfires were ignited in the West as dry lighting storms swept across California, Nevada, Utah, and Southern Idaho. Despite these drastic conditions, Federal, State and local fire crews have been relentless in their efforts to control these wildfires, literally putting themselves between these infernos and our homes, our, communities, and our resources.

I also want to express my heartfelt sympathies towards the hundreds of communities and thousands of families affected by this year's fires. Our thoughts and prayers are with them as they begin the difficult task of cleaning up and returning their lives to normal.

At any given time, as many as 15,000 fire personnel are assigned to large, uncontained wildfires throughout the West. This year, and every year, these brave men and women overcome extremely volatile weather conditions and terrain to contain nearly 98 percent of all wildfires during their initial attack. That is why I am introducing a Senate Resolution recognizing the heroic efforts of firefighters to contain these dangerous fires in the West. Senators BENNETT, ENSIGN, WYDEN, DOMENICI, KYL, BARASSO, SALAZAR, CRAIG, and CANTWELL have joined me in cosponsoring this resolution. Clearly, this Senate Resolution already has strong bipartisan support, and I urge my remaining colleagues to lend their support.

Mr. TESTER. I ask unanimous consent the resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid on the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 286) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 286

Whereas the annual peak of the Western wildfire season occurs during July and August;

Whereas the 2007 Western wildfire season has been characterized by continued drought, record-setting temperatures, extreme fuel conditions, and widespread dry lightning storms;

Whereas firefighters have had to contend with extreme fire behavior and rapid rates of fire spread;

Whereas, as of July 23, 2007, more than 55,000 wildfires have burned more than 4,000,000 acres of land, which is more than 8,000 fires and 1,000,000 acres higher than the average reported fire rate over the last 10 years;

Whereas, from July 6 through July 8, 2007, more than 1,200 fires were ignited in the Western United States, most of which were caused by dry lightning storms that swept across California, Nevada, Idaho, and Utah;

Whereas, as of July 23, 2007—

(1) the State of Idaho has reported more than 760 fires that have burned more than 800,000 acres;

(2) the State of Utah has reported more than 670 fires that have burned more than 660,000 acres;

(3) the State of Nevada has reported more than 560 fires that have burned more than 510,000 acres;

(4) the State of Oregon has reported more than 1,200 fires that have burned nearly 212,000 acres;

(5) the State of California has reported more than 4,600 fires that have burned more than 117,000 acres;

(6) the State of Arizona has reported more than 1,600 fires that have burned more than 88,000 acres;

(7) the State of Washington has reported more than 680 fires that have burned more than 64,000 acres;

(8) the State of New Mexico has reported more than 870 fires that have burned nearly 35,000 acres;

(9) the State of Montana has reported more than 960 fires that have burned more than 19,000 acres;

(10) the State of Wyoming has reported more than 200 fires that have burned more than 18,000 acres; and

(11) the State of Colorado has reported more than 740 fires that have burned more than 7,400 acres;

Whereas, at any given time during the Western wildfire season, as many as 14,000 firefighters are assigned to large, uncontained fires throughout the Western United States; and

Whereas, despite tremendously volatile weather and terrain conditions, Federal, State, and local firefighting units have contained between 95 and 98 percent of all wildfires during initial attack: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the heroic efforts of firefighters to contain wildfires and protect lives, homes, and rural economies throughout the Western United States; and

(2) encourages the people and government officials of the United States to express their

appreciation to the brave men and women serving in the firefighting services.

HONORING THE 1ST BATTALION OF THE 133RD INFANTRY

Mr. TESTER. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 287, which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 287) honoring and expressing gratitude to the 1st Battalion of the 133rd Infantry (''Ironman Battalion'') of the Iowa National Guard.

There being no objection, the Senate proceeded to consider the resolution.

Mr. TESTER. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, en bloc, and that any statements relating thereto be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 287) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 287

Whereas 476 members of the 1st Battalion, 133rd Infantry of the Iowa National Guard were mobilized for active duty in September and October of 2005;

Whereas 80 members of the 1st Battalion, 133rd Infantry have been providing essential support to the Battalion from Iowa National Guard installations in Waterloo, Iowa, and Dubuque, Iowa, and at least 490 members of the 1st Battalion, 133rd Infantry were deployed to Iraq in April and May of 2006;

Whereas the members of the 1st Battalion, 133rd Infantry have been serving bravely and honorably since April and May of 2006 in the al-Anbar Province of Iraq, one of the most dangerous parts of Iraq;

Whereas the 1st Battalion, 133rd Infantry deployed as part of the 1st Brigade Combat Team of the 34th Infantry Division, which has completed the longest continuous deployment of any National Guard unit during Operation Iraqi Freedom;

Whereas the 1st Battalion, 133rd Infantry is the longest-serving Iowa Army National Guard unit since World War II;

Whereas the CBS program ''60 Minutes'' devoted an entire hour to telling the story of the 1st Battalion, 133rd Infantry on May 27, 2007;

Whereas the members of the 1st Battalion, 133rd Infantry have completed over 500 missions, providing security for convoys operating in al-Anbar Province;

Whereas the members of the 1st Battalion, 133rd Infantry have logged over 4,000,000 mission miles, and have delivered over ⅓ of the fuel needed to sustain coalition forces in Iraq;

Whereas the members of the 1st Battalion, 133rd Infantry have detained over 60 insurgents;

Whereas the members of the 1st Battalion, 133rd Infantry were scheduled to return home in April 2007, but had their tours of duty extended until July 2007;

Whereas the members of the 1st Battalion, 133rd Infantry left behind civilian jobs, friends, and families in order to serve the United States;

Whereas 1st Battalion, 133rd Infantry members Sergeant 1st Class Scott E. Nisely and Sergeant Kampha B. Sourivong gave the ultimate sacrifice for their country when they were tragically killed during combat operations near Al Asad, Iraq, on September 30, 2006; and

Whereas the United States will be forever indebted to the soldiers and families of the 1st Battalion, 133rd Infantry for their sacrifices and their contributions to the mission of the United States in Iraq: Now, therefore, be it

Resolved, That the Senate honors and expresses gratitude for the service and sacrifices of the members and families of the 1st Battalion of the 133rd Infantry of the Iowa National Guard upon the return home of the Battalion from its deployment in Iraq.

SUPPORTING THE GOALS AND IDEALS OF THE NATIONAL ANTHEM PROJECT

Mr. TESTER. I ask unanimous consent that the Senate now proceed to the immediate consideration of Calendar No. 276, S. Res. 236.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 236) supporting the goals and ideals of the National Anthem Project, which has worked to restore America's voice by re-teaching Americans to sing the national anthem.

There being no objection, the Senate proceeded to consider the resolution.

Mr. TESTER. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid on the table, en bloc, and any statements relating thereto be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 236) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 236

Whereas a Harris Interactive Survey discovered that of men and women 18 years of age and older, 61 percent of those surveyed did not know all the lyrics of the first stanza of the national anthem, and of those who answered the question affirmatively, 58 percent had received at least 5 years of music education while growing up;

Whereas an ABC News poll revealed that more than 1 in 3 Americans (38 percent) do not know that the official name of the national anthem is ''The Star-Spangled Banner'', less than 35 percent of American teenagers can name Francis Scott Key as the author of the national anthem, and as few as 15 percent of American youth can sing the words to the anthem from memory;

Whereas the national anthem, ''The Star-Spangled Banner'', holds a special place in the hearts and minds of the American people as a symbol of national unity, resolve, and willingness to sacrifice in order to preserve the Nation's sacred heritage of freedom;

Whereas the National Anthem Project has inspired the American people to have a greater appreciation of their patriotic musical heritage while learning American history;

Whereas music educators are the among the leading caretakers of this important piece of our Nation's heritage, in that many students learn the national anthem in music class;

Whereas our Nation's future is enhanced by the quality of the historic knowledge and awareness provided to children of all ages through learning about the national anthem, and that high-quality music education represents a worthy commitment to our children and our Nation's future; and

Whereas, the national anthem is the symbol of American ideals and freedom around the world: Now, therefore, be it

Resolved, That the Senate—

(1) supports the goals and ideals of the National Anthem Project;

(2) commends the American citizens who have participated in this project; and

(3) encourages the people of the United States to learn the national anthem, ''The Star-Spangled Banner'', and its proud history.

RECOGNIZING THE LONG DISTANCE RUNS IN THE PEOPLE'S REPUBLIC OF CHINA

Mr. TESTER. I ask unanimous consent that the Foreign Relations Committee be discharged from further consideration of S. Res. 255 and that the Senate then proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 255), recognizing and supporting the long distance runs that will take place in the People's Republic of China in 2007 and the U.S. in 2007 to promote friendship between the peoples of the two countries.

There being no objection, the Senate proceeded to consider the resolution.

Mr. TESTER. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, en bloc, and that any statements relating thereto be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 255) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 255

Whereas, in 1984, American long distance runner Stan Cottrell of Tucker, Georgia, was welcomed into the People's Republic of China where he completed the 2,125-mile Great Friendship Run along the Great Wall of China in 53 days, an event which was chronicled in the international press and serves as a sign of international friendship;

Whereas those involved in the Great Friendship Run over 2 decades ago are committed to running again to revisit the experience and to promote friendship between the peoples of China and the United States;

Whereas in China, a 2,200-mile run from the Great Wall of China to Hong Kong will take place October 15 to December 15, 2007;

Whereas in the United States, a 4,000-mile relay style run from San Francisco, California, to the United States Capitol Building

in Washington, D.C., will take place May 7 to June 20, 2008, and cross the continent; and

Whereas 3 Chinese long distance runners will participate with Stan Cottrell and others in the run to take place in the United States: Now, therefore, be it

Resolved, That the Senate recognizes and supports the long distance runs that will take place in the People's Republic of China in 2007 and the United States in 2008 to promote friendship between the peoples of China and the United States.

200TH ANNIVERSARY OF ARCHDIOCESE OF NEW YORK

Mr. TESTER. I ask unanimous consent that the Judiciary Committee be discharged from further consideration of S. Res. 277 and the Senate then proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 277) commemorating the 200th anniversary of the Archdiocese of New York.

There being no objection, the Senate proceeded to consider to the resolution.

Mr. TESTER. I ask unanimous consent that the resolution be agreed to, the preamble agreed to, the motions to reconsider be laid upon the table en bloc, and that any statements relating thereto be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 277) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 277

Whereas it is a tradition of the Senate to honor and pay tribute to those places and institutions within the United States with historic significance that has contributed to the culture and traditions of the citizens of the United States;

Whereas, in accordance with this tradition, the Senate is proud to commemorate the 200th anniversary of the Archdiocese of New York and its history of faith and service;

Whereas the Archdiocese of New York has planned a year-long series of events beginning in April 2007 to celebrate its bicentennial;

Whereas the Archdiocese of New York is coordinating with Catholic Charities of New York to institute an Archdiocese of New York Day of Service to celebrate its history of serving the broader community;

Whereas, on April 8, 1808, the Diocese of New York was established with the Most Reverend R. Luke Concanen as its first Bishop, and the Diocese was elevated to an Archdiocese in 1850;

Whereas, on March 15, 1875, His Eminence John Cardinal McCloskey, the second Archbishop of the Archdiocese of New York, became the first Cardinal Archbishop of the Roman Catholic Church in the United States;

Whereas the Archdiocese of New York has welcomed Papal visits from Pope Paul VI, on October 5, 1965, and Pope John Paul II, on October 7, 1979 and October 5, 1995;

Whereas, on September 14, 1975, Elizabeth Ann Seton, a member of the Archdiocese of New York and founder of the modern Catholic education parochial school system, became the first person born in the United States to be named a saint;

Whereas Elizabeth Ann Seton is described on the front doors of St. Patrick's Cathedral as a ''Daughter of New York'' and several schools are named after her, including Seton Hall University in South Orange, New Jersey;

Whereas the Archdiocese of New York is currently under the spiritual guidance of His Eminence Edward M. Cardinal Egan, who was installed on June 19, 2000 and elevated to Cardinal on February 21, 2001;

Whereas the Archdiocese of New York originally included the entirety of the States of New York and New Jersey, an area that is now divided into 12 dioceses;

Whereas the Archdiocese of New York has 2,500,000 Catholics in its fold;

Whereas the Archdiocese of New York consists of 402 parishes, 278 elementary and high schools, and 3,729 charitable ministries, including Catholic Charities, hospitals, nursing homes, and outreach programs; and

Whereas, throughout its rich historical past and up to the present day, the Archdiocese of New York has been sustained by the beneficent efforts of countless parishioners and ministries that have generously supported their community with abundant kindness and good deeds: Now, therefore, be it

Resolved, That the Senate commemorates the 200th anniversary of the Archdiocese of New York.

RUSSIAN FEDERATION SUSPENSION OF CONVENTIONAL ARMED FORCES IN EUROPE TREATY

Mr. TESTER. Mr. President, I ask unanimous consent that the Foreign Relations Committee be discharged from further consideration of S. Res. 278 and the Senate then proceed to its consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 278) regarding the announcement of the Russian Federation of its suspension of implementation of the Conventional Armed Forces in Europe Treaty.

There being no objection, the Senate proceeded to consider the resolution.

Mr. TESTER. I ask unanimous consent that the resolution be agreed to, the preamble agreed to, the motions to reconsider be laid upon the table en bloc, and that any statements relating thereto be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 278) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 278

Whereas the Treaty on Conventional Armed Forces in Europe, signed at Paris November 19, 1990 (''the CFE Treaty''), was agreed upon and signed by 22 States Parties in order to establish predictability, transparency, and stability in the balance of conventional military forces and equipment in an area of Europe stretching from the Atlantic Ocean to the Ural Mountains;

Whereas there are now 30 States Parties to the CFE Treaty, including Armenia, Azerbaijan, Belarus, Belgium, Bulgaria, Canada, Czech Republic, Denmark, France, Georgia, Germany, Greece, Hungary, Iceland, Italy, Kazakhstan, Luxembourg, Moldova, Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, Slovakia, Spain, Turkey, Ukraine, the United Kingdom, and the United States;

Whereas the CFE Treaty is recognized as one of the most successful arms control treaties of the modern era and has served as a cornerstone of European security as the continent emerged from the shadows of the Cold War;

Whereas the CFE Treaty facilitated the destruction or conversion of over 52,000 battle tanks, armored combat vehicles, artillery pieces, combat aircraft, and attack helicopters;

Whereas the CFE Treaty continues to enable an unprecedented level of transparency into military equipment holdings and troop deployments in Europe, including over 4,000 on-site inspections of military units and installations implemented since the entry into force of the Treaty;

Whereas, on November 19, 1999, at the Organization for Security and Co-operation in Europe Summit in Istanbul, Turkey, the parties to the CFE Treaty signed an Adaptation Agreement to reflect the dissolution of the Warsaw Pact, the expansion of membership in the North Atlantic Treaty Organization (''NATO''), and other changes in the European geopolitical environment;

Whereas, at the time of the signing of the Adaptation Agreement, the Russian Federation made a series of pledges, known as the Istanbul Commitments, to withdraw its remaining military forces and equipment from the territory of Georgia and Moldova or otherwise negotiate consensual agreements on their continued presence;

Whereas while the Government of the Russian Federation has taken initial steps towards fulfilling the Istanbul Commitments, it continues to maintain troops and associated equipment in both Georgia and Moldova without the express sovereign consent of the governments of either of those countries, and the United States and other parties to the CFE Treaty have therefore refrained from taking steps to ratify the Adaptation Agreement;

Whereas, on April 26, 2007, President of the Russian Federation, Vladimir Putin, in a speech to the Federation Council of the Russian Federation, announced his intention to initiate an unspecified ''moratorium'' on Russian compliance with the CFE Treaty, citing the refusal of NATO Members to ratify the Adaptation Agreement, concerns over the proposed United States missile defense deployment in Poland and the Czech Republic, and new basing arrangements between the United States Government and the Governments of Bulgaria and Romania as unacceptable encroachments on the security of the Russian Federation;

Whereas the Government of the Russian Federation subsequently requested, as is its right under the CFE Treaty, an Extraordinary Conference to discuss its outstanding concerns, which was held from June 12 to June 15, 2007, in Vienna, Austria;

Whereas, on July 14, 2007, President Putin issued a formal decree announcing the intention of the Russian Federation to suspend compliance with the CFE Treaty after providing 150 days advance notice to the other CFE Treaty signatories;

Whereas President Putin justified his decision on ''extraordinary circumstances'' that ''affect the security of the Russian Federation and require immediate measures'';

Whereas the CFE Treaty provides a formal mechanism for withdrawal of a State Party from the Treaty following 150 days of notice, but does not contain any provision for suspension; and

Whereas the Department of State, in responding to the announcement by the Government of the Russian Federation to suspend compliance with the CFE Treaty, declared, ''The United States is disappointed by the Russian announcement of its intention to suspend implementation of the Conventional Armed Forces in Europe (CFE) Treaty. The United States remains committed to CFE's full implementation. We also remain committed to the ratification and entry into force of the Adapted CFE Treaty. We look forward to continuing to engage with Russia and the other States Parties to the Treaty to create the conditions necessary for ratification by all 30 CFE States.'': Now, therefore, be it

Resolved, That—

(1) it is the sense of the Senate that the decision of the Government of the Russian Federation to suspend implementation of the Treaty on Conventional Armed Forces in Europe, signed at Paris November 19, 1990 (''the CFE Treaty''), is a regrettable step that will unnecessarily heighten tensions in Europe;

(2) the Senate recognizes the enduring value of the CFE Treaty as a cornerstone of European security and affirms its support for the basic principles of transparency, accountability, host country consent for the stationing of foreign military forces, and the rule of law embodied in the CFE Treaty and the 1999 Adaptation Agreement thereto;

(3) the Senate strongly urges the Government of the Russian Federation to reconsider its suspension of CFE implementation and engage with the other parties to the CFE Treaty to resolve outstanding problems and establish an agreed approach leading to the eventual implementation of the Adaption Agreement to the CFE Treaty;

(4) the Senate calls on the Russian Federation to fulfill its Istanbul Commitments of 1999 and move speedily to withdraw all remaining forces and military equipment from Georgia and Moldova;

(5) the Senate encourages all parties to the CFE Treaty to engage the Russian Federation in seeking innovative and constructive mechanisms to fully implement the Istanbul Commitments, consistent with the principles and objectives of the Organization of Security and Cooperation in Europe (OSCE) and making full use of OSCE mechanisms;

(6) the Senate calls on all States Parties to ensure that the resolution of the current disputes surrounding the CFE Treaty be considered a priority at the highest political levels, recognizing that the CFE Treaty is important both as an arms control treaty and as an essential building block for stable relations between the Russian Federation and neighboring countries in Europe; and

(7) the Senate encourages officials of the Government of the Russian Federation to refrain from belligerent statements that only further polarize relations and jeopardize security in Europe.

75TH ANNIVERSARY OF THE MILITARY ORDER OF THE PURPLE HEART

Mr. TESTER. I ask unanimous consent that the Armed Services Committee be discharged from further consideration of S. Con. Res. 26 and the Senate proceed to its consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the concurrent resolution by title.

The legislative clerk read as follows:

A concurrent resolution (S. Con. Res. 26) recognizing the 75th anniversary of the Military Order of the Purple Heart and commending recipients of the Purple Heart for their courageous demonstrations of gallantry and heroism on behalf of the United States.

There being no objection, the Senate proceeded to consider the resolution.

Mr. TESTER. I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table en bloc, and that any statements relating thereto be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (S. Con. Res. 26) was agreed to.

The preamble was agreed to.

The concurrent resolution, with its preamble, reads as follows:

S. CON. RES. 26

Whereas the Purple Heart is a combat decoration awarded to members of the Armed Forces who are wounded by an instrument of war wielded by the enemy;

Whereas the Purple Heart is awarded posthumously to the next of kin in the name of members of the Armed Forces who are killed in action or die of wounds received in action;

Whereas the Purple Heart was originally conceived as the Badge of Military Merit by General George Washington on August 7, 1782;

Whereas 2007 marks the 225th anniversary of the Badge of Military Merit, the predecessor of the Purple Heart;

Whereas the practice of awarding the Purple Heart was revived in 1932, the 200th anniversary of George Washington's birth, out of respect for his memory and military achievements;

Whereas more than 1,535,000 Purple Hearts have been awarded to members of the Armed Forces who fought in defense of freedom and democracy in World War I, World War II, the Korean War, the Vietnam War, Operation Desert Storm, Operation Enduring Freedom, Operation Iraqi Freedom, and other expeditionary conflicts;

Whereas approximately 550,000 recipients of the Purple Heart are alive today;

Whereas the organization known as the Military Order of the Purple Heart was formed on October 19, 1932, for the protection and mutual interest of members of the Armed Forces who have received the Purple Heart; and

Whereas the Military Order of the Purple Heart is composed exclusively of recipients of the Purple Heart and is the only veterans' service organization comprised strictly of combat veterans: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) congratulates the Military Order of the Purple Heart on its 75th anniversary as a national organization whose goals are to preserve and sustain the honor of the Armed Forces;

(2) commends all recipients of the Purple Heart for their courageous demonstrations of gallantry and heroism on behalf of the United States; and

(3) encourages the people of the United States to take time to learn about the Purple Heart and the honor, courage, and bravery it symbolizes.

ORDERS FOR WEDNESDAY, AUGUST 1, 2007

Mr. TESTER. I ask unanimous consent that when the Senate completes its business today, it stand adjourned until 9:30 a.m., Wednesday August 1; that on Wednesday, following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, and the time for the two leaders be reserved for their use later in the day; that there be a period of morning business for 30 minutes, with Senators permitted to speak therein for up to 10 minutes each and the time under the control of the Republican leader or his designee; that following the period of morning business, the Senate resume consideration of H.R. 976 and resume consideration of the Ensign amendment No. 2538, with 30 minutes of debate prior to a vote in relation to the amendment, with the time equally divided and controlled between Senators ENSIGN and BAUCUS or their designees, with no second-degree amendments in order prior to the vote; that upon the use or yielding back of the time, the Senate proceed to vote in relation to the amendment without further intervening action or debate; that on Wednesday at 12 noon, Senator BYRD be recognized to speak as in morning business for up to 30 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. TESTER. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand adjourned under the previous order.

There being no objection, the Senate, at 9:31 p.m., adjourned until Wednesday, August 1, 2007, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF ENERGY

Robert L. Smolen, of Pennsylvania, to be Deputy Administrator for Defense Programs, National Nuclear Security Administration, vice Thomas P. D'Agostino.

ENVIRONMENTAL PROTECTION AGENCY

Andrew R. Cochran, of Virginia, to be Inspector General, Environmental Protection Agency, vice Nikki Rush Tinsley, resigned.