

(Mr. BINGAMAN) was added as a cosponsor of S. 726, a bill to amend the Public Health Service Act to provide for the licensing of biosimilar and biogeneric biological products, and for other purposes.

S. 752

At the request of Mr. DURBIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. 752, a bill to reform the financing of Senate elections, and for other purposes.

S. 795

At the request of Mr. HATCH, the names of the Senator from Missouri (Mr. BOND), the Senator from Indiana (Mr. BAYH) and the Senator from Rhode Island (Mr. REED) were added as cosponsors of S. 795, 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. 812

At the request of Mr. BAUCUS, the name of the Senator from Idaho (Mr. RISCH) was added as a cosponsor of S. 812, a bill to amend the Internal Revenue Code of 1986 to make permanent the special rule for contributions of qualified conservation contributions.

S. 819

At the request of Mr. DURBIN, the names of the Senator from Rhode Island (Mr. WHITEHOUSE) and the Senator from Massachusetts (Mr. KENNEDY) were added as cosponsors of S. 819, a bill to provide for enhanced treatment, support, services, and research for individuals with autism spectrum disorders and their families.

S. 827

At the request of Mr. BINGAMAN, his name was added as a cosponsor of S. 827, a bill to establish a program to reunite bondholders with matured unredeemed United States savings bonds.

S. 832

At the request of Mr. NELSON of Florida, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 832, a bill to amend title 36, United States Code, to grant a Federal charter to the Military Officers Association of America, and for other purposes.

S. 833

At the request of Mr. SCHUMER, the names of the Senator from Rhode Island (Mr. REED) and the Senator from Illinois (Mr. BURRIS) were added as cosponsors of S. 833, a bill to amend title XIX of the Social Security Act to permit States the option to provide Medicaid coverage for low-income individuals infected with HIV.

S. 846

At the request of Mr. DURBIN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of S. 846, a bill to award a congressional

gold medal to Dr. Muhammad Yunus, in recognition of his contributions to the fight against global poverty.

S. 908

At the request of Mr. BAYH, the name of the Senator from Georgia (Mr. ISAKSON) was added as a cosponsor of S. 908, a bill to amend the Iran Sanctions Act of 1996 to enhance United States diplomatic efforts with respect to Iran by expanding economic sanctions against Iran.

S. 909

At the request of Ms. STABENOW, her name was added as a cosponsor of S. 909, a bill to provide Federal assistance to States, local jurisdictions, and Indian tribes to prosecute hate crimes, and for other purposes.

At the request of Mr. BEGICH, his name was added as a cosponsor of S. 909, supra.

S. 925

At the request of Mrs. GILLIBRAND, the name of the Senator from Illinois (Mr. BURRIS) was added as a cosponsor of S. 925, a bill to direct the Secretary of Health and Human Services to study the presence of contaminants and impurities in cosmetics and personal care products marketed to and used by children.

S. 956

At the request of Mr. TESTER, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 956, a bill to amend title XVIII of the Social Security Act to exempt unsanctioned State-licensed retail pharmacies from the surety bond requirement under the Medicare Program for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

S. 982

At the request of Mr. MENENDEZ, his name was added as a cosponsor of S. 982, a bill to protect the public health by providing the Food and Drug Administration with certain authority to regulate tobacco products.

S. 984

At the request of Mrs. BOXER, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 984, a bill to amend the Public Health Service Act to provide for arthritis research and public health, and for other purposes.

S. 987

At the request of Mr. DURBIN, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. 987, a bill to protect girls in developing countries through the prevention of child marriage, and for other purposes.

S. 1026

At the request of Mr. CORNYN, the names of the Senator from Iowa (Mr. GRASSLEY), the Senator from Nevada (Mr. ENSIGN), the Senator from Arizona (Mr. KYL) and the Senator from Kansas (Mr. ROBERTS) were added as cosponsors of S. 1026, a bill to amend the Uni-

Voting Act to improve procedures for the collection and delivery of marked absentee ballots of absent overseas uniformed service voters, and for other purposes.

S. 1052

At the request of Mr. CONRAD, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 1052, a bill to amend the small, rural school achievement program and the rural and low-income school program under part B of title VI of the Elementary and Secondary Education Act of 1965.

S. 1057

At the request of Mr. TESTER, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1057, a bill to amend the Public Health Service Act to provide for the participation of physical therapists in the National Health Service Corps Loan Repayment Program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BINGAMAN:

S. 1060. A bill to comprehensively prevent, treat, and decrease overweight and obesity in our Nation's populations; to the Committee on Health, Education, Labor, and Pensions.

Mr. BINGAMAN. Mr. President, I rise today to introduce the Obesity Prevention, Treatment and Research Act of 2009. This legislation would develop a national strategy to organize our efforts to combat childhood and adult obesity. It would help foster unprecedented collaborations and collective actions across agencies, and among private entities, individuals, and communities.

The prevalence of obesity in the U.S. has grown to staggering proportions. According to the Centers for Disease Control and Prevention National Center for Health Statistics, 66 percent of adults and 32 percent of children are considered either overweight or obese. Over the past 30 years, the obesity rate has more than doubled across all age groups. The U.S. now has the highest prevalence of obesity among the developed nations. In fact, the prevalence of obesity in the U.S. in 2006, 34 percent, is more than twice the average for other developed nations.

The Obesity Prevention, Treatment and Research Act of 2009 comprehensively addresses the obesity and overweight epidemic by focusing on coordinating and augmenting existing prevention and treatment activities. This legislation is based on recommendations of the Institutes of Medicine, IOM, to confront the obesity epidemic. It focuses on developing dynamic new collaborations and will improve access for beneficiaries in Medicare, Medicaid, and other Federal programs to nutritional counseling, prevention services, and physical education programs.

Obesity is a costly problem for the U.S. both in terms of health care expenditures and the loss of life. The incidence of type 2 diabetes, high blood pressure, and progressive liver disease—ailments once associated only with adults—is rising among overweight children. These health risks compound with age, since overweight children and adolescents are more likely to become obese adults. For the first time in our history, the lifespan of a child born today may be less than that of his or her parents. Interventions aimed at significantly decreasing the prevalence of these illnesses are extremely cost effective and are critical to overall disease prevention and health promotion efforts. The Trust for America's Health recently reported that an investment of just \$10 per person per year in proven community-based disease prevention programs would yield a \$2.8 billion annual health expenditure reduction. Put another way, our nation would recoup nearly \$1 over and above the cost of a comprehensive disease prevention and health promotion program for every \$1 invested in the first 1 to 2 years of the program. To that end, my legislation creates grant programs to provide funding to schools, community health centers, academic institutions, State medical societies, State health departments, and communities to reduce the prevalence of obesity and improve the prevention and treatment of individuals who are obese or overweight.

The Obesity Prevention, Treatment and Research Act of 2009 establishes the U.S. Council on Overweight & Obesity Prevention, USCO-OP, which is charged with creating a comprehensive strategy to prevent, treat and reduce the prevalence of overweight individuals and obesity. This advisory council will update Federal guidelines; identify best practices; conduct ongoing surveillance and monitoring of existing Federal programs; and make recommendations to coordinate budgets, policies, and programs across Federal agencies in collaboration with private and public partners. In addition, the Council will help develop and update the daily physical activity requirements in our schools, and identify activities that families can do together.

It is also critical to recognize that certain populations are more vulnerable than others to the obesity epidemic. Minorities, especially from Hispanic and Native American communities, are disproportionately affected by this disease. For example, in my home State of New Mexico, approximately 26 percent of Hispanic and 32 percent of Native American adolescents, grades 9–12, are overweight or obese; the rate of prevalence is less than 20 percent among white, non-Hispanic adolescents. I have, therefore, prioritized grants in this legislation to these populations and required Federal reporting on research and data related to obesity in disproportionately affected groups. This includes grants

aimed at behavioral risk factors such as sedentary lifestyles and poor nutrition.

This bill will help further develop and then increase funding to the Department of Agriculture's Fresh Fruit and Vegetable Program. This will help ensure that low-income children will have access to healthier foods within their schools. In addition, the Secretary of Health and Human Services and the Secretary of Agriculture will be tasked to consult with the USCO-OP to update and reform Federal oversight of food and beverage labeling. Such reforms include improving the transparency of labeling with regard to nutritional and caloric value of food and beverages.

I think it is imperative that we provide treatment to those individuals who are likely to develop obesity-related ailments before the full onset of disease. The Obesity Prevention, Treatment and Research Act of 2009 does this by expanding coverage of Medicare to include medical nutritional counseling for beneficiaries who are overweight or obese and are considered pre-diabetics. In addition, my legislation gives States the option to include medical nutrition therapy services in Medicaid and SCHIP.

There is no doubt that the obesity epidemic has grown immensely. I am confident, however, that it can be stopped but it requires a nationwide commitment for resolution. I look forward to working with my colleagues to enact this legislation this year.

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

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

S. 1060

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Obesity Prevention, Treatment, and Research Act of 2009".

SEC. 2. FINDINGS.

Congress finds the following:

(1) In 2001, the United States Surgeon General released the Call to Action to Prevent and Decrease Overweight and Obesity to bring attention to the public health problems related to obesity.

(2) Since the Surgeon General's call to action, the problems of obesity and overweight have become epidemic, occurring in all ages, ethnicities and races, and individuals in every State.

(3) The United States now has the highest prevalence of obesity among the developed nations, according to 2006 data by the Organisation for Economic Co-operation and Development. The prevalence of obesity in the United States (34 percent) is more than twice the average for other developed nations (13 percent). The closest nation in prevalence of obesity is the United Kingdom (24 percent) which is over 25 percent less than the United States.

(4) The National Health and Nutrition Examination Survey in 2006 estimated that 32 percent of children and adolescents aged 2 to 19 and an alarming 66 percent of adults are overweight or obese.

(5) More than 30 percent of young people in grades 9 through 12 do not regularly engage in vigorous intensity physical activity, while almost 40 percent of adults are sedentary and 70 percent report getting less than 20 minutes of regular physical activity per day.

(6) The Institute of Medicine, in their 2005 publication "Preventing Childhood Obesity: Health in the Balance", reported that over the last 3 decades, the rate of childhood obesity has tripled for children aged 6 to 11 years, and doubled for children aged 2 to 5 years old and in adolescents aged 12 to 19 years old. In 2004, approximately 9,000,000 children over 6 years of age were obese. Only 2 percent of children eat a healthy diet consistent with Federal nutrition guidelines.

(7) For children born in 2000, it is estimated the lifetime risk of being diagnosed with type 2 diabetes is 40 percent for females and 30 percent for males.

(8) Overweight and obesity disproportionately affect minority populations and women. According to the 2006 Behavioral Risk Factor Surveillance System of the Centers for the Disease Control and Prevention, 61 percent of adults in the United States are overweight or obese.

(9) The Centers for the Disease Control and Prevention estimates the annual expenditures related to overweight and obesity in the United States to be \$117,000,000,000 in 2001 and rising rapidly.

(10) The Centers for the Disease Control and Prevention estimates that the increase in the number of overweight and obese Americans between 1987 and 2001 resulted in a 27 percent increase in per capita health costs, and that as many as 112,000 deaths per year are associated with obesity.

(11) Being overweight or obese increases the risk of chronic diseases including diabetes, heart disease, stroke, certain cancers, arthritis, and other health problems.

(12) According to the National Institute of Diabetes and Digestive and Kidney Diseases, individuals who are obese have a 50 to 100 percent increased risk of premature death.

(13) Healthy People 2010 goals identify overweight and obesity as 1 of the Nation's leading health problems and include objectives for increasing the proportion of adults who are at a healthy weight, reducing the proportion of adults who are obese, and reducing the proportion of children and adolescents who are overweight or obese.

(14) Another Healthy People 2010 goal is to eliminate health disparities among different segments of the population. Obesity is a health problem that disproportionately impacts medically underserved populations.

(15) Food and beverage advertisers are estimated to spend \$10,000,000 to \$12,000,000,000 per year to target children and youth.

(16) The United States spends less than 2 percent of its annual health expenditures on prevention.

(17) Employer health promotion investments net a return of \$3 for every \$1 invested.

(18) High-energy dense and low-nutrient dense foods represent 30 percent of American's total calorie intake. Fast food company menus are twice the energy density of recommended healthful diets.

(19) Research suggests that individuals eat too much high-energy dense foods without feeling full because the brain's pathways that regulate hunger and influence normal food intake are not triggered by these foods.

(20) Packaging, product placement, and high-energy dense food content manipulation contribute to the overweight and obesity epidemic in the United States.

(21) Such marketing and content manipulation techniques have been used by other industries to encourage consumption at the expense of health. To help individuals make

healthy choices, education and information must be available with clear, consistent, and accurate labeling.

TITLE I—OBESITY TREATMENT, PREVENTION, AND REDUCTION

SEC. 101. UNITED STATES COUNCIL ON OVERWEIGHT-OBESITY PREVENTION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by—

(1) redesignating section 399R (as inserted by section 2 of Public Law 110-373) as section 399S;

(2) redesignating section 399R (as inserted by section 3 of Public Law 110-374) as section 399T; and

(3) adding at the end the following:

“SEC. 399U. UNITED STATES COUNCIL ON OVERWEIGHT-OBESITY PREVENTION.

“(a) ESTABLISHMENT.—The Secretary shall convene a United States Council on Overweight-Obesity Prevention (referred to in this section as ‘USCO-OP’).

“(b) MEMBERSHIP.—

“(1) IN GENERAL.—USCO-OP shall be composed of 20 members, which shall consist of—

“(A) the Secretary;

“(B) the Secretary (or his or her designee) of—

“(i) the Department of Agriculture;

“(ii) the Department of Education;

“(iii) the Department of Housing and Urban Development;

“(iv) the Department of the Interior

“(v) the Federal Trade Commission;

“(vi) the Department of Transportation; and

“(vii) any other Federal agency that the Secretary of Health and Human Services determines appropriate;

“(C) the Chairman (or his or her designee) of the Federal Communications Commission;

“(D) the Director (or his or her designee) of the Centers for Disease Control and Prevention, the National Institutes of Health, and the Agency for Healthcare Research and Quality;

“(E) the Administrator of the Centers for Medicare and Medicaid Services (or his or her designee);

“(F) the Commissioner of Food and Drugs (or his or her designee); and

“(G) a minimum of 5 representatives, appointed by the Secretary, of expert organizations such as public health associations, key healthcare provider groups, planning and development organizations, education associations, advocacy groups, relevant industries, State and local leadership, and other entities as determined appropriate by the Secretary.

“(2) APPOINTMENTS.—The Secretary shall accept nominations for representation on USCO-OP through public comment before the initial appointment of members of USCO-OP under paragraph (1)(G), and on a regular basis for open positions thereafter, but not less than every 2 years.

“(3) CHAIRPERSON.—The chairperson of USCO-OP shall be—

“(A) an individual appointed by the President; and

“(B) until the date that an individual is appointed under subparagraph (A), the Secretary.

“(c) MEETINGS.—

“(1) IN GENERAL.—USCO-OP shall meet—

“(A) not later than 180 days after the date of enactment of the Obesity Prevention, Treatment, and Research Act of 2009; and

“(B) at the call of the chairperson thereafter, but in no case less often than 2 times per year.

“(2) MEETINGS OF FEDERAL AGENCIES.—The representatives of the Federal agencies on USCO-OP shall meet on a regular basis, as determined by the Secretary, to develop strategies to coordinate budgets and discuss

other issues that are not otherwise permitted to be discussed in a public forum. The purpose of such meetings shall be to allow more rapid interagency strategic planning and intervention implementation to address the overweight and obesity epidemic.

“(d) DUTIES OF USCO-OP.—USCO-OP shall—

“(1) develop strategies to comprehensively prevent, treat, and reduce overweight and obesity;

“(2) coordinate interagency cooperation and action related to the prevention, treatment, and reduction of overweight and obesity in the United States;

“(3) identify best practices in communities to address overweight and obesity;

“(4) work with appropriate entities to evaluate the effectiveness of obesity and overweight interventions;

“(5) update the National Institutes of Health 1998 ‘Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report’ and include sections on childhood obesity in such updated report;

“(6) conduct ongoing surveillance and monitoring using tools such as the National Health and Nutrition Examination Survey and the Behavioral Risk Factor Surveillance System and assure adequate and consistent funding to support data collection and analysis to inform policy;

“(7) make recommendations to coordinate budgets, grant and pilot programs, policies, and programs across Federal agencies to cohesively address overweight and obesity, including with respect to the grant programs carried out under sections 306(n), 399V, and 1904(a)(1)(H);

“(8) make recommendations to update and improve the daily physical activity requirements for students under the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.) and include recommendations about physical activities that families can do together, and involving parents in these activities;

“(9) make recommendations about coverage for obesity-related services and for an early and periodic screening, diagnostic, and treatment services program under the State Children’s Health Insurance Program established under title XXI of the Social Security Act;

“(10) make recommendations for obesity-related information, including height, weight, and body mass index, to be included in electronic health records for the purpose of ongoing surveillance and monitoring; and

“(11) provide guidelines for childhood obesity health care related treatment under the early and periodic screening, diagnostic, and treatment services program under the Medicaid program established under title XIX of the Social Security Act and otherwise described in section 2103(c)(5) of such Act.

“(e) REPORT.—Not later than 18 months after the date of enactment of the Obesity Prevention, Treatment, and Research Act of 2009, and on an annual basis thereafter, USCO-OP shall submit to the President and to the relevant committees of Congress, a report that—

“(1) summarizes the activities and efforts of USCO-OP under this section to coordinate interagency prevention, treatment, and reduction of obesity and overweight, including a detailed strategic plan with recommendations for each Federal agency;

“(2) evaluates the effectiveness of these coordinated interventions and conducts interim assessments and reporting of health outcomes, achievement of milestones, and implementation of strategic plan goals starting with the second report, and yearly thereafter; and

“(3) makes recommendations for the following year’s strategic plan based on data and findings from the previous year.

“(f) TECHNICAL ASSISTANCE.—The Department of Health and Human Services may provide technical assistance to USCO-OP to carry out the activities under this section.

“(g) PERMANENCE OF COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to USCO-OP.”

SEC. 102. GRANTS AND DEMONSTRATION PROGRAMS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN POPULATIONS DISPROPORTIONATELY AFFECTED BY OBESITY AND OVERWEIGHT.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 101, is amended by adding at the end the following:

“SEC. 399V. GRANTS AND DEMONSTRATION PROGRAMS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN POPULATIONS DISPROPORTIONATELY AFFECTED BY OBESITY AND OVERWEIGHT.

“(a) ELIGIBLE ENTITY.—For purposes of this section, the term ‘eligible entity’ means—

“(1) a city, county, Indian tribe, tribal organization, territory, or State;

“(2) a local, tribal, or State educational agency;

“(3) a Federal medical facility, including a federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act), an Indian Health Service hospital or clinic, any health facility or program operated by or pursuant to a contractor grant from the Indian Health Service, an Indian Health Service entity, an urban Indian center, an Indian tribal clinic, a health care for the homeless center, a rural health center, migrant health center, and any other Federal medical facility;

“(4) any entity meeting the criteria for medical home under section 204 of the Tax Relief and Health Care Act of 2006 (Public Law 109-432);

“(5) a nonprofit organization (such as an academic health center or community health center);

“(6) a health department;

“(7) any licensed or certified health provider;

“(8) an accredited university or college;

“(9) a community-based organization;

“(10) a local city planning agency; and

“(11) any other entity determined appropriate by the Secretary.

“(b) APPLICATION.—An eligible entity that desires a grant under this section shall submit an application at such time, in such manner, and containing such information as the Secretary may require, including a plan for the use of funds that may be awarded and an evaluation of any training that will be provided under such grant.

“(c) GRANT DEMONSTRATION AND PILOT PROGRAM.—

“(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in consultation with the United States Council on Overweight-Obesity Prevention under section 399U, shall establish and evaluate a grant demonstration and pilot program for entities to—

“(A) prevent, treat, or otherwise reduce overweight and obesity;

“(B) increase the number of children and adults who safely walk or bike to school or work;

“(C) increase the availability and affordability of fresh fruits and vegetables in the community;

“(D) expand safe and accessible walking paths and recreational facilities to encourage physical activity, and other interventions to create healthy communities;

“(E) create advertising, social marketing, and public health campaigns promoting healthier food choices, increased physical activity, and healthier lifestyles targeted to individuals and to families;

“(F) promote increased rates and duration of breast-feeding; and

“(G) increase worksite and employer promotion of and involvement in community initiatives that prevent, treat, or otherwise reduce overweight and obesity.

“(2) SPECIAL PRIORITY.—Special priority will be given to grant proposals that target communities or populations disproportionately affected by overweight or obesity, including Native Americans, other minorities, and women.

“(d) GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN POPULATIONS DISPROPORTIONATELY AFFECTED BY OBESITY AND OVERWEIGHT.—

“(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may award grants to eligible entities to promote health behaviors for women and children in target populations, especially racial and ethnic minority populations in medically underserved communities.

“(2) USE OF FUNDS.—An award under this section shall be used to carry out any of the following:

“(A) To educate, promote, prevent, treat and determine best practices in overweight and obese populations.

“(B) To address behavioral risk factors including sedentary lifestyle, poor nutrition, being overweight or obese, and use of tobacco, alcohol or other substances that increase the risk of morbidity and mortality. Special priority will be given to grant applications that—

“(i) propose interventions that address embedded levels of influence on behavior, including the individual, family, peers, community and society; and

“(ii) utilize techniques that promote community involvement in the design and implementation of interventions including community diagnosis and community-based participatory research.

“(C) To develop and implement interventions to promote a balance of energy consumption and expenditure, to attain healthier weight, prevent obesity, and reduce morbidity and mortality associated with overweight and obesity.

“(D)(i) To train primary care physicians and other licensed or certified health professionals on how to identify, treat, and prevent obesity or eating disorders and aid individuals who are overweight, obese, or who suffer from eating disorders.

“(ii) To use evidence-based findings or recommendations that pertain to the prevention and treatment of obesity, being overweight, and eating disorders to conduct educational conferences, including Internet-based courses and teleconferences, on—

“(I) how to treat or prevent obesity, being overweight, and eating disorders;

“(II) the link between obesity, being overweight, eating disorders and related serious and chronic medical conditions;

“(III) how to discuss varied strategies with patients from at-risk and diverse populations to promote positive behavior change and healthy lifestyles to avoid obesity, being overweight, and eating disorders;

“(IV) how to identify overweight, obese, individuals with eating disorders, and those who are at risk for obesity and being overweight or suffer from eating disorders and, therefore, at risk for related serious and chronic medical conditions; and

“(V) how to conduct a comprehensive assessment of individual and familial health risk factors and evaluate the effectiveness of

the training provided by such entity in increasing knowledge and changing attitudes and behaviors of trainees.

“(iii) In awarding a grant to carry out an activity under this subparagraph, preference shall be given to an entity described in subsection (a)(4).

“(e) REPORTING TO CONGRESS.—Not later than 3 years after the date of enactment of this section, the Director of the Centers for Disease Control and Prevention shall submit to the Secretary and Congress a report concerning the result of the activities conducted through the grants awarded under this section.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, \$50,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2013.”

SEC. 103. NATIONAL CENTER FOR HEALTH STATISTICS.

Section 306 of the Public Health Service Act (42 U.S.C. 242k) is amended—

(1) in subsection (m)(4)(B), by striking “subsection (n)” each place it appears and inserting “subsection (o)”;

(2) by redesignating subsection (n) as subsection (o); and

(3) by inserting after subsection (m) the following:

“(n)(1) The Secretary, acting through the Center, may provide for the—

“(A) collection of data for determining the fitness levels and energy expenditure of adults, children, and youth; and

“(B) analysis of data collected as part of the National Health and Nutrition Examination Survey and other data sources.

“(2) In carrying out paragraph (1), the Secretary, acting through the Center, may make grants to States, public entities, and nonprofit entities.

“(3) The Secretary, acting through the Center, may provide technical assistance, standards, and methodologies to grantees supported by this subsection in order to maximize the data quality and comparability with other studies.”

SEC. 104. HEALTH DISPARITIES REPORT.

Not later than 18 months after the date of enactment of this Act, and annually thereafter, the Director of the Agency for Healthcare Research and Quality shall review all research that results from the activities carried out under this Act (and the amendments made by this Act) and determine if particular information may be important to the report on health disparities required by section 903(c)(3) of the Public Health Service Act (42 U.S.C. 299a–1(c)(3)).

SEC. 105. PREVENTIVE HEALTH SERVICES BLOCK GRANT.

Section 1904(a)(1) of the Public Health Service Act (42 U.S.C. 300w–3(a)(1)) is amended by adding at the end the following:

“(H) Activities and community education programs designed to address and prevent overweight, obesity, and eating disorders through effective programs to promote healthy eating, and exercise habits and behaviors.”

SEC. 106. REPORT ON OBESITY AND EATING DISORDERS RESEARCH.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on research conducted on causes and health implications (including mental health implications) of being overweight, obesity, and eating disorders.

(b) CONTENT.—The report described in subsection (a) shall contain—

(1) descriptions on the status of relevant, current, ongoing research being conducted in the Department of Health and Human Services including research at the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and other offices and agencies;

(2) information about what these studies have shown regarding the causes, prevention, and treatment of, being overweight, obesity, and eating disorders; and

(3) recommendations on further research that is needed, including research among diverse populations, the plan of the Department of Health and Human Services for conducting such research, and how current knowledge can be disseminated.

TITLE II—FOOD AND BEVERAGE LABELING FOR HEALTHY CHOICES

SEC. 201. FOOD AND BEVERAGE LABELING FOR HEALTHY CHOICES.

(a) USCO-OP.—In this section, the term “USCO-OP” means the United States Council on Overweight-Obesity Prevention under section 399U of the Public Health Service Act (as added by section 101).

(b) REFORM OF FOOD AND BEVERAGE LABELING.—The Secretary of Health and Human Services and the Secretary of Agriculture, in consultation with the USCO-OP, shall, through regulation or other appropriate action, update and reform Federal oversight of food and beverage labeling. Such reform shall include improving the transparency of such labeling with regard to nutritional and caloric value of food and beverages.

TITLE III—HEALTHY CHOICES FOOD AND BEVERAGE PROGRAMS

SEC. 301. FRESH FRUIT AND VEGETABLE PROGRAM.

Section 19(i) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1769a(i)) is amended—

(1) by redesignating paragraphs (3) through (7) as paragraphs (4) through (8); and

(2) by inserting after paragraph (2) the following:

“(3) ADDITIONAL MANDATORY FUNDING.—

“(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall transfer to the Secretary of Agriculture to carry out and expand the program under this section, to remain available until expended—

“(i) on October 1, 2009, \$80,000,000;

“(ii) on July 1, 2010, \$130,000,000;

“(iii) on July 1, 2011, \$202,000,000;

“(iv) on July 1, 2012, \$300,000,000; and

“(v) on July 1, 2013, and on each July 1 thereafter, the amount made available for the previous fiscal year, as adjusted under subparagraph (B).

“(B) ADJUSTMENT.—On July 1, 2013, and on each July 1 thereafter the amount made available under subparagraph (A)(v) shall be calculated by adjusting the amount made available for the previous fiscal year to reflect changes in the Consumer Price Index of the Bureau of Labor Statistics for fresh fruits and vegetables, with the adjustment—

“(i) rounded down to the nearest dollar increment; and

“(ii) based on the unrounded amounts for the preceding 12-month period.

“(C) ALLOCATION.—Funds made available under this paragraph shall be allocated among the States and the District of Columbia in the same manner as funds made available under paragraph (1).”

TITLE IV—AMENDMENTS TO THE SOCIAL SECURITY ACT

SEC. 401. COVERAGE OF EVIDENCE-BASED PREVENTIVE SERVICES UNDER MEDICARE, MEDICAID, AND SCHIP.

(a) MEDICARE.—Section 1861(ddd) of the Social Security Act, as added by section 101 of

the Medicare Improvements for Patients and Providers Act of 2008, is amended—

(1) in paragraph (2), by striking “paragraph (1)” and inserting “paragraphs (1) and (3)”; and

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

“(3) The term ‘additional preventive services’ includes any evidence-based preventive services which the Secretary has determined are reasonable and necessary, including, as so determined, smoking cessation and prevention services, diet and exercise counseling, and healthy weight and obesity counseling.”

(b) STATE OPTION TO PROVIDE MEDICAL ASSISTANCE FOR EVIDENCE-BASED PREVENTIVE SERVICES.—

(1) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(A) in subsection (a)—

(i) in paragraph (27), by striking “and” at the end;

(ii) by redesignating paragraph (28) as paragraph (29); and

(iii) by inserting after paragraph (27) the following:

“(28) evidence-based preventive services described in subsection (y); and”;

(B) by adding at the end the following:

“(y) For purposes of subsection (a)(28), evidence-based preventive services described in this subsection are any preventive services which the Secretary has determined are reasonable and necessary through the process for making national coverage determinations (as defined in section 1869(f)(1)(B)) under title XVIII, including, as so determined, smoking cessation and prevention services, diet and exercise counseling, and healthy weight and obesity counseling.”

(2) CONFORMING AMENDMENT.—Section 1902(a)(10)(C)(iv) of such Act is amended by inserting “, and (28)” after “(24)”.

(c) STATE OPTION TO PROVIDE CHILD HEALTH ASSISTANCE FOR EVIDENCE-BASED PREVENTIVE SERVICES.—Section 2110(a) of the Social Security Act (42 U.S.C. 1397jj(a)) is amended—

(1) by redesignating paragraph (28) as paragraph (29); and

(2) by inserting after paragraph (27) the following:

“(28) Evidence-based preventive services described in section 1905(y).”

SEC. 402. COVERAGE OF MEDICAL NUTRITION COUNSELING UNDER MEDICARE, MEDICAID, AND SCHIP.

(a) MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY SERVICES FOR PEOPLE WITH PRE-DIABETES.—Section 1861(s)(2)(V) of the Social Security Act (42 U.S.C. 1395x(s)(2)(V)) is amended by inserting after “beneficiary with diabetes” the following “, pre-diabetes or its risk factors (including hypertension, dyslipidemia, obesity, or overweight).”

(b) STATE OPTION TO PROVIDE MEDICAL ASSISTANCE FOR MEDICAL THERAPY SERVICES.—

(1) IN GENERAL.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d), as amended by section 401(b), is amended—

(A) in paragraph (28), by striking “and” at the end;

(B) by redesignating paragraph (29) as paragraph (30); and

(C) by inserting after paragraph (28) the following:

“(29) medical nutrition therapy services (as defined in section 1861(vv)(1)) for individuals with pre-diabetes or obesity, or who are overweight (as defined by the Secretary); and”.

(2) CONFORMING AMENDMENT.—Section 1902(a)(10)(C)(iv) of such Act, as amended by section 401(b)(2), is amended by striking “and (28)” and inserting “(28), and (29)”.

(c) STATE OPTION TO PROVIDE CHILD HEALTH ASSISTANCE FOR MEDICAL NUTRITION

THERAPY SERVICES.—Section 2110(a) of the Social Security Act (42 U.S.C. 1397jj(a)), as amended by section 401(c), is amended—

(1) by redesignating paragraph (29) as paragraph (30); and

(2) by inserting after paragraph (28) the following:

“(29) Medical nutrition therapy services (as defined in section 1861(vv)(1)) for individuals with pre-diabetes or obesity, or who are overweight (as defined by the Secretary).”

SEC. 403. AUTHORIZING EXPANSION OF MEDICARE COVERAGE OF MEDICAL NUTRITION THERAPY SERVICES.

(a) AUTHORIZING EXPANDED ELIGIBLE POPULATION.—Section 1861(s)(2)(V) of the Social Security Act (42 U.S.C. 1395x(s)(2)(V)), as amended by section 402, is amended—

(1) by redesignating clauses (i) through (iii) as subclauses (I) through (III), respectively, and indenting each such clause an additional 2 ems;

(2) by striking “in the case of a beneficiary with diabetes, pre-diabetes or its risk factors (including hypertension, dyslipidemia, obesity, overweight), or a renal disease who—” and inserting “in the case of a beneficiary—

“(i) with diabetes, pre-diabetes or its risk factors (including hypertension, dyslipidemia, obesity, overweight), or a renal disease who—”;

(3) by adding “or” at the end of subclause (III) of clause (i), as so redesignated; and

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

“(ii) who is not described in clause (i) but who has another disease, condition, or disorder for which the Secretary has made a national coverage determination (as defined in section 1869(f)(1)(B)) for the coverage of such services.”

(b) COVERAGE OF SERVICES FURNISHED BY PHYSICIANS.—Section 1861(vv)(1) of the Social Security Act (42 U.S.C. 1395x(vv)(1)) is amended by inserting “or which are furnished by a physician” before the period at the end.

(c) NATIONAL COVERAGE DETERMINATION PROCESS.—In making a national coverage determination described in section 1861(s)(2)(V)(ii) of the Social Security Act, as added by subsection (a)(4), the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall—

(1) consult with dietetic and nutrition professional organizations in determining appropriate protocols for coverage of medical nutrition therapy services for individuals with different diseases, conditions, and disorders; and

(2) consider the degree to which medical nutrition therapy interventions prevent or help prevent the onset or progression of more serious diseases, conditions, or disorders.

SEC. 404. CLARIFICATION OF EPSDT INCLUSION OF PREVENTION, SCREENING, AND TREATMENT SERVICES FOR OBESITY AND OVERWEIGHT; SCHIP COVERAGE.

(a) IN GENERAL.—Section 1905(r)(5) of the Social Security Act (42 U.S.C. 1396d(r)(5)) is amended by inserting “, including weight and BMI measurement and monitoring, as well as appropriate treatment services (including but not limited to) medical nutrition therapy services (as defined in section 1861(vv)(1)), physical therapy or exercise training, and behavioral health counseling, based on recommendations of the United States Council on Overweight-Obesity Prevention under section 399U of the Public Health Service Act and such other expert recommendations and studies as determined by the Secretary” before the period.

(b) SCHIP.—

(1) REQUIRED COVERAGE.—Section 2103 (42 U.S.C. 1397cc) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking “and (7)” and inserting “(7), and (9)”; and

(B) in subsection (c)—

(i) by redesignating paragraph (7) as paragraph (9); and

(ii) by inserting after paragraph (6), the following:

“(7) PREVENTION, SCREENING, AND TREATMENT SERVICES FOR OBESITY AND OVERWEIGHT.—The child health assistance provided to a targeted low-income child shall include coverage of weight and BMI measurement and monitoring, as well as appropriate treatment services (including but not limited to) medical nutrition therapy services (as defined in section 1861(vv)(1)), physical therapy or exercise training, and behavioral health counseling, based on recommendations of the United States Council on Overweight-Obesity Prevention under section 399U of the Public Health Service Act and such other expert recommendations and studies as determined by the Secretary.”

(2) CONFORMING AMENDMENT.—Section 2102(a)(7)(B) (42 U.S.C. 1397bb(c)(2)) is amended by striking “section 2103(c)(5)” and inserting “paragraphs (5) and (7) of section 2103(c)”.

SEC. 405. INCLUSION OF PREVENTIVE SERVICES IN QUALITY MATERNAL AND CHILD HEALTH SERVICES.

Section 501(b) of the Social Security Act (42 U.S.C. 701(b)) is amended by adding at the end the following new paragraph:

“(5) The term ‘quality maternal and child health services’ includes the following:

“(A) Evidence-based preventive services described in section 1905(y).

“(B) Medical nutrition counseling for individuals with pre-diabetes or obesity, or who are overweight (as defined by the Secretary).

“(C) Weight and BMI measurement and monitoring, as well as appropriate treatment services (including but not limited to) medical nutrition therapy services (as defined in section 1861(vv)(1)), physical therapy or exercise training, and behavioral health counseling, based on recommendations of the United States Council on Overweight-Obesity Prevention under section 399U of the Public Health Service Act and such other expert recommendations and studies as determined by the Secretary.”

SEC. 406. CHILDHOOD OBESITY INFORMATION, GUIDELINES, AND REPORTING.

The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare and Medicaid Services, shall—

(1) not later than 18 months after the date of the enactment of this Act, provide the State agencies responsible for administering the State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and the State child health plan approved under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) with relevant data, information, and recommendations, as the Administrator deems appropriate, regarding the risks associated with childhood obesity and the importance of identifying at-risk children for treatment;

(2) not later than 18 months after the date of the enactment of this Act, issue guidelines, or amend existing guidelines, concerning the development of pediatric obesity prevention programs for at-risk populations through the use of managed care techniques, integrated service delivery models, disease management programs, and other methods that the Administrator deems appropriate;

(3) provide for the annual reporting by such State agencies of the number of children enrolled in a State Medicaid or child health plan that are—

(A) screened for overweight or obesity; and

(B) identified as at-risk for overweight or obesity and have been provided with appropriate medical follow-up services or counseling; and

(4) prepare and submit an annual report to Congress on the percentage of children enrolled in a State Medicaid or child health plan that are screened for overweight or obesity and, for those identified as at-risk, receive appropriate medical follow-up services or counseling.

SEC. 407. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b), this title, and the amendments made under this title, take effect on October 1, 2010.

(b) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title 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 previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

NOTICES OF HEARINGS

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a business meeting has been scheduled before Committee on Energy and Natural Resources. The business meeting will be held on Thursday, May 21, 2009 at 10:30 a.m., in room SD-366 of the Dirksen Senate office building.

The purpose of the business meeting is to consider pending energy legislation.

For further information, please contact Sam Fowler at (202) 224-7571 or Amanda Kelly at (202) 224-6836.

PRIVILEGES OF THE FLOOR

Mr. DORGAN. Mr. President, I ask unanimous consent that William “Bill” Curlin have full floor privileges during the consideration of the supplemental appropriations bill. He is a fellow in my office.

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

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. DURBIN. Madam President, I ask unanimous consent that the Senate proceed to executive session to consider Calendar Nos. 134, 135, 136, 137, 138, 141, 142, 143, 145, 146, 147, 148, 149, 150, and 151.

NOMINATION OF THOMAS R. LAMONT

I would like to add, Madam President, before I ask for this consent, that one of the numbers I have just read relates to the nomination of Thomas Lamont, to serve as Assistant Secretary of the Army for Manpower and Reserve Affairs.

Mr. Lamont is a friend of mine. He lives in my hometown, and I have known him for many years. He and his wife Bridget are close friends.

Tom is a dedicated public servant. He has spent 25 years in the Judge Advocate General’s division of the Illinois Army National Guard, where he was a State staff judge advocate general before retiring with the rank of colonel in the year 2007.

He was also elected to the board of trustees at the University of Illinois. He served in the highest capacities with the Office of the State Attorney Appellate Prosecutor, Civil Litigation in the Office of the Illinois Attorney General, and the Illinois Board of Higher Education.

He has practiced law in Springfield, my hometown, where he has built a sterling reputation for integrity and ability.

Most recently, Tom has served as special counsel to the University of Illinois.

With this confirmation, his broad array of service and experience will serve our Nation. The Army and America need leaders such as Tom Lamont.

With our Army’s soldiers deployed around the world, with their families counting on good leadership in the Pentagon to make certain they are well trained, serve us well, and come home safely, we have an excellent person to serve as Assistant Secretary of the Army for Manpower and Reserve Affairs in Tom Lamont of Springfield, IL.

I was happy to recommend his name to the President.

NOMINATION OF MARGARET A. HAMBURG

Madam President, one of the nominees to be considered and voted out this evening is to serve in the administration with a special responsibility for the Food and Drug Administration. Margaret A. Hamburg is certainly well qualified to serve in that capacity. There are many responsibilities to be dealt with in the agency, including the safety of drugs, pharmaceuticals, medical devices, and food in America. It is an issue that is near and dear to me. I have spoken to the nominee about it personally, and I wish to commend her.

Madam President, I ask unanimous consent that the nominations be confirmed en bloc, and the motions to reconsider be laid upon the table en bloc; that no further motions be in order; that any statements relating to the nominations be printed in the RECORD; that the President be immediately notified of the Senate’s action, and the Senate then resume legislative session.

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

The nominations considered and confirmed en bloc are as follows:

DEPARTMENT OF THE TREASURY

Neal S. Wolin, of Illinois, to be Deputy Secretary of the Treasury.

DEPARTMENT OF VETERANS AFFAIRS

John U. Sepulveda, of Virginia, to be an Assistant Secretary of Veterans Affairs (Human Resources).

Jose D. Riojas, of Texas, to be an Assistant Secretary of Veterans Affairs (Operations, Security, and Preparedness).

William A. Gunn, of Virginia, to be General Counsel, Department of Veterans Affairs.

Roger W. Baker, of Virginia, to be an Assistant Secretary of Veterans Affairs (Information and Technology).

DEPARTMENT OF THE INTERIOR

Rhea S. Suh, of California, to be an Assistant Secretary of the Interior.

DEPARTMENT OF ENERGY

David B. Sandalow, of the District of Columbia, to be an Assistant Secretary of Energy (International Affairs and Domestic Policy).

Daniel B. Poneman, of Virginia, to be Deputy Secretary of Energy.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Margaret A. Hamburg, of the District of Columbia, to be Commissioner of Food and Drugs, Department of Health and Human Services.

[NEW REPORTS]

DEPARTMENT OF DEFENSE

Robert O. Work, of Virginia, to be Under Secretary of the Navy.

Raymond Edwin Mabus, Jr., of Mississippi, to be Secretary of the Navy.

Thomas R. Lamont, of Illinois, to be an Assistant Secretary of the Army.

Paul N. Stockton, of California, to be an Assistant Secretary of Defense.

Andrew Charles Weber, of Virginia, to be Assistant to the Secretary of Defense for Nuclear and Chemical and Biological Defense Programs.

Charles A. Blanchard, of Arizona, to be General Counsel of the Department of the Air Force.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate will now resume legislative session.

UNANIMOUS CONSENT AGREEMENT—EXECUTIVE CALENDAR

Mr. DURBIN. Madam President, as in executive session, I ask unanimous consent that on Tuesday, May 19, following disposition of H.R. 627, the Senate proceed to executive session to consider Calendar No. 29, the nomination of Gary Gensler to be a Commissioner of the Commodity Futures Trading Commission; that there be 60 minutes of debate with respect to the nomination, with the time equally divided and controlled between Senators HARKIN and CHAMBLISS or their designees, with Senators CANTWELL, CARDIN, and SANDERS each controlling 5 minutes of the majority’s time; that at 2:15 p.m. the Senate proceed to vote on confirmation of the nomination; that upon confirmation of Calendar No. 29, the Senate then proceed to Calendar No. 30, that the nomination be confirmed and the motion to reconsider be laid upon the table; that no further motions be in