SANDERS) was added as a cosponsor of S. 1003, a bill to increase immunization rates.

S. 1019

At the request of Mr. HARKIN, the name of the Senator from Wisconsin (Mr. KOHL) was added as a cosponsor of S. 1019, a bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for the purchase of hearing aids.

S. 1038

At the request of Mrs. FEINSTEIN, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 1038, a bill to improve agricultural job opportunities, benefits, and security for aliens in the United States and for other purposes.

S. 1050

At the request of Mr. LAUTENBERG, his name was added as a cosponsor of S. 1050, a bill to amend title XXVII of the Public Health Service Act to establish Federal standards for health insurance forms, quality, fair marketing, and honesty in out-of-network coverage in the group and individual health insurance markets, to improve transparency and accountability in those markets, and to establish a Federal Office of Health Insurance Oversight to monitor performance in those markets, and for other purposes.

S. 1057

At the request of Mr. TESTER, the names of the Senator from Maine (Ms. COLLINS) and the Senator from Utah (Mr. BENNETT) were added as cosponsors 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.

S. 1102

At the request of Mr. LIEBERMAN, the names of the Senator from Hawaii (Mr. AKAKA), the Senator from California (Mrs. BOXER), the Senator from Ohio (Mr. BROWN), the Senator from Washington (Ms. CANTWELL), the Senator from Maryland (Mr. CARDIN), the Senator from Pennsylvania (Mr. CASEY), the Senator from Connecticut (Mr. DODD), the Senator from Illinois (Mr. DURBIN), the Senator from Wisconsin (Mr. FEINGOLD), the Senator from New York (Mrs. GILLIBRAND), the Senator from Massachusetts (Mr. KENNEDY), the Senator from Massachusetts (Mr. KERRY), the Senator from New Jersey (Mr. LAUTENBERG), the Senator from Vermont (Mr. LEAHY), the Senator from Michigan (Mr. LEVIN), the Senator from Oregon (Mr. MERKLEY), the Senator from Maryland (Ms. MIKULSKI), the Senator from Washington (Mrs. MURRAY), the Senator from Vermont (Mr. SANDERS), the Senator from New York (Mr. SCHUMER), the Senator from Rhode Island (Mr. WHITEHOUSE) and the Senator from Oregon (Mr. WYDEN) were added as cosponsors of S. 1102, a bill to provide benefits to domestic partners of Federal employees.

S. 1108

At the request of Mr. LAUTENBERG, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 1108, a bill to require application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor for each all-urban and rural State.

S. 1112

At the request of Mr. DODD, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1112, a bill to make effective the proposed rule of the Food and Drug Administration relating to sunscreen drug products, and for other purposes.

S. RES. 97

At the request of Mr. TESTER, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. Res. 97, a resolution designating June 1, 2009, as ''Collector Car Appreciation Day'' and recognizing that the collection and restoration of historic and classic cars is an important part of preserving the technological achievements and cultural heritage of the United States.

S. RES. 139

At the request of Ms. MIKULSKI, the name of the Senator from Florida (Mr. MARTINEZ) was added as a cosponsor of S. Res. 139, a resolution commemorating the 20th anniversary of the end of communist rule in Poland.

S. RES. 151

At the request of Mrs. GILLIBRAND, her name was added as a cosponsor of S. Res. 151, a resolution designates a national day of remembrance on October 30, 2009, for nuclear weapons program workers.

AMENDMENT NO. 1155

At the request of Mr. NELSON of Florida, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of amendment No. 1155 intended to be proposed to H.R. 2346, a bill making supplemental appropriations for the fiscal year ending September 30, 2009, and for other purposes.

AMENDMENT NO. 1161

At the request of Mr. BROWN, the name of the Senator from Oregon (Mr. MERKLEY) was added as a cosponsor of amendment No. 1161 proposed to H.R. 2346, a bill making supplemental appropriations for the fiscal year ending September 30, 2009, and for other purposes.

AMENDMENT NO. 1164

At the request of Mr. ISAKSON, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of amendment No. 1164 proposed to H.R. 2346, a bill making supplemental appropriations for the fiscal year ending September 30, 2009, and for other purposes.

AMENDMENT NO. 1179

At the request of Mr. KAUFMAN, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of amendment No. 1179 proposed to H.R. 2346, a bill making supplemental appropriations for the fiscal year ending September 30, 2009, and for other purposes.

AMENDMENT NO. 1189

At the request of Mrs. HUTCHISON, the names of the Senator from Pennsylvania (Mr. CASEY), the Senator from Utah (Mr. BENNETT), the Senator from New Mexico (Mr. BINGAMAN), the Senator from Massachusetts (Mr. KERRY), the Senator from Minnesota (Ms. KLOBUCHAR), the Senator from Maryland (Mr. CARDIN), the Senator from Nebraska (Mr. NELSON), the Senator from Kansas (Mr. BROWNBACK), the Senator from Kansas (Mr. ROBERTS), the Senator from Iowa (Mr. GRASSLEY), the Senator from North Carolina (Mr. BURR), the Senator from Nebraska (Mr. JOHANNS), the Senator from New York (Mr. SCHUMER), the Senator from Iowa (Mr. HARKIN), the Senator from Louisiana (Ms. LANDRIEU), the Senator from New Hampshire (Mrs. SHAHEEN), the Senator from Idaho (Mr. CRAPO), the Senator from Idaho (Mr. RISCH), the Senator from Florida (Mr. NELSON), the Senator from Maine (Ms. SNOWE), the Senator from Hawaii (Mr. INOUYE), the Senator from Wisconsin (Mr. FEINGOLD), the Senator from Maine (Ms. COLLINS), the Senator from Pennsylvania (Mr. SPECTER), the Senator from Wisconsin (Mr. KOHL), the Senator from North Dakota (Mr. DORGAN), the Senator from Virginia (Mr. WEBB), the Senator from Mississippi (Mr. WICKER), the Senator from Texas (Mr. CORNYN), the Senator from Arkansas (Mrs. LINCOLN), and the Senator from South Dakota (Mr. THUNE) were added as cosponsors of amendment No. 1189 proposed to H.R. 2346, a bill making supplemental appropriations for the fiscal year ending September 30, 2009, and for other purposes.

AMENDMENT NO. 1191

At the request of Mr. LEAHY, the names of the Senator from New Jersey (Mr. MENENDEZ) and the Senator from Delaware (Mr. KAUFMAN) were added as cosponsors of amendment No. 1191 proposed to H.R. 2346, a bill making supplemental appropriations for the fiscal year ending September 30, 2009, and for other purposes.

AMENDMENT NO. 1198

At the request of Mr. LUGAR, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of amendment No. 1198 intended to be proposed to H.R. 2346, a bill making supplemental appropriations for the fiscal year ending September 30, 2009, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. LEAHY (for himself, Mr. SANDERS, Mrs. SHAHEEN, and Mr. GREGG):

S. 1117. A bill to authorize the Secretary of the Interior to provide assistance in implementing cultural heritage, conservation, and recreational activities in the Connecticut River watershed of the States of New Hampshire

and Vermont; to the Committee on Energy and Natural Resources.

Mr. LEAHY. Mr. President, I am pleased to introduce today the Upper Connecticut River Partnership Act. This legislation will help bring recognition to New England's largest river ecosystem and one of our Nation's 14 American Heritage Rivers.

The purpose of this legislation is to help the communities along the river protect and enhance their rich cultural history, economic vitality, and the environmental integrity of the river.

From its origin in the mountains of northern New Hampshire, the Connecticut River runs over 400 miles and eventually empties into Long Island Sound. The river forms a natural boundary between my home state of Vermont and New Hampshire, and travels through the States of Massachusetts and Connecticut. The river and surrounding valley have long shaped and influenced development in the New England region. This river is one of America's earliest developed rivers, with European settlements going back over 350 years. The industrial revolution blossomed in the Connecticut River Valley, supported by new technologies such as canals and mills run by hydropower.

I am pleased that the entire Senate delegations from Vermont and New Hampshire have cosponsored this bill. For years our States have worked together, to help communities on both sides of the river develop local partnerships to protect the Connecticut River valley of Vermont and New Hampshire. While great improvements have been made to the river, its overall health remains threatened by water and air pollution, habitat loss, hydroelectric dams, and invasive species.

Historically, the people throughout the Upper Connecticut River Valley have functioned cooperatively and the river serves to unite Vermont and New Hampshire communities economically, culturally, and environmentally.

Citizens on both sides of the river know just how special this region is and have worked side by side for years to protect it. Efforts have been underway for some time to restore the Atlantic salmon fishery, protect threatened and endangered species, and support urban riverfront revitalization.

In 1989, Vermont and New Hampshire came together to create the Connecticut River Joint Commissions—a unique partnership between the states, local businesses, all levels of Government within the 2 States and citizens from all walks of life. This partnership helps coordinate the efforts of towns, watershed managers and other local groups to implement the Connecticut River Corridor Management Plan. This Plan has become the blueprint for how communities along the river can work with one another with Vermont and New Hampshire and with the federal government to protect the river's resources.

The Upper Connecticut River Partnership Act would help carry out the recommendations of the Connecticut River Corridor Management Plan, which was developed under New Hampshire law with the active participation of Vermont citizens and communities.

This act would also provide the Secretary of the Interior with the much needed ability to assist the States of New Hampshire and Vermont with technical and financial aid for the Upper Connecticut River Valley through the Connecticut River Joint Commissions. The act would also assist local communities with cultural heritage outreach and education programs while enriching the recreational activities already active in the Connecticut River Watershed of Vermont and New Hampshire.

Lastly, the bill will require that the Secretary of the Interior establish a Connecticut River Grants and Technical Assistance Program to help local community groups develop new projects as well as build on existing ones to enhance the river basin.

In the future, I hope this bill will help bring renewed recognition and increased efforts to conserve the Connecticut River as one of our Nation's great natural and economic resources.

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 follwos:

S. 1117

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 ''Upper Connecticut River Partnership Act''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) the upper Connecticut River watershed in the States of New Hampshire and Vermont is a scenic region of historic villages located in a working landscape of farms, forests, and the mountainous headwaters and broad fertile floodplains of New England's longest river, the Connecticut River;

(2) the River provides outstanding fish and wildlife habitat, recreation, and hydropower generation for the New England region;

(3) the upper Connecticut River watershed has been recognized by Congress as part of the Silvio O. Conte National Fish and Wildlife Refuge, established by the Silvio O. Conte National Fish and Wildlife Refuge Act (16 U.S.C. 668dd note; Public Law 102–212);

(4) the demonstrated commitment to stewardship of the River by the citizens living in the watershed led to the Presidential designation of the River as 1 of 14 American Heritage Rivers on July 30, 1998;

(5) the River is home to the bi-State Connecticut River Scenic Byway, which was declared a National Scenic Byway by the Department of Transportation in 2005 to foster heritage tourism in the region;

(6) each of the legislatures of the States of Vermont and New Hampshire has established a commission for the Connecticut River watershed, and the 2 commissions, known collectively as the ''Connecticut River Joint Commissions''—

(A) have worked together since 1989; and

(B) serve as the focal point and catalyst for cooperation between Federal agencies, States, communities, and citizens;

(7) in 1997, as directed by the legislatures, the Connecticut River Joint Commissions, with the substantial involvement of 5 bi-State local river subcommittees appointed to represent riverfront towns, produced the 6 volume Connecticut River Corridor Management Plan, to be used as a blueprint in educating agencies, communities, and the public in how to be good neighbors to a great river;

(8) in 2009, after 3 years of broad consultation, the Connecticut River Joint Commissions have substantially expanded and published updates via the Connecticut River Recreation Management Plan and the Water Resources Management Plan to guide public and private activities in the watershed;

(9) through a joint legislative resolution, the legislatures of the States of Vermont and New Hampshire have requested that Congress provide for continuation of cooperative partnerships and that Federal agencies support the Connecticut River Joint Commissions in carrying out the recommendations of the Connecticut River Corridor Management Plan;

(10) this Act effectuates certain recommendations of the Connecticut River Corridor Management Plan that are most appropriately directed by the States through the Connecticut River Joint Commissions, with assistance from the National Park Service and the United States Fish and Wildlife Service; and

(11) where implementation of those recommendations involves partnership with local communities and organizations, support for the partnership should be provided by the Secretary.

(b) PURPOSE.—The purpose of this Act is to authorize the Secretary to provide to the States of New Hampshire and Vermont (including communities in those States), through the Connecticut River Joint Commissions, technical and financial assistance for management of the River.

SEC. 3. DEFINITIONS.

In this Act:

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior.

(2) STATE.—The term ''State'' means—

(A) the State of New Hampshire; or

(B) the State of Vermont.

SEC. 4. CONNECTICUT RIVER GRANTS AND TECHNICAL ASSISTANCE PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a Connecticut River Grants and Technical Assistance Program to provide grants and technical assistance to State and local governments, nonprofit organizations, and the private sector to carry out projects for the conservation, restoration, and interpretation of historic, cultural, recreational, and natural resources in the upper Connecticut River watershed.

(b) CRITERIA.—The Secretary, in consultation with the Connecticut River Joint Commissions, shall develop criteria for determining the eligibility of applicants for, and reviewing and prioritizing applications for, grants or technical assistance under the program.

(c) COST-SHARING.—

(1) FEDERAL SHARE.—The Federal share of the cost of carrying out a grant project under subsection (a) shall not exceed 75 percent.

(2) NON-FEDERAL SHARE.—The non-Federal share of the cost of a project may be provided in the form of an in-kind contribution of services or materials.

SEC. 5. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated to carry out this Act $1,000,000 for each fiscal year.

By Mr. HARKIN:

S. 1121. A bill to amend part D of title V of the Elementary and Secondary Education Act of 1965 to provide grants for the repair, renovation, and construction of elementary and secondary schools, including early learning facilities at the elementary schools; to the Committee on Health, Education, Labor, and Pensions.

Mr. HARKIN. Mr. President, I rise today to introduce the School Building Fairness Act of 2009. I offer this legislation to meet the urgent need for Federal support to repair crumbling schools in disadvantaged and rural school districts.

This bill would authorize up to $6 billion annually to fund a new program of Federal grants to States for the repair, renovation, and construction of public schools. States would award the grants competitively, with priority given to high-poverty and rural school districts, as well as school districts that plan to make their facilities more energy efficient and environmentally friendly. Districts receiving this federal funding would then be required to provide a local match.

I know this approach to school construction and repair can work because this bill is modeled on the success of the Iowa Demonstration and Construction Grant Program in my home State. Over the last decade, I have secured $121 million in Federal funds that more than 300 school districts across Iowa have used for school construction and repair. This modest Federal investment has leveraged more than $600 million in additional local funding.

In addition to improving the learning environment for students, the School Building Fairness Act will provide a stimulus to the economy by creating jobs in thousands of communities all across the country for workers in the construction industry, as well as architects and engineers.

It will also spur school districts to make their facilities more environmentally friendly and energy-efficient. According to the 2006 report ''Greening America's Schools: Costs and Benefits,'' green schools use an average of 33 percent less energy than conventionally built schools, and generate financial savings of about $70 per square foot.

Safe, modern, healthy school buildings are essential to creating an environment where students can reach their academic potential. Yet too many students in the U.S., particularly those most at risk of being left behind, attend school in facilities that are old, overcrowded and run-down.

We all agree that school infrastructure requires constant maintenance. Unfortunately, far too many schools have been forced to neglect ongoing issues, most likely due to lack of funds, which can lead to health and safety problems for students, educators and staff. The most recent Infrastructure Report Card issued by the American Society of Civil Engineers gives public schools a D grade. Now, I do not know many parents who would find D grades acceptable for their children. So why on Earth would we stand by while the state of the buildings in which our children learn are assigned such a grade?

Despite the declining condition of many public schools, federal grant funding is generally not available to leverage local spending. In fiscal year 2001, in the Senate Labor, Health and Human Services, and Education Appropriations Subcommittee, which I then chaired, I was able to secure $1.2 billion for school repair and renovation. I continue to hear nothing but positive feedback from educators across the country about that funding.

But that one-time investment amounted to nothing more than a drop in the bucket compared to the estimated national need. At the beginning of this decade, the National Center for Education Statistics estimated that the nation's K–12 public schools needed $127 billion in repairs and upgrades. A 2008 analysis by the American Federation of Teachers found that the Nation's school infrastructure needs total an estimated $254.6 billion.

This bill is called the School Building Fairness Act because, as I said, States will give preference in awarding grants to high-poverty and rural districts. Currently, spending on school facilities is almost twice as high in affluent districts as in disadvantaged districts. This is one of those ''savage inequalities'' that Jonathan Kozol writes about—inequalities that largely explain the learning gap between affluent and poor children.

Something is seriously wrong when children go to modern, gleaming shopping malls and sports arenas, but attend public schools with crumbling walls and leaking roofs. This sends exactly the wrong message to children about our priorities as adults.

With the School Building Fairness Act, we have a chance to get our priorities right, and to provide a desperately needed boost to school districts all across America.

I hope that my colleagues will join me to help create safe, modern, and healthy school environments so all of our children can grow to be the leaders of tomorrow.

By Mr. BARRASSO (for himself, Mr. JOHNSON, Mr. UDALL of Colorado, Mr. BENNET, Mr. RISCH, and Mr. BENNETT):

S. 1122. A bill to authorize the Secretary of Agriculture and the Secretary of the Interior to enter into cooperative agreements with State foresters authorizing State foresters to provide certain forest, rangeland, and watershed restoration and protection services; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. BARRASSO. Mr. President, I am proud to introduce the Good Neighbor Forestry Act today along with my Senators JOHNSON, UDALL of Colorado, BENNET of Colorado, RISCH, and BENNETT of Utah. This legislation authorizes cooperative action between western states and the U.S. Forest Service or Bureau of Land Management to complete forest and rangeland health projects on private, State and Federal lands.

Almost half of the land in Wyoming is managed by Federal agencies. Our State has a long history of forestry, grazing and multiple use of public lands. Recreation and tourism on our public lands is a pillar of our economy. The people of Wyoming are proud stewards of our public lands and our state depends on the public lands for our future.

It is my goal to enact common-sense policies to address the management needs of our Federal lands. Wyoming forests, like those of all states across the West, are facing management challenges. We have an opportunity to meet those challenges with policies that encourage forest and rangeland health. Preventing forest fires, removing invasive species, addressing watershed health and conserving wildlife habitat require ''big picture'' thinking. We have to address these threats at the landscape level.

Resource challenges do not stop at fencelines, and neither should our policy.

The Good Neighbor Forestry Act would set in place a cooperative management policy. This act would allow the State of Wyoming to go forward with forest and rangeland health projects as agreed to by the U.S. Forest Service or Bureau of Land Management. With this authority, the agencies can cooperatively pursue projects that address landscape-level needs. This authority would provide on-the-ground management that our private, State, and Federal lands desperately need.

I am pleased to introduce this legislation today. It is of great importance to the people of Wyoming, and public land communities across the West. I hope the U.S. Senate will proceed quickly with its passage to enhance western states' response to growing management challenges.

The people of Wyoming demand on-the-ground results. This legislation can deliver those results. I hope we can pass it expediently.

Mr. President, I ask unanimous cnsent 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. 1122

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 ''Good Neighbor Forestry Act''.

SEC. 2. DEFINITIONS.

In this Act:

(1) ELIGIBLE STATE.—The term ''eligible State'' means a State that contains National Forest System land or Bureau of Land Management land located west of the 100th meridian.

(2) SECRETARY.—The term ''Secretary'' means—

(A) the Secretary of Agriculture, with respect to National Forest System land; or

(B) the Secretary of the Interior, with respect to Bureau of Land Management land.

(3) STATE FORESTER.—The term ''State forester'' means the head of a State agency with jurisdiction over State forestry programs in an eligible State.

SEC. 3. COOPERATIVE AGREEMENTS AND CONTRACTS.

(a) IN GENERAL.—The Secretary may enter into a cooperative agreement or contract (including a sole source contract) with a State forester to authorize the State forester to provide the forest, rangeland, and watershed restoration and protection services described in subsection (b) on National Forest System land or Bureau of Land Management land, as applicable, in the eligible State.

(b) AUTHORIZED SERVICES.—The forest, rangeland, and watershed restoration and protection services referred to in subsection (a) include the conduct of—

(1) activities to treat insect infected trees;

(2) activities to reduce hazardous fuels; and

(3) any other activities to restore or improve forest, rangeland, and watershed health, including fish and wildlife habitat.

(c) STATE AS AGENT.—Except as provided in subsection (f), a cooperative agreement or contract entered into under subsection (a) may authorize the State forester to serve as the agent for the Secretary in providing the restoration and protection services authorized under subsection (a).

(d) SUBCONTRACTS.—In accordance with applicable contract procedures for the eligible State, a State forester may enter into subcontracts to provide the restoration and protection services authorized under a cooperative agreement or contract entered into under subsection (a).

(e) TIMBER SALES.—Subsections (d) and (g) of section 14 of the National Forest Management Act of 1976 (16 U.S.C. 472a) shall not apply to services performed under a cooperative agreement or contract entered into under subsection (a).

(f) RETENTION OF NEPA RESPONSIBILITIES.—Any decision required to be made under the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.) with respect to any restoration and protection services to be provided under this Act by a State forester on National Forest System land or Bureau of Land Management land, as applicable, shall not be delegated to a State forester or any other officer or employee of the eligible State.

(g) APPLICABLE LAW.—The restoration and protection services to be provided under this Act shall be carried out on a project-to-project basis under existing authorities of the Forest Service or Bureau of Land Management, as applicable.

SEC. 4. TERMINATION OF EFFECTIVENESS.

(a) IN GENERAL.—The authority of the Secretary to enter into cooperative agreements and contracts under this Act terminates on September 30, 2018.

(b) CONTRACT DATE.—The termination date of a cooperative agreement or contract entered into under this Act shall not extend beyond September 30, 2019.

By Ms. COLLINS (for herself, Mrs. LINCOLN, and Mr. BOND):

S. 1123. A bill to provide for a five-year payment increase under the Medicare program for home health services furnished in a rural area; to the Committee on Finance.

Ms. COLLINS. Mr. President, I rise today with my colleagues from Arkansas and Missouri to introduce the Medicare Rural Home Health Payment Fairness Act to reinstate the 5 percent add-on payment for home health services in rural areas that expired on January 1, 2007.

Home health has become an increasingly important part of our health care system. The kinds of highly skilled—and often technically complex—services that our Nation's home health caregivers provide have enabled millions of our most frail and vulnerable older and disabled citizens to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes. I have accompanied several of Maine's caring home health nurses on their visits to some of their patients. I have seen first hand the difference that they are making for Maine's elderly.

Surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and other factors. Because of the longer travel times, rural caregivers are unable to make as many visits in a day as their urban counterparts. The executive director of the Visiting Nurses of Aroostook in Northern Maine, where I am from, tells me her agency covers 6,600 square miles with a total population of only 73,000. This agency's costs are understandably much higher than other agencies due to the long distances the staff must drive to see clients. Moreover, the staff is not able to see as many patients due to time on the road.

Agencies in rural areas are also frequently smaller than their urban counterparts, which means that their relative costs are higher. Smaller agencies with fewer patients and fewer visits mean that fixed costs, particularly those associated with meeting regulatory requirements, are spread over a much smaller number of patients and visits, increasing overall per-patient and per-visit costs.

Moreover, in many rural areas, home health agencies are the primary caregivers for homebound beneficiaries with limited access to transportation. These rural patients often require more time and care than their urban counterparts, and are understandably more expensive for agencies to serve. If the extra rural payment is not extended, agencies may be forced to make decisions not to accept rural patients with greater care needs. That could translate into less access to health care for ill, homebound seniors. The result would likely be that these seniors would be hospitalized more frequently and would have to seek care in nursing homes, adding considerable cost to the system.

Failure to extend the rural add-on payment will only put more pressure on rural home health agencies that are already operating on very narrow margins and could force some of the agencies to close their doors altogether. Many home health agencies operating in rural areas are the only home health providers in large geographic areas. If any of these agencies were forced to close, the Medicare patients in that region could lose all of their access to home care.

The legislation we are introducing today will extend the rural add-on for 5 years and help to ensure that Medicare patients in rural areas continue to have access to the home health services they need. I urge all of our colleagues to join us as cosponsors.

By Mr. DURBIN:

S. 1125. A bill to amend the National Voter Registration Act of 1993 to provide for the treatment of institutions of higher education as voter registration agencies; to the Committee on Rules and Administration.

Mr. DURBIN. 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. 1125

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 ''Student Voter Opportunity To Encourage Registration Act of 2009'' or the ''Student VOTER Act of 2009''.

SEC. 2. TREATMENT OF UNIVERSITIES AS VOTER REGISTRATION AGENCIES.

(a) IN GENERAL.—Section 7(a) of the National Voter Registration Act of 1993 (42 U.S.C. 1973gg–5(a)) is amended—

(1) in paragraph (2)—

(A) by striking ''and'' at the end of subparagraph (A);

(B) by striking the period at the end of subparagraph (B) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) each institution of higher education (as defined in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001)) in the State that receives Federal funds.''; and

(2) in paragraph (6)(A), by inserting ''or, in the case of an institution of higher education, with each registration of a student for enrollment in a course of study'' after ''assistance,''.

(b) AMENDMENT TO HIGHER EDUCATION ACT OF 1965.—Section 487(a) of the Higher Education Act of 1965 (20 U.S.C. 1094(a)) is amended by striking paragraph (23).

By Mr. REID:

S. 1126. A bill to require the Director of National Intelligence to submit a report to Congress on retirement benefits for former employees of Air America and for other purposes; to the Select Committee on Intelligence.

Mr. REID. Mr. President, it has been said that ''The nation which forgets its defenders will itself be forgotten.'' I believe it. This is why I rise today to again introduce legislation to help correct an injustice for those who have served our country in times of crisis.

Many people have never heard of Air America. This top-secret passenger and cargo airline was a Government corporation owned and operated by the

Central Intelligence Agency during the Cold War.

Forty-eight years ago, the first Air America pilots were killed in covert military action in Laos. On May 30th, 1961, Charles Mateer and Walter Wizbowski crashed their helicopter in rugged terrain and unpredictable weather while trying to land in order to resupply besieged Hmong during the Cold War.

Air America employed several hundred U.S. citizens like Mr. Mateer and Wizbowski to conduct covert missions throughout the Cold War. During the Vietnam War, they carried nearly 12,000 government-sponsored passengers each month including troops and refugees. During the final days of the Vietnam war, Air America helicopters evacuated some 41,000 Americans, diplomats and friendly Vietnamese. Throughout the Cold War, numerous Air Force and Navy pilots were saved by heroic Air America helicopter rescue missions after being shot down behind enemy lines.

Air America personnel paid a costly burden to run these dangerous missions. Sadly, at least 86 American pilots were killed in action while operating aircraft for our Government. In all, Air America had 240 pilots and crewmembers killed in action.

In order to be able to conduct these high-risk missions, Air America operations were conducted by the CIA with strict secrecy. The Government ownership of the company was never acknowledged at the time and was not known to the public. Only a small number of officials were aware that, as employees of the CIA, Air America personnel were entitled to standard benefits provided to Federal employees.

Despite their heroic service to our nation, Air America employees are now being neglected by our Government.

Frustrated by Federal intransience and bureaucracy, former Air America employees from Nevada came to me and requested congressional assistance to help them obtain Federal civil service retirement benefits.

Today, the legislation I am introducing helps move us closer to correcting this injustice.

Mr. President, the ''Air America Veteran's Act'' recognizes these employees by requiring the Director of National Intelligence to submit a report to Congress about the number of Air America beneficiaries and the benefits owed to them. This report is critical because it will provide the justification Congress needs to ensure that these veterans are treated equitably and fairly by their Government.

I encourage all of my colleagues to join me in cosponsoring this important legislation to correct this injustice. These great Americans have earned these benefits and the gratitude of a thankful Nation. Now is our chance to honor their service and begin recognizing their sacrifices.

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

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

S. 1126

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 ''Air America Veterans Act of 2009''.

SEC. 2. DEFINITIONS.

In this Act:

(1) AIR AMERICA.—The term ''Air America'' means Air America, Incorporated.

(2) ASSOCIATED COMPANY.—The term ''associated company'' means any entity associated with, predecessor to, or subsidiary to Air America, including Air Asia Company Limited, CAT Incorporated, Civil Air Transport Company Limited, and the Pacific Division of Southern Air Transport during the period when such an entity was owned and controlled by the United States Government.

SEC. 3. REPORT ON RETIREMENT BENEFITS FOR FORMER EMPLOYEES OF AIR AMERICA.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Director of National Intelligence shall submit to Congress a report on the advisability of providing Federal retirement benefits to United States citizens for the service of such citizens prior to 1977 as employees of Air America or an associated company during a period when Air America or the associated company was owned or controlled by the United States Government and operated or managed by the Central Intelligence Agency.

(b) REPORT ELEMENTS.—The report required by subsection (a) shall include the following:

(1) The history of Air America and the associated companies prior to 1977, including a description of—

(A) the relationship between Air American and the associated companies and the Central Intelligence Agency or any other element of the United States Government;

(B) the workforce of Air America and the associated companies;

(C) the missions performed by Air America, the associated companies, and their employees for the United States; and

(D) the casualties suffered by employees of Air America and the associated companies in the course of their employment.

(2) A description of—

(A) the retirement benefits contracted for or promised to the employees of Air America and the associated companies prior to 1977;

(B) the contributions made by such employees for such benefits;

(C) the retirement benefits actually paid such employees;

(D) the entitlement of such employees to the payment of future retirement benefits; and

(E) the likelihood that such employees will receive any future retirement benefits.

(3) An assessment of the difference between—

(A) the retirement benefits that former employees of Air America and the associated companies have received or will receive by virtue of their employment with Air America and the associated companies; and

(B) the retirement benefits that such employees would have received or be eligible to receive if such employment was deemed to be employment by the United States Government and their service during such employment was credited as Federal service for the purpose of Federal retirement benefits.

(4)(A) Any recommendations regarding the advisability of legislative action to treat such employment as Federal service for the purpose of Federal retirement benefits in light of the relationship between Air America and the associated companies and the United States Government and the services and sacrifices of such employees to and for the United States.

(B) If legislative action is considered advisable under subparagraph (A), a proposal for such action and an assessment of its costs.

(5) The opinions of the Director of the Central Intelligence Agency, if any, on any matters covered by the report that the Director of the Central Intelligence Agency considers appropriate.

(c) ASSISTANCE OF COMPTROLLER GENERAL.—The Comptroller General of the United States shall, upon the request of the Director of National Intelligence and in a manner consistent with the protection of classified information, assist the Director in the preparation of the report required by subsection (a).

(d) FORM.—The report required by subsection (a) shall be submitted in unclassified form, but may include a classified annex.

By Mr. DURBIN (for himself and Mr. BURR):

S. 1129. A bill to authorize the Secretary of Education to award grants to local educational agencies to improve college enrollment; to the Committee on Health, Education, Labor, and Pensions.

Mr. DURBIN. Mr. President, an educated workforce is crucial to the success of the American economy. A recent report from the consulting firm McKinsey, ''The Economic Impact of the Achievement Gap in America's Schools,'' concludes that if America had raised the educational attainment of our students to those of high-performing nations like Finland and South Korea between 1983 and 1998, U.S. G.D.P. in 2008 would have been between $1.3 trillion and $2.3 trillion higher than it is today. If the gap between low-income American students and American students of higher means had been narrowed, G.D.P. in 2008 would have been $400 billion to $670 billion higher.

If we want to be economically competitive and avoid future recessions, we need to close the achievement gap in education for all Americans. In his first speech to Congress, President Obama set a goal of having the highest college graduation rate in the world by 2020. Too many students are not receiving a college education, and we will have to do far better to reach the President's goal.

Of students who were in eighth grade in 2000, only 20 percent of the lowest-income students will earn a college degree by 2012, compared to 68 percent of the highest income group. Every student who wants to go to college should have that opportunity, and we should provide them with the tools they need.

Today, I am introducing the Pathways to College Act with Senator BURR, which creates grants for school districts to help them increase the number of low-income students who are entering and succeeding in college.

Lack of guidance and information about college has a real effect on students in poor schools. The Consortium

on Chicago School Research released a report last year, ''Potholes on the Road to College,'' that looks at the difficulties Chicago Public School students face during the college application process. The Consortium discovered that only 41 percent of Chicago Public School students who wanted to go to college took the steps necessary to apply to and enroll in a 4-year college. Only one-third of students enrolled in a college that matched their qualifications. Of the students who had the grades and test scores to attend a selective college, 29 percent went to a community college or skipped college entirely.

The Pathways to College Act would create a grant program for school districts serving low-income students to increase their college-enrollment rates. The Consortium's ''Potholes'' report found that the most important factor in whether students enroll in a four-year college is if they attended a school where teachers create a strong college-going culture and help students with the process of applying. The Pathways to College Act would provide the funding to help school districts improve the college-going culture in schools and guide students through the college admissions process.

The Pathways to College Act provides flexibility to school districts to achieve higher college enrollment rates, but requires that each school accurately track their results so we can learn from what works. Chicago Public Schools is doing a great job—both in tackling the problem and in documenting progress. Under the leadership of Arne Duncan, Chicago Public Schools responded aggressively to the ''Potholes'' report.

A team of postsecondary coaches were deployed in high schools to work with students and counselors. To ensure that financial aid is not a roadblock, FAFSA completion rates are tracked so that counselors can follow-up with students. A spring-break college tour took 500 students to see colleges across the country. Because Chicago Public Schools tracks its college enrollment rates, we know that their efforts are working.

Half of the 2007 graduating class enrolled in college, an increase of 6.5 percent in 4 years. The national increase was less than 1 percent in the same time-frame. Nationally, the number of African-American graduates going to college has decreased by 6 percent over the last 4 years while the Chicago rate has increased by almost 8 percent.

Applying to college is not easy. Low-income students often need the most help to achieve their college dreams. When schools focus on college and provide the tools to get there, students make the connection between the work they are doing now and their future goals in college and life. Students in those schools are more likely enroll in college and are also more likely to work hard in high school to be prepared for college when they arrive. The bill we are introducing today tries to ensure that lack of information never prevents a student from achieving his or her college dream.

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. 1129

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 ''Pathways to College Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) An educated workforce is crucial to the success of the United States economy. Access to higher education for all students is critical to maintaining an educated workforce. More than 80 percent of the 23,000,000 jobs that will be created in the next 10 years will require postsecondary education. Only 36 percent of all 18- to 24-year olds are currently enrolled in postsecondary education.

(2) Workers with bachelor's degrees earn on average $17,000 more annually than workers with only high school diplomas. Workers who earn bachelor's degrees can be expected to earn $1,000,000 more over a lifetime than those who only finished high school.

(3) In order to prepare students for college, all schools should—

(A) provide student guidance to engage students in college and career awareness; and

(B) ensure that students enroll in a rigorous curriculum to prepare for postsecondary education.

(4) The Department of Education reports that the average student-to-counselor ratio in high schools is 315:1. This is far higher than the ratio recommended by the American School Counselor Association, which is 250:1. While school counselors at private schools spend an average of 58 percent of their time on postsecondary education counseling, school counselors in public schools spend an average of 25 percent of their time on postsecondary education counseling.

(5) While just 57 percent of students from the lowest income quartile enroll in college, 87 percent of students from the top income quartile enroll. Of students who were in eighth grade in 2000, only 20 percent of the lowest-income students are projected to attain a bachelor's degree by 2012, compared to 68 percent of the highest income group, according to the Advisory Committee on Student Financial Assistance in 2006.

(6) A recent report by the Consortium on Chicago School Research found that only 41 percent of Chicago public school students who aspire to go to college took the steps necessary to apply to and enroll in a 4-year institution of higher education. The report also reveals that only ⅓ of Chicago students who want to attend a 4-year institution of higher education enroll in a school that matches their qualifications. Even among students qualified to attend a selective college, 29 percent enrolled in a community college or did not enroll at all.

(7) The Consortium found that many Chicago public school students do not complete the Free Application for Federal Student Aid, even though students who apply for Federal financial aid are 50 percent more likely to enroll in college. Sixty-five percent of public secondary school counselors at low-income schools believe that students and parents are discouraged from considering college as an option due to lack of knowledge about financial aid.

(8) Low-income and first-generation families often overestimate the cost of tuition and underestimate available aid; students from these backgrounds have access to fewer college application resources and financial aid resources than other groups, and are less likely to fulfill their postsecondary plans as a result.

(9) College preparation intervention programs can double the college-going rates for at-risk youth, can expand students' educational aspirations, and can boost college enrollment and graduation rates.

SEC. 3. GRANT PROGRAM.

(a) DEFINITIONS.—In this Act:

(1) COLLEGE-GOING RATE.—The term ''college-going rate'' means the percentage of high school graduates who enroll at an institution of higher education in the school year immediately following graduation from high school.

(2) ELIGIBLE LOCAL EDUCATIONAL AGENCY.—The term ''eligible local educational agency'' means a local educational agency in which a majority of the high schools served by the agency are high-need high schools.

(3) HIGH-NEED HIGH SCHOOL.—The term ''high-need high school'' means a high school in which not less than 50 percent of the students enrolled in the school are—

(A) eligible to receive a free or reduced price lunch under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.);

(B) eligible to be counted under section 1124(c) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6333(c)); or

(C) in families eligible for assistance under the State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

(4) HIGH SCHOOL.—The term ''high school'' means a nonprofit institutional day or residential school, including a public charter high school, that provides high school education, as determined under State law.

(5) HIGH SCHOOL GRADUATION RATE.—The term ''high school graduation rate''—

(A) means the percentage of students who graduate from high school with a regular diploma in the standard number of years; and

(B) is clarified in section 200.19(b)(1) of title 34, Code of Federal Regulations.

(6) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given the term in section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)).

(7) LOCAL EDUCATIONAL AGENCY.—The term ''local educational agency'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(8) PARENT.—The term ''parent'' has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(9) SECRETARY.—The term ''Secretary'' means the Secretary of Education.

(b) COMPETITIVE GRANTS TO ELIGIBLE LOCAL EDUCATIONAL AGENCIES.—The Secretary is authorized to award grants, on a competitive basis, to eligible local educational agencies to carry out the activities described in this section.

(c) DURATION.—Grants awarded under this section shall be 5 years in duration.

(d) DISTRIBUTION.—In awarding grants under this section, the Secretary shall ensure that the grants are distributed among the different geographic regions of the United States, and among eligible local educational agencies serving urban and rural areas.

(e) APPLICATIONS.—

(1) IN GENERAL.—Each eligible local educational agency desiring a grant under this

section shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

(2) CONTENTS.—Each application submitted under paragraph (1) shall include a description of the program to be carried out with grant funds and—

(A) a detailed description of the high school population to be targeted by the program, the particular college-access needs of such population, and the resources available for meeting such needs;

(B) measurable objectives of the program, including goals for increasing the number of college applications submitted by each student and the number of students submitting applications, increasing Free Application for Federal Student Aid completion rates, and increasing school-wide college-going rates across the local educational agency;

(C) a description of the local educational agency's plan to work cooperatively, where applicable, with programs funded under chapters 1 and 2 of subpart 2 of part A of title IV of the Higher Education Act of 1965 (20 U.S.C. 1070a–11 et seq. and 1070a–21 et seq.), including the extent to which the agency commits to sharing facilities, providing access to students, and developing compatible record-keeping systems;

(D) a description of the activities, services, and training to be provided by the program, including a plan to provide structure and support for all students in the college search, planning, and application process;

(E) a description of the methods to be used to evaluate the outcomes and effectiveness of the program;

(F) an assurance that grant funds will be used to supplement, and not supplant, any other Federal, State, or local funds available to carry out activities of the type carried out under the grant;

(G) an explanation of the method used for calculating college enrollment rates for each high school served by the eligible local educational agency that is based on externally verified data, and, when possible, aligned with existing State or local methods;

(H) a plan to make the program sustainable over time, including the use of matching funds from non-Federal sources; and

(I) a description of the local educational agency's plan to work cooperatively, where applicable, with the program funded under part H of title VIII of the Higher Education Act of 1965 (20 U.S.C. 1161h et seq.), including the extent to which the agency commits to using and leveraging—

(i) the needs assessment and recommendations;

(ii) the model for measuring college enrollment; and

(iii) comprehensive services.

(3) METHOD OF CALCULATING ENROLLMENT RATES.—

(A) IN GENERAL.—A method included in an application under paragraph (2)(G)—

(i) shall, at a minimum, track students' first-time enrollment in institutions of higher education; and

(ii) may track progress toward completion of a postsecondary degree.

(B) DEVELOPMENT IN CONJUNCTION.—An eligible local educational agency may develop a method pursuant to paragraph (2)(G) in conjunction with an existing public or private entity that currently maintains such a method.

(f) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary shall give special consideration to applications from eligible local educational agencies serving schools with the highest percentages of poverty.

(g) USE OF FUNDS.—

(1) IN GENERAL.—An eligible local educational agency that receives a grant under this section shall develop and implement, or expand, a program to increase the number of low-income students who enroll in postsecondary educational institutions, including institutions with competitive admissions criteria.

(2) REQUIRED USE OF FUNDS.—Each program funded under this section shall—

(A) provide professional development to high school teachers and school counselors in postsecondary education advising;

(B) implement a comprehensive college guidance program for all students in a high school served by an eligible local educational agency under this section that—

(i) ensures that all students and their parents, are regularly notified throughout the students' time in high school, beginning in the first year of high school, of—

(I) high school graduation requirements;

(II) college entrance requirements;

(III) the economic and social benefits of higher education;

(IV) college expenses, including information about expenses by institutional type, differences between sticker price and net price, and expenses beyond tuition; and

(V) the resources for paying for college, including the availability, eligibility, and variety of financial aid;

(ii) provides assistance to students in registering for and preparing for college entrance tests;

(iii) provides one-on-one guidance and assistance to students in applying to an institution of higher education and in applying for Federal financial aid assistance and other State, local, and private financial aid assistance and scholarships;

(iv) provides opportunities for students to explore postsecondary opportunities outside of the school setting, such as college fairs, career fairs, college tours, workplace visits, or other similar activities; and

(v) provides not less than 1 meeting for each student, not later than the first semester of the first year of high school, with a school counselor, college access personnel (including personnel involved in programs funded under chapters 1 and 2 of subpart 2 of part A of title IV of the Higher Education Act of 1965 (20 U.S.C. 1070a–11 et seq. and 1070a–21 et seq.)), trained teacher, or other professional or organization, such as a community-based organization, approved by the school, to discuss postsecondary options, outline postsecondary goals, and create a plan to achieve those goals, and provides not less than 2 meetings in each year to discuss progress on the plan;

(C) ensure that each high school served by the eligible local educational agency develops a comprehensive, school-wide plan of action to strengthen the college-going culture within the high school; and

(D) create or maintain a postsecondary access center in the school setting that provides information on colleges and universities, career opportunities, and financial aid options and provide a setting in which professionals working in college access programs, such as those funded under chapters 1 and 2 of subpart 2 of part A of title IV of the Higher Education Act of 1965 (20 U.S.C. 1070a–11 et seq. and 1070a–21 et seq.), can meet with students.

(3) ALLOWABLE USE OF FUNDS.—Each program funded under this section may—

(A) establish mandatory postsecondary planning classes for high school students to assist in the college preparation and application process;

(B) hire and train postsecondary coaches with expertise in the college-going process to supplement existing school counselors;

(C) increase the number of school counselors who specialize in the college-going process serving students;

(D) train student leaders to assist in the creation of a college-going culture in their schools;

(E) establish partnerships with programs funded under chapters 1 and 2 of subpart 2 of part A of title IV of the Higher Education Act of 1965 (20 U.S.C. 1070a–11 et seq. and 1070a–21 et seq.)), and with community and nonprofit organizations to increase college-going rates at high schools served by the eligible local educational agency;

(F) provide long-term postsecondary follow up with graduates of the high schools served by the eligible local educational agencies, including increasing alumni involvement in mentoring and advising roles within the high school; and

(G) deliver college and career planning curriculum as a stand-alone course, or embedded in other classes, or delivered through the guidance curriculum by the school counselor for all students in high school.

(h) SUPPLEMENT, NOT SUPPLANT.—Funds made available under this section shall be used to supplement, and not supplant, other Federal, State, and local funds available to carry out the activities described in this section.

(i) TECHNICAL ASSISTANCE.—The Secretary, directly or through contracting through a full and open process with 1 or more organizations that have demonstrated experience providing technical assistance to raise school-wide college-going rates in local educational agencies in not less than 3 States, shall provide technical assistance to grantees in carrying out this section. The technical assistance shall—

(1) provide assistance in the calculation and analysis of college-going rates for all grant recipients;

(2) provide semi-annual analysis to each grant recipient recommending best practices based on a comparison of the recipient's data with that of high schools with similar demographics; and

(3) provide annual best practices conferences for all grant recipients.

(j) REPORTING REQUIREMENTS.—Each eligible local educational agency receiving a grant under this section shall collect and report annually to the Secretary such information for the local educational agency and for each high school assisted under this section on the results of the activities assisted under the grant as the Secretary may reasonably require, including information on—

(1) the number and percentage of students who enroll in an institution of higher education in the school year immediately following the students' high school graduation as measured by externally verified school-wide college enrollment data;

(2) the number and percentage of students who graduate from high school on time with a regular high school diploma;

(3) the number and percentage of students, at each grade level, who are on track to graduate from high school on time and with a regular high school diploma;

(4) the number and percentage of senior high school students who apply to an institution of higher education and the average number of applications completed and submitted by students;

(5) the number and percentage of senior high school students who file the Free Application for Federal Student Aid forms;

(6) the number and percentage of students, in grade 10, who take early admissions assessments, such as the PSAT;

(7) the number and percentage of students, in grades 11 and 12, who take the SAT or ACT, and the students' mean scores on such assessments;

(8) where data are available, the number and percentage of students enrolled in remedial mathematics or English courses during their freshman year at an institution of higher education;

(9) the number and percentage of students, in grades 11 and 12, enrolled in not less than 2 of the following:

(A) a dual credit course; or

(B) an Advanced Placement or International Baccalaureate course; and

(10) the number and percentage of students who meet or exceed State reading or language arts, mathematics, or science standards, as measured by State academic assessments required under section 1111(b)(3) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(3)).

(k) REPORTING OF DATA.—Each eligible local educational agency receiving a grant under this section shall report to the Secretary, where possible, the information required under subsection (j) disaggregated in the same manner as information is disaggregated under section 1111(h)(1)(C)(i) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(h)(1)(C)(i)).

(l) EVALUATIONS BY GRANTEES.—Each eligible local educational agency that receives a grant under this section shall—

(1) conduct periodic evaluations of the effectiveness of the activities carried out under the grant toward increasing schoolwide college-going rates;

(2) use such evaluations to refine and improve activities conducted with the grant and the performance measures for such activities; and

(3) make the results of such evaluations publicly available, including by providing public notice of such availability.

(m) REPORT.—From the amount appropriated for any fiscal year, the Secretary shall reserve such sums as may be necessary—

(1) to conduct an independent evaluation, by grant or by contract, of the programs carried out under this section, which shall include an assessment of the impact of the program on high school graduation rates and college-going rates; and

(2) to prepare and submit a report on the results of the evaluation described in paragraph (1) to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor of the House of Representatives.

(n) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for fiscal year 2010 and each of the 5 succeeding fiscal years.

By Ms. SNOWE (for herself, Mr. CONRAD, Mr. WYDEN, and Ms. COLLINS):

S. 1130. A bill to provide for a demonstration project regarding Medicaid reimbursements for stabilization of emergency medical conditions by nonpublicly owned or operated institutions for mental diseases; to the Committee on Finance.

Ms. SNOWE. Mr. President, today, I rise to introduce the Medicaid Emergency Psychiatric Care Demonstration Project Act. I am pleased to be joined by Senators CONRAD, WYDEN and COLLINS in this effort. We are introducing this legislation to address an unfair conflict in two Federal laws—the Institution for Mental Diseases, IMD, Exclusion and The Emergency Medical and Labor Treatment Act, EMTALA.

EMTALA requires all hospitals, including freestanding psychiatric hospitals, to stabilize patients who come in with an emergency medical condition. At the same time, under an outdated Medicaid provision called the IMD exclusion, adult Medicaid patients, 21–64, are not covered for inpatient psychiatric care in a freestanding psychiatric hospital, but are covered in a general hospital psychiatric unit. Yet both types of hospitals are required to stabilize any patient—which may require hospitalization—who comes to them for emergency care regardless of ability to pay.

In order to correct this inequity, we have introduced the Medicaid Emergency Psychiatric Care Demonstration Project Act. This legislation would establish a 3-year, demonstration program capped at $75 million, which would allow states to apply for federal Medicaid matching funds to demonstrate that covering Medicaid patients in freestanding, non-governmental psychiatric hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms, and improve the efficiency and cost-effectiveness of inpatient psychiatric care. Our legislation helps alleviate a problem where patients with significant mental health needs are often forced to endure prolonged stays in emergency rooms and hospitals without the psychiatric attention they require.

The measure is supported by 27 national healthcare organizations, including the National Alliance for the Mentally Ill—the country's largest advocacy organization for the mentally ill, the National Association of Psychiatric Health Systems, the American Hospital Association, the Federation of American Hospitals, the American Psychiatric Association, the National Association of County Behavioral Healthcare Directors, the American College of Emergency Physicians, and the Emergency Nurses Association.

By Mr. WYDEN (for himself, Mr. BURR, Mr. WHITEHOUSE, and Mr. CARDIN):

S. 1131. A bill to amend title XVIII of the Social Security Act to provide certain high cost Medicare beneficiaries suffering from multiple chronic conditions with access to coordinated, primary care medical services in lower cost treatment settings, such as their residences, under a plan of care developed by a team of qualified and experienced health care professionals; to the Committee on Finance.

Mr. WYDEN. Mr. President, I am reintroducing the Independence at Home Act together with colleagues in the Senate and the House. Mr. BURR, Mr. WHITEHOUSE, Mr. CARDIN and I are proud to join forces with our House colleagues, Mr. MARKEY, and his cosponsor, Mr. SMITH, to move forward with this important legislation to provide a coordinated team-based approach to primary care for chronically ill Medicare beneficiaries in their own homes. Returning to basics like paying doctors for home visits to vulnerable patients, and following them through the course of their illness while saving taxpayers money, is the kind of legislation I am proud to introduce.

The Independence at Home, or IAH, Act comes at the perfect time. The American people and the federal government need to save money on health care, while having more choices and getting better results. This delivery model has a proven track record of doing just this. Similar ''house calls'' programs, currently operating across the country, are reducing costs, improving care quality, and helping people remain independent as long as possible. This delivery model is also providing much needed relief to caregivers who are often juggling a full-time job while caring for their very ill family member. This is medical care Americans want and deserve.

It is not too often that health policy has good outcome results before the pilot program phase begins, but that is exactly the case with the IAH Act. Similar home health delivery models, such as the Veterans Administration's Home-Based Primary Care, Boston, Massachusetts' Urban Medical's House Calls Program, and Portland, Oregon's Housecall Providers have been so successful in improving quality and reducing costs, that our bill guarantees 5 percent savings to Medicare.

These successful home health programs have demonstrated that the optimal way to address the challenges of caring for persons with chronic conditions is to better integrate their care and to work with their caregivers. Medical problems are best managed and coordinated by health care professionals who know their patients, their problems, their medications, and their other health care providers. Using this approach, the Independence at Home Act provides a better, more cost-effective way for Medicare patients with chronic conditions to get the care they need. It further advances Medicare reform by creating incentives for providers to develop better and lower cost health care for the highest cost beneficiaries.

This bipartisan, bicameral bill would create a pilot program to improve in-home care availability for beneficiaries with multiple chronic conditions. This is a win-win for all involved. It will help people remain in their homes for longer periods of time, it will improve the quality of care, and physicians will receive a bundled payment for coordinating this care with a team of healthcare providers.

More specifically, the Independence at Home Act establishes a two-phase three-year Medicare pilot project that uses a patient-centered health care delivery model to ensure that Medicare beneficiaries with multiple chronic conditions can remain independent for as long as possible in a comfortable environment. By incorporating lessons from past Medicare demonstration projects and from current home health

models, this bill provides for programs that hold providers accountable for quality, mandatory annual minimum savings, and patient satisfaction. Savings are generated by providing better care to Medicare beneficiaries with multiple chronic conditions and reducing duplicative and unnecessary services, hospitalization, and other health care costs.

Persons eligible for the program include Medicare beneficiaries with functional impairments, two or more chronic health problems, and recent use of other health services. Each IAH patient will receive a comprehensive assessment at least annually. The assessment will inform a plan for care that is directed by an IAH physician, nurse-practitioner, or physician's assistant. The plan is developed by an IAH plan coordinator in collaboration with the patient and caregiver. Medication management is provided by pharmacists due to their expertise in pharmacology, and electronic medical records and health information technology will be employed to improve patient care and reduce costs.

The two-phase pilot program will take place in the thirteen highest-cost states plus thirteen additional states. After review of Phase I and the evaluation report, the Secretary may elect to expand the program nationwide so it could then become an ongoing benefit for Medicare beneficiaries.

A shared-savings agreement incentive program allows this innovative delivery model to attract and maintain providers. The IAH organization will be required to demonstrate savings of at least 5 percent annually compared with the costs of serving non-participating Medicare chronically ill beneficiaries. The IAH organization may keep 80 percent of savings beyond the required 5 percent savings as an incentive to maximize the financial benefits of being an IAH organization. Any savings beyond 25 percent would be split, with 50 percent directed to the IAH organization and 50 percent to Medicare. In Phase II, the Secretary may modify the payment incentive structure to increase savings to the Medicare Trust Fund only if it will not impede access to IAH services to eligible beneficiaries.

I would like to thank my fellow Senate cosponsors, RICHARD BURR, SHELDON WHITEHOUSE, and BENJAMIN CARDIN, and my cosponsor in the House, Representative ED MARKEY, and his cosponsor, CHRIS SMITH, for their support. I also thank Rahm Emanuel for his support of IAH in the last Congress. I would also like to thank all our staff who worked so hard on this legislation, particularly Gregory Hinrichsen in my office. Finally, I would like to thank the following groups for voicing their support for this legislation: The American Academy of Home Care Physicians; The American Academy of Neurology; The AARP; The Alzheimer's Association; The Alzheimer's Foundation of America; The American Academy of Nurse Practitioners; The American College of Nurse Practitioners; American Academy of Physician Assistants; The American Society of Consultant Pharmacists; The National Family Caregivers Association; The Family Caregiver Alliance/National Center on Caregiving; The American Association of Homes and Services for the Aging; The Housecalls Doctors of Texas; The Maryland-National Capital Home Care Association; The Visiting Nurse Associations of America; Housecall Providers, Inc. of Portland, OR; Intel Corp.; The National Council on Aging; U.S. PIRG; Massachusetts Neurologic Society; Naples Health Care Associates; Urban Medical House Calls of Boston, MA; MD2U Doctors Who Make Housecalls (Louisville, KY); Wyeth Pharmaceuticals.

I urge all of my colleagues to support this important legislation to help Medicare patients get better care at lower cost.

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

S. 1131

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 ''Independence at Home Act of 2009''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) According to the November 2007 Congressional Budget Office Long Term Outlook for Health Care Spending, unless changes are made to the way health care is delivered, growing demand for resources caused by rising health care costs and to a lesser extent the nation's expanding elderly population will confront Americans with increasingly difficult choices between health care and other priorities. However, opportunities exist to constrain health care costs without adverse health care consequences.

(2) Medicare beneficiaries with multiple chronic conditions account for a disproportionate share of Medicare spending compared to their representation in the overall Medicare population, and evidence suggests that such patients often receive poorly coordinated care, including conflicting information from health providers and different diagnoses of the same symptoms.

(3) People with chronic conditions account for 76 percent of all hospital admissions, 88 percent of all prescriptions filled, and 72 percent of physician visits.

(4) Studies show that hospital utilization and emergency room visits for patients with multiple chronic conditions can be reduced and significant savings can be achieved through the use of interdisciplinary teams of health care professionals caring for patients in their places of residence.

(5) The Independence at Home Act creates a chronic care coordination pilot project to bring primary care medical services to the highest cost Medicare beneficiaries with multiple chronic conditions in their home or place of residence so that they may be as independent as possible for as long as possible in a comfortable setting.

(6) The Independence at Home Act generates savings by providing better, more coordinated care across all treatment settings to the highest cost Medicare beneficiaries with multiple chronic conditions, reducing duplicative and unnecessary services, and avoiding unnecessary hospitalizations, nursing home admissions, and emergency room visits.

(7) The Independence at Home Act holds providers accountable for improving beneficiary outcomes, ensuring patient and caregiver satisfaction, and achieving cost savings to Medicare on an annual basis.

(8) The Independence at Home Act creates incentives for practitioners and providers to develop methods and technologies for providing better and lower cost health care to the highest cost Medicare beneficiaries with the greatest incentives provided in the case of highest cost beneficiaries.

(9) The Independence at Home Act contains the central elements of proven home-based primary care delivery models that have been utilized for years by the Department of Veterans Affairs and ''house calls'' programs across the country to deliver coordinated care for chronic conditions in the comfort of a patient's home or place of residence.

SEC. 3. ESTABLISHMENT OF VOLUNTARY INDEPENDENCE AT HOME CHRONIC CARE COORDINATION PILOT PROJECT UNDER TRADITIONAL MEDICARE FEE-FOR-SERVICE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended—

(1) by amending subsection (c) of section 1807 (42 U.S.C. 1395b–8) to read as follows:

''(c) INDEPENDENCE AT HOME CHRONIC CARE COORDINATION PILOT PROJECT.—A pilot project for Independence at Home chronic care coordination programs for high cost Medicare beneficiaries with multiple chronic conditions is set forth in section 1807A.''; and

(2) by inserting after section 1807 the following new section:

''INDEPENDENCE AT HOME CHRONIC CARE COORDINATION PILOT PROJECT

''SEC. 1807A. (a) IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall provide for the phased in development, implementation, and evaluation of Independence at Home programs described in this section to meet the following objectives:

''(A) To improve patient outcomes, compared to comparable beneficiaries who do not participate in such a program, through reduced hospitalizations, nursing home admissions, or emergency room visits, increased symptom self-management, and similar results.

''(B) To improve satisfaction of patients and caregivers, as demonstrated through a quantitative pre-test and post-test survey developed by the Secretary that measures patient and caregiver satisfaction of care coordination, educational information, timeliness of response, and similar care features.

''(C) To achieve a minimum of 5 percent cost savings in the care of beneficiaries under this title suffering from multiple high cost chronic diseases.

''(2) INITIAL IMPLEMENTATION (PHASE I).—

''(A) IN GENERAL.—In carrying out this section and to the extent possible, the Secretary shall enter into agreements with at least two unaffiliated Independence at Home organizations in each of the 13 highest cost States (based on average per capita expenditures per State under this title), in the District of Columbia, and in 13 additional States that are representative of other regions of the United States and include medically underserved rural and urban areas, to provide chronic care coordination services for a period of three years or until those agreements are terminated by the Secretary. Such agreements under this paragraph shall continue in effect until the Secretary makes the determination described in paragraph (3) or until those agreements are supplanted by new agreements under such paragraph. The phase of implementation under this paragraph is

referred to in this section as the 'initial implementation' phase or 'phase I'.

''(B) PREFERENCE.—In selecting Independence at Home organizations under this paragraph, the Secretary shall give a preference, to the extent practicable, to organizations that—

''(i) have documented experience in furnishing the types of services covered by this section to eligible beneficiaries in the home or place of residence using qualified teams of health care professionals that are directed by individuals who have the qualifications of Independence at Home physicians, or in cases when such direction is provided by an Independence at Home physician to a physician assistant who has at least one year of experience providing gerontological medical and related services for chronically ill individuals in their homes, or other similar qualification as determined by the Secretary to be appropriate for the Independence at Home program, by the physician assistant acting under the supervision of an Independence at Home physician and as permitted under State law, or Independence at Home nurse practitioners;

''(ii) have the capacity to provide services covered by this section to at least 150 eligible beneficiaries; and

''(iii) use electronic medical records, health information technology, and individualized plans of care.

''(3) EXPANDED IMPLEMENTATION PHASE (PHASE II).—

''(A) IN GENERAL.—For periods beginning after the end of the 3-year initial implementation period under paragraph (2), subject to subparagraph (B), the Secretary shall renew agreements described in paragraph (2) with Independence at Home organization that have met all 3 objectives specified in paragraph (1) and enter into agreements described in paragraph (2) with any other organization that is located in any State or the District of Columbia, that was not an Independence at Home organization during the initial implementation period, and that meets the qualifications of an Independence at Home organization under this section. The Secretary may terminate and not renew such an agreement with an organization that has not met such objectives during the initial implementation period. The phase of implementation under this paragraph is referred to in this section as the 'expanded implementation' phase or 'phase II'.

''(B) CONTINGENCY.—The expanded implementation under subparagraph (A) shall not occur if the Secretary finds, not later than 60 days after the date of issuance of the independent evaluation under paragraph (5), that continuation of the Independence at Home project is not in the best interest of beneficiaries under this title or in the best interest of Federal health care programs.

''(4) ELIGIBILITY.—No organization shall be prohibited from participating under this section during expanded implementation phase under paragraph (3) (and, to the extent practicable, during initial implementation phase under paragraph (2)) because of its small size as long as it meets the eligibility requirements of this section.

''(5) INDEPENDENT EVALUATIONS.—

''(A) IN GENERAL.—The Secretary shall contract for an independent evaluation of the initial implementation phase under paragraph (2) with an interim report to Congress to be provided on such evaluation as soon as practicable after the first year of such phase and a final report to be provided to Congress as soon as practicable following the conclusion of the initial implementation phase, but not later than 6 months following the end of such phase. Such an evaluation shall be conducted by individuals with knowledge of chronic care coordination programs for the targeted patient population and demonstrated experience in the evaluation of such programs.

''(B) INFORMATION TO BE INCLUDED.—Each such report shall include an assessment of the following factors and shall identify the characteristics of individual Independence at Home programs that are the most effective in producing improvements in—

''(i) beneficiary, caregiver, and provider satisfaction;

''(ii) health outcomes appropriate for patients with multiple chronic diseases; and

''(iii) cost savings to the program under this title, such as in reducing—

''(I) hospital and skilled nursing facility admission rates and lengths of stay;

''(II) hospital readmission rates; and

''(III) emergency department visits

''(C) BREAKDOWN BY CONDITION.—Each such report shall include data on performance of Independence at Home organizations in responding to the needs of eligible beneficiaries with specific chronic conditions and combinations of conditions, as well as the overall eligible beneficiary population.

''(6) AGREEMENTS.—

''(A) IN GENERAL.—The Secretary shall enter into agreements, beginning not later than one year after the date of the enactment of this section, with Independence at Home organizations that meet the participation requirements of this section, including minimum performance standards developed under subsection (e)(3), in order to provide access by eligible beneficiaries to Independence at Home programs under this section.

''(B) AUTHORITY.—If the Secretary deems it necessary to serve the best interest of the beneficiaries under this title or the best interest of Federal health care programs, the Secretary may—

''(i) require screening of all potential Independence at Home organizations, including owners, (such as through fingerprinting, licensure checks, site-visits, and other database checks) before entering into an agreement;

''(ii) require a provisional period during which a new Independence at Home organization would be subject to enhanced oversight (such as prepayment review, unannounced site visits, and payment caps); and

''(iii) require applicants to disclose previous affiliation with entities that have uncollected Medicare or Medicaid debt, and authorize the denial of enrollment if the Secretary determines that these affiliations pose undue risk to the program.

''(7) REGULATIONS.—At least three months before entering into the first agreement under this section, the Secretary shall publish in the Federal Register the specifications for implementing this section. Such specifications shall describe the implementation process from initial to final implementation phases, including how the Secretary will identify and notify potential enrollees and how and when beneficiaries may enroll and disenroll from Independence at Home programs and change the programs in which they are enrolled.

''(8) PERIODIC PROGRESS REPORTS.—Semiannually during the first year in which this section is implemented and annually thereafter during the period of implementation of this section, the Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report that describes the progress of implementation of this section and explaining any variation from the Independence at Home program as described in this section.

''(9) ANNUAL BEST PRACTICES CONFERENCE.—During the initial implementation phase and to the extent practicable at intervals thereafter, the Secretary shall provide for an annual Independence at Home teleconference for Independence at Home organizations to share best practices and review treatment interventions and protocols that were successful in meeting all 3 objectives specified in paragraph (1).

''(b) DEFINITIONS.—For purposes of this section:

''(1) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means bathing, dressing, grooming, transferring, feeding, or toileting.

''(2) CAREGIVER.—The term 'caregiver' means, with respect to an individual with a qualifying functional impairment, a family member, friend, or neighbor who provides assistance to the individual.

''(3) ELIGIBLE BENEFICIARY.—

''(A) IN GENERAL.—The term 'eligible beneficiary' means, with respect to an Independence at Home program, an individual who—

''(i) is entitled to benefits under part A and enrolled under part B, but not enrolled in a plan under part C;

''(ii) has a qualifying functional impairment and has been diagnosed with two or more of the chronic conditions described in subparagraph (C); and

''(iii) within the 12 months prior to the individual first enrolling with an Independence at Home program under this section, has received benefits under part A for the following services:

''(I) Non-elective inpatient hospital services.

''(II) Services in the emergency department of a hospital.

''(III) Any one of the following:

''(aa) Skilled nursing or sub-acute rehabilitation services in a Medicare-certified nursing facility.

''(bb) Comprehensive acute rehabilitation facility or Comprehensive outpatient rehabilitation facility services.

''(cc) Skilled nursing or rehabilitation services through a Medicare-certified home health agency.

''(B) DISQUALIFICATIONS.—Such term does not include an individual—

''(i) who is receiving benefits under section 1881;

''(ii) who is enrolled in a PACE program under section 1894;

''(iii) who is enrolled in (and is not disenrolled from) a chronic care improvement program under section 1807;

''(iv) who within a 12-month period has been a resident for more than 90 days in a skilled nursing facility, a nursing facility (as defined in section 1919), or any other facility identified by the Secretary;

''(v) who resides in a setting that presents a danger to the safety of in-home health care providers and primary caregivers; or

''(vi) whose enrollment in an Independence at Home program the Secretary determines would be inappropriate.

''(C) CHRONIC CONDITIONS DESCRIBED.—The chronic conditions described in this subparagraph are the following:

''(i) Congestive heart failure.

''(ii) Diabetes.

''(iii) Chronic obstructive pulmonary disease.

''(iv) Ischemic heart disease.

''(v) Peripheral arterial disease.

''(vi) Stroke.

''(vii) Alzheimer's Disease and other dementias designated by the Secretary.

''(viii) Pressure ulcers.

''(ix) Hypertension.

''(x) Neurodegenerative diseases designated by the Secretary which result in high costs under this title, including amyotropic lateral sclerosis (ALS), multiple sclerosis, and Parkinson's disease.

''(xi) Any other chronic condition that the Secretary identifies as likely to result in high costs to the program under this title when such condition is present in combination with one or more of the chronic conditions specified in the preceding clauses.

''(4) INDEPENDENCE AT HOME ASSESSMENT.—The term 'Independence at Home assessment' means a determination of eligibility of an individual for an Independence at Home program as an eligible beneficiary (as defined in paragraph (3)), a comprehensive medical history, physical examination, and assessment of the beneficiary's clinical and functional status that—

''(A) is conducted in person by an individual—

''(i) who—

''(I) is an Independence at Home physician or an Independence at Home nurse practitioner; or

''(II) a physician assistant, nurse practitioner, or clinical nurse specialist, as defined in section 1861(aa)(5), who is employed by an Independence at Home organization and is supervised by an Independence at Home physician or Independence at Home nurse practitioner; and

''(ii) does not have an ownership interest in the Independence at Home organization unless the Secretary determines that it is impracticable to preclude such individual's involvement; and

''(B) includes an assessment of—

''(i) activities of daily living and other comorbidities;

''(ii) medications and medication adherence;

''(iii) affect, cognition, executive function, and presence of mental disorders;

''(iv) functional status, including mobility, balance, gait, risk of falling, and sensory function;

''(v) social functioning and social integration;

''(vi) environmental needs and a safety assessment;

''(vii) the ability of the beneficiary's primary caregiver to assist with the beneficiary's care as well as the caregiver's own physical and emotional capacity, education, and training;

''(viii) whether, in the professional judgment of the individual conducting the assessment, the beneficiary is likely to benefit from an Independence at Home program;

''(ix) whether the conditions in the beneficiary's home or place of residence would permit the safe provision of services in the home or residence, respectively, under an Independence at Home program;

''(x) whether the beneficiary has a designated primary care physician whom the beneficiary has seen in an office-based setting within the previous 12 months; and

''(xi) other factors determined appropriate by the Secretary.

''(5) INDEPENDENCE AT HOME CARE TEAM.—The term 'Independence at Home care team'—

''(A) means, with respect to a participant, a team of qualified individuals that provides services to the participant as part of an Independence at Home program; and

''(B) includes an Independence at Home physician or an Independence at Home nurse practitioner and an Independence at Home coordinator (who may also be an Independence at Home physician or an Independence at Home nurse practitioner).

''(6) INDEPENDENCE AT HOME COORDINATOR.—The term 'Independence at Home coordinator' means, with respect to a participant, an individual who—

''(A) is employed by an Independence at Home organization and is responsible for coordinating all of the services of the participant's Independence at Home plan;

''(B) is a licensed health professional, such as a physician, registered nurse, nurse practitioner, clinical nurse specialist, physician assistant, or other health care professional as the Secretary determines appropriate, who has at least one year of experience providing and coordinating medical and related services for individuals in their homes; and

''(C) serves as the primary point of contact responsible for communications with the participant and for facilitating communications with other health care providers under the plan.

''(7) INDEPENDENCE AT HOME ORGANIZATION.—The term 'Independence at Home organization' means a provider of services, a physician or physician group practice, a nurse practitioner or nurse practitioner group practice which receives payment for services furnished under this title (other than only under this section) and which—

''(A) has entered into an agreement under subsection (a)(2) to provide an Independence at Home program under this section;

''(B)(i) provides all of the services of the Independence at Home plan in a participant's home or place of residence, or

''(ii) if the organization is not able to provide all such services in such home or residence, has adequate mechanisms for ensuring the provision of such services by one or more qualified entities;

''(C) has Independence at Home physicians, clinical nurse specialists, nurse practitioners, or physician assistants available to respond to patient emergencies 24 hours a day, seven days a week;

''(D) accepts all eligible beneficiaries from the organization's service area, as determined under the agreement with the Secretary under this section, except to the extent that qualified staff are not available; and

''(E) meets other requirements for such an organization under this section.

''(8) INDEPENDENCE AT HOME PHYSICIAN.—The term 'Independence at Home physician' means a physician who—

''(A) is employed by or affiliated with an Independence at Home organization, as required under paragraph (7)(C), or has another contractual relationship with the Independence at Home organization that requires the physician to make in-home visits and to be responsible for the plans of care for the physician's patients;

''(B) is certified—

''(i) by the American Board of Family Physicians, the American Board of Internal Medicine, the American Osteopathic Board of Family Physicians, the American Osteopathic Board of Internal Medicine, the American Board of Emergency Medicine, or the American Board of Physical Medicine and Rehabilitation; or

''(ii) by a Board recognized by the American Board of Medical Specialties and determined by the Secretary to be appropriate for the Independence at Home program;

''(C) has—

''(i) a certification in geriatric medicine as provided by American Board of Medical Specialties; or

''(ii) passed the clinical competency examination of the American Academy of Home Care Physicians and has substantial experience in the delivery of medical care in the home, including at least two years of experience in the management of Medicare patients and one year of experience in home-based medical care including at least 200 house calls; and

''(D) has furnished services during the previous 12 months for which payment is made under this title.

''(9) INDEPENDENCE AT HOME NURSE PRACTITIONER.—The term 'Independence at Home nurse practitioner' means a nurse practitioner who—

''(A) is employed by or affiliated with an Independence at Home organization, as required under paragraph (7)(C), or has another contractual relationship with the Independence at Home organization that requires the nurse practitioner to make in-home visits and to be responsible for the plans of care for the nurse practitioner's patients;

''(B) practices in accordance with State law regarding scope of practice for nurse practitioners;

''(C) is certified—

''(i) as a Gerontologic Nurse Practitioner by the American Academy of Nurse Practitioners Certification Program or the American Nurses Credentialing Center; or

''(ii) as a family nurse practitioner or adult nurse practitioner by the American Academy of Nurse Practitioners Certification Board or the American Nurses Credentialing Center and holds a certificate of Added Qualification in gerontology, elder care or care of the older adult provided by the American Academy of Nurse Practitioners, the American Nurses Credentialing Center or a national nurse practitioner certification board deemed by the Secretary to be appropriate for an Independence at Home program; and

''(D) has furnished services during the previous 12 months for which payment is made under this title.

''(10) INDEPENDENCE AT HOME PLAN.—The term 'Independence at Home plan' means a plan established under subsection (d)(2) for a specific participant in an Independence at Home program.

''(11) INDEPENDENCE AT HOME PROGRAM.—The term 'Independence at Home program' means a program described in subsection (d) that is operated by an Independence at Home organization.

''(12) PARTICIPANT.—The term 'participant' means an eligible beneficiary who has voluntarily enrolled in an Independence at Home program.

''(13) QUALIFIED ENTITY.—The term 'qualified entity' means a person or organization that is licensed or otherwise legally permitted to provide the specific service (or services) provided under an Independence at Home plan that the entity has agreed to provide.

''(14) QUALIFYING FUNCTIONAL IMPAIRMENT.—The term 'qualifying functional impairment' means an inability to perform, without the assistance of another person, two or more activities of daily living.

''(15) QUALIFIED INDIVIDUAL.—The term 'qualified individual' means a individual that is licensed or otherwise legally permitted to provide the specific service (or services) under an Independence at Home plan that the individual has agreed to provide.

''(c) IDENTIFICATION AND ENROLLMENT OF PROSPECTIVE PROGRAM PARTICIPANTS.—

''(1) NOTICE TO ELIGIBLE INDEPENDENCE AT HOME BENEFICIARIES.—The Secretary shall develop a model notice to be made available to Medicare beneficiaries (and to their caregivers) who are potentially eligible for an Independence at Home program by participating providers and by Independence at Home programs. Such notice shall include the following information:

''(A) A description of the potential advantages to the beneficiary participating in an Independence at Home program.

''(B) A description of the eligibility requirements to participate.

''(C) Notice that participation is voluntary.

''(D) A statement that all other Medicare benefits remain available to beneficiaries who enroll in an Independence at Home program.

''(E) Notice that those who enroll in an Independence at Home program will be responsible for copayments for house calls made by Independence at Home physicians, physician assistants, or by Independence at Home nurse practitioners, except that such copayments may be reduced or eliminated at the discretion of the Independence at Home physician, physician assistant, or Independence at Home nurse practitioner involved in accordance with subsection (f).

''(F) A description of the services that could be provided.

''(G) A description of the method for participating, or withdrawing from participation, in an Independence at Home program or becoming no longer eligible to so participate.

''(2) VOLUNTARY PARTICIPATION AND CHOICE.—An eligible beneficiary may participate in an Independence at Home program through enrollment in such program on a voluntary basis and may terminate such participation at any time. Such a beneficiary may also receive Independence at Home services from the Independence at Home organization of the beneficiary's choice but may not receive Independence at Home services from more than one Independence at Home organization at a time.

''(d) INDEPENDENCE AT HOME PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—Each Independence at Home program shall, for each participant enrolled in the program—

''(A) designate—

''(i) an Independence at Home physician or an Independence at Home nurse practitioner; and

''(ii) an Independence at Home coordinator;

''(B) have a process to ensure that the participant received an Independence at Home assessment before enrollment in the program;

''(C) with the participation of the participant (or the participant's representative or caregiver), an Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as permitted under State law, or an Independence at Home nurse practitioner, and the Independence at Home coordinator, develop an Independence at Home plan for the participant in accordance with paragraph (2);

''(D) ensure that the participant receives an Independence at Home assessment at least every 6 months after the original assessment to ensure that the Independence at Home plan for the participant remains current and appropriate;

''(E) implement all of the services under the participant's Independence at Home plan and in instances in which the Independence at Home organization does not provide specific services within the Independence at Home plan, ensure that qualified entities successfully provide those specific services; and

''(F) provide for an electronic medical record and electronic health information technology to coordinate the participant's care and to exchange information with the Medicare program and electronic monitoring and communication technologies and mobile diagnostic and therapeutic technologies as appropriate and accepted by the participant.

''(2) INDEPENDENCE AT HOME PLAN.—

''(A) IN GENERAL.—An Independence at Home plan for a participant shall be developed with the participant, an Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as permitted under State law, an Independence at Home nurse practitioner, or an Independence at Home coordinator, and, if appropriate, one or more of the participant's caregivers and shall—

''(i) document the chronic conditions, comorbidities, and other health needs identified in the participant's Independence at Home assessment;

''(ii) determine which services under an Independence at Home plan described in subparagraph (C) are appropriate for the participant; and

''(iii) identify the qualified entity responsible for providing each service under such plan.

''(B) COMMUNICATION OF INDIVIDUALIZED INDEPENDENCE AT HOME PLAN TO THE INDEPENDENCE AT HOME COORDINATOR.—If the individual responsible for conducting the participant's Independence at Home assessment and developing the Independence at Home plan is not the participant's Independence at Home coordinator, the Independence at Home physician or Independence at Home nurse practitioner is responsible for ensuring that the participant's Independence at Home coordinator has such plan and is familiar with the requirements of the plan and has the appropriate contact information for all of the members of the Independence at Home care team.

''(C) SERVICES PROVIDED UNDER AN INDEPENDENCE AT HOME PLAN.—An Independence at Home organization shall coordinate and make available through referral to a qualified entity the services described in the following clauses (i) through (iii) to the extent they are needed and covered by under this title and shall provide the care coordination services described in the following clause (iv) to the extent they are appropriate and accepted by a participant:

''(i) Primary care services, such as physician visits, diagnosis, treatment, and preventive services.

''(ii) Home health services, such as skilled nursing care and physical and occupational therapy.

''(iii) Phlebotomy and ancillary laboratory and imaging services, including point of care laboratory and imaging diagnostics.

''(iv) Care coordination services, consisting of—

''(I) Monitoring and management of medications by a pharmacist who is certified in geriatric pharmacy by the Commission for Certification in Geriatric Pharmacy or possesses other comparable certification demonstrating knowledge and expertise in geriatric pharmacotherapy, as well as assistance to participants and their caregivers with respect to selection of a prescription drug plan under part D that best meets the needs of the participant's chronic conditions.

''(II) Coordination of all medical treatment furnished to the participant, regardless of whether such treatment is covered and available to the participant under this title.

''(III) Self-care education and preventive care consistent with the participant's condition.

''(IV) Education for primary caregivers and family members.

''(V) Caregiver counseling services and information about, and referral to, other caregiver support and health care services in the community.

''(VI) Referral to social services, such as personal care, meals, volunteers, and individual and family therapy.

''(VII) Information about, and access to, hospice care.

''(VIII) Pain and palliative care and end-of-life care, including information about developing advanced directives and physicians orders for life sustaining treatment.

''(3) PRIMARY TREATMENT ROLE WITHIN AN INDEPENDENCE AT HOME CARE TEAM.—An Independence at Home physician, a physician assistant under the supervision of an Independence at Home physician and as permitted under State law, or an Independence at Home nurse practitioner may assume the primary treatment role as permitted under State law.

''(4) ADDITIONAL RESPONSIBILITIES.—

''(A) OUTCOMES REPORT.—Each Independence at Home organization offering an Independence at Home program shall monitor and report to the Secretary, in a manner specified by the Secretary, on—

''(i) patient outcomes;

''(ii) beneficiary, caregiver, and provider satisfaction with respect to coordination of the participant's care; and

''(iii) the achievement of mandatory minimum savings described in subsection (e)(6).

''(B) ADDITIONAL REQUIREMENTS.—Each such organization and program shall provide the Secretary with listings of individuals employed by the organization, including contract employees, and individuals with an ownership interest in the organization and comply with such additional requirements as the Secretary may specify.

''(e) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—An agreement under this section with an Independence at Home organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

''(2) CLINICAL, QUALITY IMPROVEMENT, AND FINANCIAL REQUIREMENTS.—The Secretary may not enter into an agreement with such an organization under this section for the operation of an Independence at Home program unless—

''(A) the program and organization meet the requirements of subsection (d), minimum quality and performance standards developed under paragraph (3), and such clinical, quality improvement, financial, program integrity, and other requirements as the Secretary deems to be appropriate for participants to be served; and

''(B) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assume financial risk for performance under the agreement with respect to payments made to the organization under such agreement through available reserves, reinsurance, or withholding of funding provided under this title, or such other means as the Secretary determines appropriate.

''(3) MINIMUM QUALITY AND PERFORMANCE STANDARDS.—

''(A) IN GENERAL.—The Secretary shall develop mandatory minimum quality and performance standards for Independence at Home organizations and programs.

''(B) STANDARDS TO BE INCLUDED.—Such standards shall include measures of—

''(i) improvement in participant outcomes;

''(ii) improvement in satisfaction of the beneficiary, caregiver, and provider involved; and

''(iii) cost savings consistent with paragraph (6).

''(C) MINIMUM PARTICIPATION STANDARD.—Such standards shall include a requirement that, for any year after the first year and except as the Secretary may provide for a program serving a rural area, an Independence at Home program had an average number of participants during the previous year of at least 100 participants.

''(4) TERM OF AGREEMENT AND MODIFICATION.—The agreement under this subsection shall be, subject to paragraphs (3)(C) and (5), for a period of three years, and the terms and conditions may be modified during the contract period by the Secretary as necessary to serve the best interest of the beneficiaries under this title or the best interest of Federal health care programs or upon the request of the Independence at Home organization.

''(5) TERMINATION AND NON-RENEWAL OF AGREEMENT.—

''(A) IN GENERAL.—If the Secretary determines that an Independence at Home organization has failed to meet the minimum performance standards under paragraph (3) or other requirements under this section, or if the Secretary deems it necessary to serve the best interest of the beneficiaries under this title or the best interest of Federal health care programs, the Secretary may terminate the agreement of the organization at the end of the contract year.

''(B) REQUIRED TERMINATION WHERE RISK TO HEALTH OR SAFETY OF A PARTICIPANT.—The Secretary shall terminate an agreement with an Independence at Home organization at any time the Secretary determines that the care being provided by such organization poses a threat to the health and safety of a participant.

''(C) TERMINATION BY INDEPENDENCE AT HOME ORGANIZATIONS.—Notwithstanding any other provision of this subsection, an Independence at Home organization may terminate an agreement with the Secretary under this section to provide an Independence at Home program at the end of a contract year if the organization provides to the Secretary and to the beneficiaries participating in the program notification of such termination more than 90 days before the end of such year. Paragraphs (6), (8), and (9)(B) shall apply to the organization until the date of termination.

''(D) NOTICE OF INVOLUNTARY TERMINATION.—The Secretary shall notify the participants in an Independence at Home program as soon as practicable if a determination is made to terminate an agreement with the Independence at Home organization involuntarily as provided in subparagraphs (A) and (B). Such notice shall inform the beneficiary of any other Independence at Home organizations that might be available to the beneficiary.

''(6) MANDATORY MINIMUM SAVINGS.—

''(A) REQUIRED.—

''(i) IN GENERAL.—Under an agreement under this subsection, each Independence at Home organization shall ensure that during any year of the agreement for its Independence at Home program, there is an aggregate savings in the cost to the program under this title for participating beneficiaries, as calculated under subparagraph (B), that is not less than 5 percent of the product described in clause (ii) for such participating beneficiaries and year.

''(ii) PRODUCT DESCRIBED.—The product described in this clause for participating beneficiaries in an Independence at Home program for a year is the product of—

''(I) the estimated average monthly costs that would have been incurred under parts A and B (and, to the extent cost information is available, part D) if those beneficiaries had not participated in the Independence at Home program; and

''(II) the number of participant-months for that year.

''(B) COMPUTATION OF AGGREGATE SAVINGS.—

''(i) MODEL FOR CALCULATING SAVINGS.—The Secretary shall contract with a nongovernmental organization or academic institution to independently develop an analytical model for determining whether an Independence at Home program achieves at least savings required under subparagraph (A) relative to costs that would have been incurred by Medicare in the absence of Independence at Home programs. The analytical model developed by the independent research organization for making these determinations shall utilize state-of-the-art econometric techniques, such as Heckman's selection correction methodologies, to account for sample selection bias, omitted variable bias, or problems with endogeneity.

''(ii) APPLICATION OF THE MODEL.—Using the model developed under clause (i), the Secretary shall compare the actual costs to Medicare of beneficiaries participating in an Independence at Home program to the predicted costs to Medicare of such beneficiaries to determine whether an Independence at Home program achieves the savings required under subparagraph (A).

''(iii) REVISIONS OF THE MODEL.—The Secretary shall require that the model developed under clause (i) for determining savings shall be designed according to instructions that will control, or adjust for, inflation as well as risk factors including, age, race, gender, disability status, socioeconomic status, region of country (such as State, county, metropolitan statistical area, or zip code), and such other factors as the Secretary determines to be appropriate, including adjustment for prior health care utilization. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the sensitivity or specificity of the calculation of costs savings.

''(iv) PARTICIPANT-MONTH.—In making the calculation described in subparagraph (A), each month or part of a month in a program year that a beneficiary participates in an Independence at Home program shall be counted as a 'participant-month'.

''(C) NOTICE OF SAVINGS CALCULATION.—No later than 30 days before the beginning of the first year of the pilot project under this section and 120 days before the beginning of any Independence at Home program year after the first such year, the Secretary shall publish in the Federal Register a description of the model developed under subparagraph (B)(i) and information for calculating savings required under subparagraph (A), including any revisions, sufficient to permit Independence at Home organizations to determine the savings they will be required to achieve during the program year to meet the savings requirement under subparagraph (A). In order to facilitate this notice, the Secretary may designate a single annual date for the beginning of all Independence at Home program years that shall not be later than one year from the date of enactment of this section.

''(7) MANNER OF PAYMENT.—Subject to paragraph (8), payments shall be made by the Secretary to an Independence at Home organization at a rate negotiated between the Secretary and the organization under the agreement for—

''(A) Independence at Home assessments; and

''(B) on a per-participant, per-month basis for the items and services required to be provided or made available under subsection (d)(2)(C)(iv).

''(8) ENSURING MANDATORY MINIMUM SAVINGS.—The Secretary shall require any Independence at Home organization that fails in any year to achieve the mandatory minimum savings described in paragraph (6) to provide those savings by refunding payments made to the organization under paragraph (7) during such year.

''(9) BUDGET NEUTRAL PAYMENT CONDITION.—

''(A) IN GENERAL.—Under this section, the Secretary shall ensure that the cumulative, aggregate sum of Medicare program benefit expenditures under parts A, B, and D for participants in Independence at Home programs and funds paid to Independence at Home organizations under this section, shall not exceed the Medicare program benefit expenditures under such parts that the Secretary estimates would have been made for such participants in the absence of such programs.

''(B) TREATMENT OF SAVINGS.—

''(i) INITIAL IMPLEMENTATION PHASE.—If an Independence at Home organization achieves aggregate savings in a year in the initial implementation phase in excess of the mandatory minimum savings described in paragraph (6)(A)(ii), 80 percent of such aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title during the initial implementation phase.

''(ii) EXPANDED IMPLEMENTATION PHASE.—If an Independence at Home organization achieves aggregate savings in a year in the expanded implementation phase in excess of 5 percent of the product described in paragraph (6)(A)(ii)—

''(I) insofar as such savings do not exceed 25 percent of such product, 80 percent of such aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title; and.

''(II) insofar as such savings exceed 25 percent of such product, in the Secretary's discretion, 50 percent of such excess aggregate savings shall be paid to the organization and the remainder shall be retained by the programs under this title.

''(f) WAIVER OF COINSURANCE FOR HOUSE CALLS.—A physician, physician assistant, or nurse practitioner furnishing services related to the Independence at Home program in the home or residence of a participant in an Independence at Home program may waive collection of any coinsurance that might otherwise be payable under section 1833(a) with respect to such services but only if the conditions described in section 1128A(i)(6)(A) are met.

''(g) REPORT.—Not later than three months after the date of receipt of the independent evaluation provided under subsection (a)(5) and each year thereafter during which this section is being implemented, the Secretary shall submit to the Committees of jurisdiction in Congress a report that shall include—

''(1) whether the Independence at Home programs under this section are meeting the minimum quality and performance standards in (e)(3);

''(2) a comparative evaluation of Independence at Home organizations in order to identify which programs, and characteristics of those programs, were the most effective in producing the best participant outcomes, patient and caregiver satisfaction, and cost savings; and

''(3) an evaluation of whether the participant eligibility criteria identified beneficiaries who were in the top ten percent of the highest cost Medicare beneficiaries.''.

(b) CONFORMING AMENDMENT.—Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended, in the matter before paragraph (1), by inserting ''and section 1807A(f)'' after ''section 1876''.

By Mr. LEAHY:

S. 1132. A bill to amend title 18, United States Code, to improve the provisions relating to the carrying of concealed weapons by law enforcement officers, and for other purposes; to the Committee on the Judiciary.

Mr. LEAHY. Mr. President, in 2003, Senator Ben Nighthorse Campbell and I, along with 68 other Senators, introduced a bill to allow qualified retired or current law enforcement officers to carry a concealed firearm across State lines. The Senate passed our bill by unanimous consent, and it was signed into law in July 2004. Passage of the Law Enforcement Officers Safety Act indicated strong confidence in the men and women who serve to protect their communities and their Nation as the first line of defense in any emergency.

Introduction of this legislation to benefit active and retired law enforcement officers across the country is especially timely as the Congress and the country have just recognized National Peace Officers Memorial Day. I am proud to introduce this legislation today and thank Senator KYL for joining me as a cosponsor.

This year, the Senate Judiciary Committee has turned its attention to State and local law enforcement. It has held hearings about the importance of Federal funding at the local level, and how strong community policing and positive community relationships are fundamental to a prosperous economy. I agree, and appreciated having the perspective at recent Judiciary Committee hearings of the State and local officials like Chief Michael Schirling and Lieutenant Kris Carlson from the Burlington, Vermont, Police Department. I hope the Senate will continue its strong support of our law enforcement officers with support for this legislation.

In 2007, the Senate Judiciary Committee twice reported the legislation I introduce today—once as a stand-alone bill and again as part of the School Safety and Law Enforcement Improvements Act. I hope the Senate will act in the interest of so many law enforcement officers across the United States by improving and building upon the current law.

Since enactment of the Law Enforcement Officers Safety Act, I have heard feedback from many in law enforcement that qualified retired officers have been subject to varying certification procedures from State to State. In many cases, differing interpretations have complicated the implementation of the law, and retired officers have experienced significant frustration in getting certified to lawfully carry a firearm under the law.

With the input of the law enforcement community, this bill proposes modest amendments to the current law, and will give retired officers more flexibility in obtaining certification. It also provides room for the variability in certification standards among the several States. For example, where a State has not set active duty standards, the retired officer can be certified pursuant to the standards set by a law enforcement agency in the State.

In addition to these changes, the bill makes clear that Amtrak officers, along with law enforcement officers of the Executive branch of the Federal Government, are covered by the law. The bill also reduces the years of service required for a retired officer to qualify under the law from 15 to 10. The bill now contains clearer standards to address mental health issues related to eligibility for officers who separate from service or retire. These are positive changes to the current law, and the requirements for eligibility would continue to require a significant term of service for a retired officer to qualify, a demonstrated commitment to law enforcement, and retirement in good standing.

The dedicated public servants who are trained to uphold the law and keep the peace deserve our support not just in their professional lives, but also when they are off-duty or retire. As a former prosecutor, I have great confidence in those who serve in law enforcement and their ability to exercise their privileges under this legislation safely and responsibly. The responsibilities they shoulder day to day on the job deserve our recognition and respect.

I hope all Senators will join us in support of this legislation.

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. 1132

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 ''Law Enforcement Officers Safety Act Improvements Act of 2009''.

SEC. 2.

(a) IN GENERAL.—Section 926B of title 18, United States Code, is amended by adding at the end the following:

''(f) For the purposes of this section, a law enforcement officer of the Amtrak Police Department or a law enforcement or police officer of the executive branch of the Federal Government qualifies as an employee of a governmental agency who is authorized by law to engage in or supervise the prevention, detection, investigation, or prosecution of, or the incarceration of any person for, any violation of law, and has statutory powers of arrest.''.

(b) ACTIVE LAW ENFORCEMENT OFFICERS.—Section 926B of title 18, United States Code is amended by striking subsection (e) and inserting the following:

''(e) As used in this section, the term 'firearm'—

''(1) except as provided in this subsection, has the same meaning as in section 921 of this title;

''(2) includes ammunition not expressly prohibited by Federal law or subject to the provisions of the National Firearms Act; and

''(3) does not include—

''(A) any machinegun (as defined in section 5845 of the National Firearms Act);

''(B) any firearm silencer (as defined in section 921 of this title); and

''(C) any destructive device (as defined in section 921 of this title).''.

(c) RETIRED LAW ENFORCEMENT OFFICERS.—Section 926C of title 18, United States Code is amended—

(1) in subsection (c)—

(A) in paragraph (1)—

(i) by striking ''retired'' and inserting ''separated from service''; and

(ii) by striking '', other than for reasons of mental instability'';

(B) in paragraph (2), by striking ''retirement'' and inserting ''separation'';

(C) in paragraph (3)—

(i) in subparagraph (A), by striking ''retirement, was regularly employed as a law enforcement officer for an aggregate of 15 years or more'' and inserting ''separation, served as a law enforcement officer for an aggregate of 10 years or more''; and

(ii) in subparagraph (B), by striking ''retired'' and inserting ''separated'';

(D) by striking paragraph (4) and inserting the following:

''(4) during the most recent 12-month period, has met, at the expense of the individual, the standards for qualification in firearms training for active law enforcement officers, as determined by the former agency of the individual, the State in which the individual resides or, if the State has not established such standards, a law enforcement agency within the State in which the individual resides;''; and

(E) by striking paragraph (5) and replacing it with the following:

''(5)(A) has not been officially found by a qualified medical professional employed by the agency to be unqualified for reasons relating to mental health and as a result of this finding will not be issued the photographic identification as described in subsection (d)(1); or

''(B) has not entered into an agreement with the agency from which the individual is separating from service in which that individual acknowledges he or she is not qualified under this section for reasons relating to mental health and for those reasons will not receive or accept the photographic identification as described in subsection (d)(1);'';

(2) in subsection (d)—

(A) paragraph (1)—

(i) by striking ''retired'' and inserting ''separated''; and

(ii) by striking ''to meet the standards'' and all that follows through ''concealed firearm'' and inserting ''to meet the active duty standards for qualification in firearms training as established by the agency to carry a firearm of the same type as the concealed firearm'';

(B) paragraph (2)—

(i) in subparagraph (A), by striking ''retired'' and inserting ''separated''; and

(ii) in subparagraph (B), by striking ''that indicates'' and all that follows through the period and inserting ''or by a certified firearms instructor that is qualified to conduct a firearms qualification test for active duty officers within that State that indicates that the individual has, not less than 1 year before the date the individual is carrying the concealed firearm, been tested or otherwise found by the State or a certified firearms instructor that is qualified to conduct a firearms qualification test for active duty officers within that State to have met—

''(I) the active duty standards for qualification in firearms training, as established by the State, to carry a firearm of the same type as the concealed firearm; or

''(II) if the State has not established such standards, standards set by any law enforcement agency within that State to carry a firearm of the same type as the concealed firearm.''; and

(3) by striking subsection (e) and inserting the following:

''(e) As used in this section—

''(1) the term 'firearm'—

''(A) except as provided in this paragraph, has the same meaning as in section 921 of this title;

''(B) includes ammunition not expressly prohibited by Federal law or subject to the provisions of the National Firearms Act; and

''(C) does not include—

''(i) any machinegun (as defined in section 5845 of the National Firearms Act);

''(ii) any firearm silencer (as defined in section 921 of this title); and

''(iii) any destructive device (as defined in section 921 of this title); and

''(2) the term 'service with a public agency as a law enforcement officer' includes service as a law enforcement officer of the Amtrak Police Department, or as a law enforcement or police officer of the executive branch of the Federal Government.''.

By Mr. WYDEN (for himself and Mr. GREGG):

S. 1133. A bill to amend title XVIII of the Social Security Act to provide for the establishment of shared decision making standards and requirements and to establish a pilot program for the implementation of shared decision making under the Medicare program; to the Committee on Finance.

Mr. WYDEN. Mr. President, I am pleased to be joined by my colleague, the distinguished Senator from New Hampshire, JUDD GREGG, to introduce an important bill that will put patients in the driver's seat of their medical care. Today, my fellow Oregonian Representative EARL BLUMENAUER is introducing the same bill in the House of Representatives.

On the Senate floor and in the Finance Committee and Health Education Labor and Pensions Committee, senators have been wrestling with health reform. The challenge before the Congress is to both expand quality, affordable coverage to all Americans while containing costs.

Cost containment requires a lot of tough choices because it will require changing how care is delivered. The time of paying for volume and low quality is past. Chairman BAUCUS rightly recognized the challenges in cost containment and took up this issue as the first area he wanted to address in the series of public roundtables held in the Finance Committee.

I believe the key to transforming the health care system and cost containment is to give patients more choices. Patients should have more choices of health insurance plans. Patients should have a choice of doctor. Patients should also have choices in their medical care.

The research by Dr. Jim Weinstein and Dr. John Wennberg with the Dartmouth Atlas Project has documented regional variations in medical care. They have found both underuse, or the failure to deliver needed evidence-based care, and overuse, or the delivery of unnecessary supply-sensitive care. Regional variations are driven by local medical opinion, rather than sound science or the preferences of well-informed patients. Just because doctors are licensed to have a hammer, doesn't make every patient a nail.

Using their research, Office of Management and Budget Director Peter Orszag and other experts have estimated that as much as 30 percent of medical spending today goes to care that is unnecessary. That is 30 percent of $2.5 trillion is $750 billion going to care that does not make patients healthier and may even harm them.

The current standard of medical care in the U.S. fails to adequately ensure that patients are informed about all their treatment options and the risks and benefits of those options. This leads to patients getting medical treatments they may not have wanted had they been fully informed of their treatment options and integrated into the decision making process. In order to deliver the right care at the right time, informed patient choice should be the goal of medical care.

Shared decision making is a collaborative process between the doctor and patient when they discuss the trade-offs among treatment options and discuss the patient's preferences and values. Shared decision making uses patient decision aids, an educational tool like a video or pamphlet that helps patients understand, communicate their beliefs and preferences related to their treatment options, and decide what medical treatments are best for them with their provider based on their medical treatment options, scientific evidence, circumstances, beliefs and preferences.

Informed patients choice depends on clinical comparative effectiveness research that compares the effectiveness of health care treatments. Shared decision making and patient decision aids use clinical comparative effectiveness research so that doctors and patients together make the right medical treatment choice for each individual patient.

This bill creates a three stage phase in of patient decision aids and shared decision making into the Medicare program. Phase I of the pilot is a 3-year period allowing 'early adopting' providers—those who already have experience using patient decision aids and incorporating them into their clinical practices—to participate in the pilot providing data for the Secretary and also serve as Shared Decision Making Resource Centers. During this period, an independent entity will develop consensus based standards for patient decision aids and a certification process to ensure decision aids are effective and provide unbiased information. An expert panel then recommends to the Secretary which patient decision aids may be used in this program.

Phase II is a 3-year period during which providers will be eligible to receive reimbursement for the use of certified patient decision aids. New providers may be added on an annual basis allowing for the gradual and voluntary expansion of shared decision making and patient decision aids to a large portion of the country.

The final stage requires all Medicare providers to ensure that Medicare beneficiaries receive shared decision making and patient decision aids prior to receiving treatment for a preference sensitive condition. If a provider does not ensure that a patient receives a patient decision aid then the provider's reimbursement may be reduced by no more than 20 percent.

This legislation is built on a shared savings model distributing 50 percent of the savings to participating providers based on their participation and performance on quality measures. Twenty-five percent of the savings are used to expand provider participation providing financial support to the Shared Decision Making Centers and providers. The final 25 percent savings are returned to the Medicare program. As shared decision making becomes the standard of practice, the shared savings percentages phases out.

I believe that this simple approach to informed patient choice is critically important to giving patients real choices by engaging them in their health care. As we look to expand access to health coverage, this bill provides a bipartisan, sensible path to putting patients in the driver's seat.

I hope my colleagues will join me in supporting this bill, and I look forward to working with Chairman BAUCUS and Ranking Member GRASSLEY and other members of the Finance Committee to secure passage of this important bill.

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. 1133

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 ''Empowering Medicare Patient Choices Act''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The Dartmouth Atlas Project's work documenting regional variations in medical care has found both underuse, or the failure to deliver needed evidence-based care, and overuse, or the delivery of unnecessary supply-sensitive care.

(2) The Dartmouth Atlas Project has also found that many clinical decisions physicians make for elective medical treatments are driven by local medical opinion, rather than sound science or the preferences of well-informed patients. For example, the Dartmouth Atlas Project found that, among the 306 Hospital Referral Regions in the United States during the period of 2002 through 2003, the incidence of surgery for back pain-related conditions and joint replacement for chronic arthritis of the hip and knee varied 5.9-, 5.6-, and 4.8-fold, respectively, from the lowest to the highest region.

(3) Discretionary surgery for the following common conditions accounts for 40 percent of Medicare spending for inpatient surgery: early stage cancer of the prostate; early stage cancer of the breast; osteoarthritis of the knee; osteoarthritis of the hip; osteoarthritis of the spine; chest pain due to coronary artery disease; stroke threat from carotid artery disease, ischemia due to peripheral artery disease; gall stones; and enlarged prostate.

(4) Decisions that involve values trade-offs between the benefits and harms of 2 or more clinically appropriate alternatives should depend on the individual patient's informed choice. In everyday practice, however, patients typically delegate decision making to their physicians who may not have good information on the patient's true preferences.

(5) The current standard of medical care in the United States fails to adequately ensure that patients are informed about their treatment options and the risks and benefits of those options. This leads to patients getting medical treatments they may not have wanted had they been fully informed of their treatment options and integrated into the decision making process.

(6) Patient decision aids are tools designed to help people participate in decision making

about health care options. Patient decision aids provide information on treatment options and help patients clarify and communicate the personal value they associate with different features of treatment options. Patient decision aids do not advise people to choose one treatment option over another, nor are they meant to replace practitioner consultation. Instead, they prepare patients to make informed, value-based decisions with their physician.

(7) The Lewin Group estimated that the change in spending resulting from the use of patient decision aids for each of 11 conditions using per-procedure costs estimated for the Medicare population studied, assuming full implementation of such patient decision aids in 2010, would save as much as $4,000,000,000.

SEC. 3. DEFINITIONS.

In this Act:

(1) ELIGIBLE PROVIDER.—

(A) IN GENERAL.—The term ''eligible provider'' means the following:

(i) A primary care practice.

(ii) A specialty practice.

(iii) A multispecialty group practice.

(iv) A hospital.

(v) A rural health clinic.

(vi) A Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)).

(vii) An integrated delivery system.

(viii) A State cooperative.

(B) INCLUSION OF MEDICARE ADVANTAGE PLANS.—Such term includes a Medicare Advantage plan offered by a Medicare Advantage organization under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

(2) PATIENT DECISION AID.—The term ''patient decision aid'' means an educational tool (such as the Internet, a video, or a pamphlet) that helps patients (or, if appropriate, the family caregiver of the patient) understand and communicate their beliefs and preferences related to their treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences.

(3) PREFERENCE SENSITIVE CARE.—The term ''preference sensitive care'' means medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient regarding the benefits, harms, and scientific evidence for each treatment option. The use of such care should depend on informed patient choice among clinically appropriate treatment options. Such term includes medical care for the conditions identified in section 5(g).

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

(5) SHARED DECISION MAKING.—The term ''shared decision making'' means a collaborative process between patient and clinician that engages the patient in decision making, provides patients with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

(6) STATE COOPERATIVE.—The term ''State cooperative'' means an entity that includes the State government and at least one other health care provider which is set up for the purpose of testing shared decision making and patient decision aids.

SEC. 4. ESTABLISHMENT OF INDEPENDENT STANDARDS FOR PATIENT DECISION AIDS.

(a) CONTRACT WITH ENTITY TO ESTABLISH STANDARDS AND CERTIFY PATIENT DECISION AIDS.—

(1) CONTRACT.—

(A) IN GENERAL.—For purposes of supporting consensus-based standards for patient decision aids and a certification process for patient decision aids for use in the Medicare program and by other interested parties, the Secretary shall identify and have in effect a contract with an entity that meets the requirements described in paragraph (4). Such contract shall provide that the entity perform the duties described in paragraph (2).

(B) TIMING FOR FIRST CONTRACT.—As soon as practicable after the date of the enactment of this Act, the Secretary shall enter into the first contract under subparagraph (A).

(C) PERIOD OF CONTRACT.—A contract under subparagraph (A) shall be for a period of 18 months (except such contract may be renewed after a subsequent bidding process).

(D) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under subparagraph (A).

(2) DUTIES.—The following duties are described in this paragraph:

(A) OPERATE AN OPEN AND TRANSPARENT PROCESS.—The entity shall conduct its business in an open and transparent manner and provide the opportunity for public comment on the activities described in subparagraphs (B) and (C).

(B) ESTABLISH STANDARDS FOR PATIENT DECISION AIDS.—

(i) IN GENERAL.—The entity shall synthesize evidence and convene a broad range of experts and key stakeholders to establish consensus-based standards, such as those developed by the International Patient Decision Aid Standard Collaboration, to determine which patient decision aids are high quality patient decision aids.

(ii) DRAFT OF PROPOSED STANDARDS.—The entity shall make a draft of proposed standards available to the public.

(iii) 60-DAY COMMENT PERIOD.—Beginning on the date the entity makes a draft of the proposed standards available under clause (ii), the entity shall provide a 60-day period for public comment on such draft.

(iv) FINAL STANDARDS.—

(I) IN GENERAL.—The standards established by the entity under this subparagraph shall be adopted by the board of the entity.

(II) PUBLIC AVAILABILITY.—The entity shall make such standards available to the public.

(C) CERTIFY PATIENT DECISION AIDS.—The entity shall review patient decision aids and certify whether patient decision aids meet the standards established under subparagraph (B) and offer a balanced presentation of treatment options from both the clinical and patient experience perspectives. In conducting such review and certification, the entity shall give priority to the review and certification of patient decision aids for conditions identified in section 5(g).

(3) REPORT TO THE EXPERT PANEL.—The entity shall submit to the expert panel established under subsection (b) a report on the standards established for patient decision aids under paragraph (2)(B) and patient decision aids that are certified as meeting such standards under paragraph (2)(C).

(4) REQUIREMENTS DESCRIBED.—The following requirements are described in this paragraph:

(A) PRIVATE NONPROFIT.—The entity is a private nonprofit organization governed by a board.

(B) EXPERIENCE.—The entity shall be able to demonstrate experience with—

(i) consumer engagement;

(ii) standard setting;

(iii) health literacy;

(iv) health care quality and safety issues;

(v) certification processes;

(vi) measure development; and

(vii) evaluating health care quality.

(C) MEMBERSHIP FEES.—If the entity requires a membership fee for participation in the functions of the entity, such fees shall be reasonable and adjusted based on the capacity of the potential member to pay the fee. In no case shall membership fees pose a barrier to the participation of individuals or groups with low or nominal resources to participate in the functions of the entity.

(b) EXPERT PANEL.—

(1) ESTABLISHMENT.—Not later than 120 days after the date of enactment of this Act, the Secretary shall establish an expert panel to make recommendations to the Secretary regarding which patient decision aids should be implemented, appropriate training for health care providers on patient decision aids and shared decision making, and appropriate quality measures for use in the pilot program under section 5 and under section 1899 of the Social Security Act, as added by section 6.

(2) DUTIES.—The expert panel shall carry out the following duties:

(A) Approve patient decision aids, from among those patient decision aids certified under paragraph (2)(C) of subsection (a) by the entity with a contract under such subsection, for use in the pilot program under section 5 (including to the extent practicable, patient decision aids for the medical care of the conditions described in section 5(g) and under section 1899 of the Social Security Act, as added by section 6.

(B) Review current training curricula for health care providers on patient decision aids and shared decision making and recommend a training process for eligible providers participating in the pilot program under section 5 on the use of such approved patient decision aids and shared decision making.

(C) Review existing quality measures regarding patient knowledge, value concordance, and health outcomes that have been endorsed through a consensus-based process and recommend appropriate quality measures for selection under section 5(h)(1).

(3) APPOINTMENT.—The expert panel shall be composed of 13 members appointed by the Secretary from among leading experts in shared decision making of whom—

(A) 2 shall be researchers;

(B) 2 shall be primary care physicians;

(C) 2 shall be from surgical specialties;

(D) 2 shall be patient or consumer community advocates;

(E) 2 shall be nonphysician health care providers (such as nurses, nurse practitioners, and physician assistants);

(F) 1 shall be from an integrated multispecialty group practice;

(G) 1 shall be from the National Cancer Institute; and

(H) 1 shall be from the Centers for Disease Control and Prevention.

(4) REPORT.—Not later than 2 years after such date of enactment and each year thereafter until the date of the termination of the expert panel under paragraph (5), the expert panel shall submit to the Secretary a report on the patient decision aids approved under paragraph (2)(A), the training process recommended under paragraph (2)(B), the quality measures recommended under paragraph (2)(C), and recommendations on other conditions or medical care the Secretary may want to include in the pilot program under section 5.

(5) TERMINATION.—The expert panel shall terminate on such date as the Secretary determines appropriate.

(c) QUALITY MEASURE DEVELOPMENT.—

(1) IN GENERAL.—Section 1890(b)(1)(A) of the Social Security Act (42 U.S.C. 1395aaa(b)(1)(A)) is amended—

(A) in clause (ii), by striking ''and'' at the end; and

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

''(iv) that address conditions described in section 5(g) of the Empowering Medicare Patient Choices Act and regional practice variations under this title; and''.

(2) CONFORMING AMENDMENT.—Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended—

(A) by inserting ''(other than subsection (b)(1)(A)(iv))'' after ''this section''; and

(B) by adding at the end the following new sentence: ''For provisions relating to funding for the duties described in subsection (b)(1)(A)(iv), see section 5(l) of the Empowering Medicare Patient Choices Act.''.

SEC. 5. ESTABLISHMENT OF SHARED DECISION MAKING PILOT PROGRAM UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Secretary shall establish a pilot program to provide for the phased-in development, implementation, and evaluation of shared decision making under the Medicare program using patient decision aids to meet the objective of improving the understanding by Medicare beneficiaries of their medical treatment options, as compared to comparable Medicare beneficiaries who do not participate in a shared decision making process using patient decision aids.

(b) INITIAL IMPLEMENTATION (PHASE I).—

(1) IN GENERAL.—During the initial implementation of the pilot program under this section (referred to in this section as ''Phase I'' of the pilot program), the Secretary shall enroll in the pilot program not more than 15 eligible providers who have experience in implementing, and have invested in the necessary infrastructure to implement, shared decision making using patient decision aids for a period of 3 years.

(2) APPLICATION.—An eligible provider seeking to participate in the pilot program during phase I shall submit to the Secretary an application at such time and containing such information as the Secretary may require.

(3) PREFERENCE.—In enrolling eligible providers in the pilot program during phase I, the Secretary shall give preference to eligible providers that—

(A) have documented experience in using patient decision aids for the conditions identified in subsection (g) and in using shared decision making;

(B) have the necessary information technology infrastructure to collect the information required by the Secretary for reporting purposes;

(C) are trained in how to use patient decision aids and shared decision making; and

(D) would be eligible to receive financial assistance as a Shared Decision Making Resource Center under subsection (c).

(c) SHARED DECISION MAKING RESOURCE CENTERS.—

(1) IN GENERAL.—The Secretary shall provide financial assistance for the establishment and support of Shared Decision Making Resource Centers (referred to in this section as ''centers'') to provide technical assistance to eligible providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decision making by eligible providers under the Medicare program.

(2) AFFILIATION.—Centers shall be affiliated with a United States-based organization or group that applies for and is awarded financial assistance under this subsection. The Secretary shall provide financial assistance to centers under this subsection on the basis of merit.

(3) OBJECTIVES.—The objective of a center is to enhance and promote the adoption of patient decision aids and shared decision making through—

(A) providing assistance to eligible providers with the implementation and effective use of, and training on, patient decision aids;

(B) the dissemination of best practices and research on the implementation and effective use of patient decision aids; and

(C) providing assistance to eligible providers applying to participate or participating in phase II of the pilot program under this section or under section 1899 of the Social Security Act, as added by section 6.

(4) REGIONAL ASSISTANCE.—Each center shall aim to provide assistance and education to all eligible providers in a region, including direct assistance to the following eligible providers:

(A) Public or not-for-profit hospitals or critical access hospitals (as defined in section 1861 (mm)(1) of the Social Security Act (42 U.S.C. 1395x(mm)(1)).

(B) Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)).

(C) Entities that are located in a rural area or in area that serves uninsured, underinsured, and medically underserved individuals (regardless of whether such area is urban or rural).

(D) Individual or small group practices (or a consortium thereof) that are primarily focused on primary care.

(5) FINANCIAL ASSISTANCE.—

(A) IN GENERAL.—The Secretary may provide financial assistance for a period of 8 years to any regional center established or supported under this subsection.

(B) COST-SHARING REQUIREMENT.—

(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall not provide as financial assistance under this subsection more than 50 percent of the capital and annual operating and maintenance funds required to establish and support such a center.

(ii) WAIVER OF COST-SHARING REQUIREMENT.—The Secretary may waive the limitation under clause (i) if the Secretary determines that, as a result of national economic conditions, such limitation would be detrimental to the pilot program under this section. If the Secretary waives such limitation under the preceding sentence, the Secretary shall submit to Congress a report containing the Secretary's justification for such waiver.

(6) NOTICE OF PROGRAM DESCRIPTION AND AVAILABILITY OF FUNDS.—The Secretary shall publish in the Federal Register, not later than 12 months after the date of the enactment of this Act, a draft description of a program for establishing and supporting regional centers under this subsection. Such draft description shall include the following:

(A) A detailed explanation of the program and the program goals.

(B) Procedures to be followed by applicants for financial assistance.

(C) Criteria for determining which applicants are qualified to receive financial assistance.

(D) Maximum support levels expected to be available to centers under the program.

(7) APPLICATION REVIEW.—The Secretary shall review each application for financial assistance under this subsection based on merit. In making a decision whether to approve such application and provide financial assistance, the Secretary shall consider at a minimum the merits of the application, including those portions of the application regarding—

(A) the ability of the applicant to provide assistance to particular categories of eligible providers with respect to the implementation and effective use of, and training on, patient decision aids;

(B) the geographical diversity and extent of the service area of the applicant; and

(C) the percentage of funding for the center that would be provided as financial assistance under this subsection and the amount of any funding or in-kind commitment from sources of funding in addition to the financial assistance provided under this subsection.

(8) BIENNIAL EVALUATION.—Each center which receives financial assistance under this subsection shall be evaluated biennially by an evaluation panel appointed by the Secretary. Each such evaluation panel shall be composed of private experts, none of whom shall be connected with the center involved, and officials of the Federal Government. Each evaluation panel shall measure the performance of the center involved against the objectives specified in paragraph (3). The Secretary shall not continue to provide financial assistance to a center under this subsection unless the most recent evaluation under this paragraph with respect to the center is overall positive.

(d) EXPANDED IMPLEMENTATION (PHASE II).—

(1) IN GENERAL.—Subject to paragraph (2), during the 3-year period beginning after the completion of phase I of the pilot program (referred to in this section as ''phase II'' of the pilot program), the Secretary shall enroll additional eligible providers to implement shared decision making using patient decision aids under the pilot program under this section. The Secretary may allow eligible providers to enroll in the pilot program on a regular basis during phase II.

(2) CONTINGENCY.—The Secretary shall not implement phase II of the pilot program if the Secretary finds, not later than 90 days after the date of submittal of the interim report under subsection (i)(2)(A), that the continued implementation of shared decision making is not in the best interest of Medicare beneficiaries.

(3) PREFERENCE.—In enrolling eligible providers in the pilot program during phase II, the Secretary shall include, to the extent practicable, eligible providers that—

(A) have or can acquire the infrastructure necessary to implement shared decision making supported by patient decision aids approved by the expert panel established under section 4(b) in a timely manner;

(B) have training in the use of patient decision aids or will participate in training for health care professionals who will be involved in such use (as specified by the Secretary); or

(C) represent high cost areas or high practice variation States under the Medicare program, and the District of Columbia.

(e) GUIDANCE.—The Secretary may, in consultation with the expert panel established under section 4(b), issue guidance to eligible providers participating in the pilot program under this section on the use of patient decision aids approved by the expert panel.

(f) REQUIREMENTS.—

(1) IMPLEMENTATION OF APPROVED PATIENT DECISION AIDS.—

(A) IN GENERAL.—During phase II of the pilot program under this section, an eligible provider participating in the pilot program shall incorporate 1 or more patient decision aids approved by the expert panel established under section 4(b) in furnishing items and services to Medicare beneficiaries with respect to 1 or more of the conditions identified in subsection (g), together with ongoing support involved in furnishing such items and services.

(B) DEFINED CLINICAL PROCESS.—During each phase of the pilot program under this section, the eligible provider shall establish and implement a defined clinical process under which, in the case of a Medicare beneficiary with 1 or more of such conditions, the eligible provider offers the Medicare beneficiary shared decision making (supported by such a patient decision aid) and collects information on the quality of patient decision making with respect to the Medicare beneficiary.

(2) FOLLOW-UP COUNSELING VISIT.—

(A) IN GENERAL.—During each phase of the pilot program under this section, an eligible provider participating in the pilot program under this section shall routinely schedule Medicare beneficiaries for a counseling visit after the viewing of such a patient decision aid to answer any questions the beneficiary may have with respect to the medical care of the condition involved and to assist the beneficiary in thinking through how their preferences and concerns relate to their medical care.

(B) PAYMENT FOR FOLLOW-UP COUNSELING VISIT.—The Secretary shall establish procedures for making payments for such counseling visits provided to Medicare beneficiaries during each phase of the pilot program under this section. Such procedures shall provide for the establishment—

(i) of a code (or codes) to represent such services; and

(ii) of a single payment amount for such service that includes the professional time of the health care provider and a portion of the reasonable costs of the infrastructure of the eligible provider.

(C) LIMITATION.—In the case of an eligible provider that is a Medicare Advantage plan, such eligible provider may not receive payment for such services.

(3) WAIVER OF COINSURANCE.—The Secretary shall establish procedures under which an eligible provider participating in the pilot program under this section may, in the case of a low-income Medicare beneficiary (as determined by the Secretary), waive any coinsurance or copayment that would otherwise apply for the follow-up counseling visit provided to such Medicare beneficiary under paragraph (2).

(4) COSTS OF IMPLEMENTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), during each phase of the pilot program, an eligible provider participating in the pilot program shall be responsible for the costs of selecting, purchasing, and incorporating such patient decision aids into the group practice, reporting data on quality measures selected under subsection (h)(1), and recording outcomes under the pilot program.

(B) FINANCIAL SUPPORT.—During each such phase, the Secretary may, in addition to payments for counseling visits under paragraph (2), provide financial support to an eligible provider participating in the pilot program to acquire the infrastructure necessary to participate in the pilot program, including the development of clinical pathways to assure that Medicare beneficiaries have access to high-quality shared decision making, the reporting of data on quality measures selected under subsection (h)(1), and the recording of outcomes under the pilot program after phase I of the pilot program (as determined appropriate by the Secretary).

(g) PREFERENCE SENSITIVE CARE DESCRIBED.—The patient decision aids approved under section 4(b)(2)(A) shall, to the extent practicable, include patient decision aids for medical care of the following conditions:

(1) Arthritis of the hip and knee.

(2) Chronic back pain.

(3) Chest pain (stable angina).

(4) Enlarged prostate (benign prostatic hypertrophy, or BPH).

(5) Early-stage prostate cancer.

(6) Early-stage breast cancer.

(7) End-of-life care.

(8) Peripheral vascular disease.

(9) Gall stones.

(10) Threat of stroke from carotid artery disease.

(11) Any other condition the Secretary identifies as appropriate.

(h) QUALITY MEASURES.—

(1) SELECTION.—

(A) IN GENERAL.—During each phase of the pilot program, the Secretary shall measure the quality and implementation of shared decision making. For purposes of making such measurements, the Secretary shall select, from among those quality measures recommended by the expert panel under section 4(b)(2)(C), consensus-based quality measures that assess Medicare beneficiaries' knowledge of the options for medical treatment relevant to their medical condition, as well as the benefits and drawbacks of those medical treatment options, and the Medicare beneficiaries' goals and concerns regarding their medical care.

(B) RISK ADJUSTMENT.—In order to ensure accurate measurement across quality measures and eligible providers, the Secretary may risk adjust the quality measures selected under this paragraph to control for external factors, such as cognitive impairment, dementia, and literacy.

(2) REPORTING DATA ON MEASURES.—During each such phase, an eligible provider participating in the pilot program shall report to the Secretary data on quality measures selected under paragraph (1) in accordance with procedures established by the Secretary.

(3) FEEDBACK ON MEASURES.—During each such phase, the Secretary shall provide confidential reports to eligible providers participating in the pilot program on the performance of the eligible provider on quality measures selected by the Secretary under paragraph (1), the aggregate performance of all eligible providers participating in the pilot program, and any improvements in such performance.

(i) EVALUATIONS AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall enter into a contract with an entity that has knowledge of shared decision making programs and demonstrated experience in the evaluation of such programs for the conduct of an independent evaluation of each phase of the pilot program under this section.

(2) REPORTS BY ENTITY CONDUCTING INDEPENDENT EVALUATION.—

(A) INTERIM REPORT.—Not later than 2 years after the implementation of phase I of the pilot program, the entity with a contract under paragraph (1) shall submit to the Secretary a report on the initial results of the independent evaluation conducted under such paragraph.

(B) FINAL REPORT.—Not later then 4 years after the implementation of phase II of the pilot program, such entity shall submit to the Secretary a report on the final results of such independent evaluation.

(C) CONTENTS OF REPORT.—Each report submitted under this paragraph shall—

(i) include an assessment of—

(I) quality measures selected under subsection (h)(1);

(II) Medicare beneficiary and health care provider satisfaction under the applicable phase of the pilot program;

(III) utilization of medical services for Medicare beneficiaries with 1 or more of the conditions described in subsection (g) and other Medicare beneficiaries as determined appropriate by the Secretary;

(IV) appropriate utilization of shared decision making by eligible providers under the applicable phase of the pilot program;

(V) savings to the Medicare program under title XVIII of the Social Security Act; and

(VI) the costs to eligible providers participating in the pilot program of selecting, purchasing, and incorporating approved patient decision aids and meeting reporting requirements under the applicable phase of the pilot program; and

(ii) identify the characteristics of individual eligible providers that are most effective in implementing shared decision making under the applicable phase of the pilot program.

(3) REPORT BY THE SECRETARY.—Not later than 12 months after the completion of phase II of the pilot program, the Secretary shall submit to Congress a report on the pilot program that includes—

(A) the results of the independent evaluation conducted under paragraph (2);

(B) an evaluation of the impact of the pilot program under this section, including the impact—

(i) of the use of patient decision aids approved by the expert panel established under section 4(b) for the medical care of the conditions described in subsection (g);

(ii) on expenditures for such conditions under the Medicare program, including a comparison of such expenditures for such conditions where such patient decision aids were used to such expenditures for such conditions where such patient decision aids were not used; and

(iii) on Medicare beneficiaries, including the understanding by beneficiaries of the options for medical care presented, concordance between beneficiary values and the medical care received, the mode of approved patient decision aid used (such as Internet, videos, and pamphlets), the timing of the delivery of such approved patient decision aid (such as the date of the initial diagnosis), and beneficiary and health care provider satisfaction with the shared decision making process;

(C) an evaluation of which eligible providers are most effective at implementing patient decision aids and assisting Medicare beneficiaries in making informed decisions on medical care; and

(D) recommendations for such legislation and administrative action as the Secretary determines appropriate.

(j) SAVINGS.—

(1) IN GENERAL.—Subject to paragraph (2), not later than 2 years after the implementation of phase I of the pilot program, and annually thereafter for the duration of phase I and the first 2 years of phase II, the Secretary shall determine if there were any savings to the Medicare program as a result of such implementation during the preceding year (or years, if applicable). In the case where the Secretary determines there were such savings, the Secretary shall use such savings as follows:

(A) Fifty percent of such savings shall be used to provide bonus payments to eligible providers participating in the pilot program who achieve high quality shared decision making (as measured by the level of participation of Medicare beneficiaries in the shared decision making process and high scores by the eligible provider on quality measures selected under subsection (h)(1)).

(B) Twenty-five percent of such savings shall be placed in a Shared Decision Making Trust Fund established by the Secretary, which shall be used to expand participation in the pilot program to providers of services and suppliers in additional settings (as determined appropriate by the Secretary) by—

(i) providing financial assistance under subsection (c); and

(ii) providing for the development of quality measures not already selected under subsection (h)(1) to assess the impact of shared decision making on the quality of patient care or the improvement of such quality measures already selected.

(C) Twenty-five percent of such savings shall be retained by the Medicare program.

(2) RETENTION OF SAVINGS BY THE MEDICARE PROGRAM.—In the case where the Secretary determines there are savings to the Medicare program as a result of the implementation of the pilot program during a year (beginning with the third year of phase II), 100 percent of such savings shall be retained by the Medicare program.

(k) WAIVER.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act as may be necessary to carry out the pilot program under this section.

(l) FUNDING.—For purposes of carrying out section 4(a), implementing the pilot program under this section (including costs incurred in conducting the evaluation under subsection (i)), and carrying out section 1890(b)(1)(A)(iv) of the Social Security Act, as added by section 4(c), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) to the Centers for Medicare & Medicaid Services Program Management Account of $300,000,000 for the period of fiscal years 2010 through 2017.

SEC. 6. ESTABLISHMENT OF SHARED DECISION MAKING STANDARDS AND REQUIREMENTS IN MEDICARE.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''ESTABLISHMENT OF SHARED DECISION MAKING STANDARDS AND REQUIREMENTS

''SEC. 1899. (a) IN GENERAL.—Based on the findings of phases I and II of the pilot program under section 5 of the Empowering Medicare Patient Choices Act the Secretary shall promulgate regulations that—

''(1) specify for which preference sensitive conditions beneficiaries should, subject to the succeeding provisions of this section, participate in shared decision making;

''(2) require providers of services and suppliers to make sure that beneficiaries receive patient decision aids as appropriate; and

''(3) specify a process for beneficiaries to elect not to use such patient decision aids.

''(b) PENALTY FOR NOT USING SHARED DECISION MAKING.—Notwithstanding any other provision of this title, the Secretary shall promulgate such regulations and issue such guidance as may be necessary to reduce by 20 percent the amount of payment under this title that would otherwise apply to an item or service specified by the Secretary if the patient does not receive a patient decision aid prior to such item or service being furnished (except in the case where the beneficiary has elected not to use such patient decision aid under the process specified under subsection (a)(3)).

''(c) SECRETARIAL AUTHORITY TO WAIVE APPLICATION OF THIS SECTION.—The Secretary may waive the application of this section to an item or service under this title if the Secretary determines either of the following:

''(1) Medical societies and others have established evidence-based transparent standards incorporating patient decision aids and shared decision making into the standard of patient care for preference sensitive conditions.

''(2) Shared decision making is not in the best interest of beneficiaries.''.

By Mr. CASEY:

SA 1134. A bill to ensure the energy independence and economic viability of the Untied States by promoting the responsible use of coal through accelerated carbon capture and storage and through advanced clean coal technology research, development, demonstration, and deployment programs, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. CASEY. Mr. President, I rise today to introduce the Responsible Use of Coal Act of 2009. This bill provides the Department of Energy with the funding needed to continue to accelerate both the research and development and the demonstration, and ultimately, the deployment of carbon capture and storage, CCS, technology. Further, this bill would position the U.S. as the world leader in CCS technology development and export, creating the potential for thousands of new clean energy jobs.

Climate change is one of the most complex and challenging imperatives that our Nation, and, the world, has ever faced. We need to move forward in crafting a national program that will reduce our greenhouse gas emissions, encourage the use of renewable power, and create clean energy jobs. As we move forward, we must do so in a manner that will ensure our energy security, protect our industries from ''carbon leakage,'' help get our economy back on track, and enable us to continue to benefit from our most abundant, affordable energy resource—coal.

Today coal provides over half of the Nation's electricity. While coal use for energy generation has more than tripled since 1970, emissions of sulfur dioxide, nitrogen oxide, and particulate matter from power plants have been dramatically reduced as the power industry deploys technologies for capturing these pollutants. Now, responding to health concerns about mercury, power plants are implementing technology to capture this toxic element. This illustrates how the development and deployment of advanced technology has allowed coal to continue to play such an important role in our energy strategy in the face of strict environmental requirements.

Coal helps keep American homes, businesses, factories, airports, schools and hospitals humming. Coal creates millions of good-paying jobs across all sectors of the economy—from direct and indirect mining and electric utility jobs to all those businesses and industries, large and small, which depend on affordable electricity to compete in the global marketplace. Coal-based electricity keeps people warm on freezing nights and comfortable during the hottest of summer days. Coal provides the reliable, secure electricity needed for the myriad of medical procedures to detect and treat cancer, heart disease and other health threats, saving innumerous lives every year. Electricity from coal is there when you need it.

Much of the world depends on coal, and developing economies like China and India are increasingly relying on coal to power them into the 21st Century. Coal supplies more than 40 percent of worldwide electricity demand. For China, the amount of electricity from coal is astonishing. Eighty percent of China's electricity comes from coal. Prior to the current global recession, China built one to two new coal plants every week.

But the continued use of coal in the U.S. and abroad has a significant challenge ahead of it—climate change. While we have made progress in the U.S. in dealing with climate change, we are still at the beginning of the process of piecing together a domestic program that will work for all of the different regions of this country and that will reduce our greenhouse gas emissions so that we meet our global commitment.

One of the key pieces that must be included in our domestic program to help meet the challenge of climate change is carbon capture and storage. I am sponsoring the Responsible Use of Coal Act of 2009 to supplement funding under the American Recovery and Reinvestment Act by further accelerating the Department of Energy's CCS research, development, demonstration, and deployment programs. Specifically the bill will promote the rapid commercial demonstration and early deployment of carbon capture and storage systems that will allow the Nation to continue to use its abundant, secure, and low-cost coal resources while moving forward with a national program to reduce the impact of man-made emissions on our environment.

The bill will promote the continued research and development of advanced CCS and other coal power generation technologies in order to drive down costs, increase performance, and foster innovation. It is crucial that, in parallel to the commercial demonstration of current CCS technology, we continue to develop and advance new CCS ideas and concepts through a robust research and development program in order to continue to lower the cost of complying with CO_2 regulations.

The bill will promote the export of U.S. CCS technologies to those countries, such as China and India, which also rely on coal as their dominant energy source—ensuring that the U.S. is the leader in developing and exporting clean coal technologies and taking advantage of the thousands of new clean energy jobs such an industry would create.

I am fully committed to work with my colleagues in the Senate in addressing climate change. At the same time, I believe that the Nation needs to recognize the critical role coal plays in driving our economic engine and to aggressively move forward in the research, development, demonstration, and deployment of CCS technology.

I urge all of my colleagues to join me in ensuring that the United States continues to enjoy the economic and energy security advantages that our domestic coal resources afford us while we move forward in crafting legislation

that will reduce our emissions of greenhouse gases.

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. 1134

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 ''Responsible Use of Coal Act of 2009''.

SEC. 2. DEFINITIONS.

In this Act:

(1) CARBON CAPTURE AND STORAGE TECHNOLOGY.—The term ''carbon capture and storage technology'' means an advanced technology or concept that the Secretary determines to have the potential—

(A) to capture or remove—

(i) carbon dioxide that is emitted from a coal-fired power plant; and

(ii) other industrial sources;

(B) to store carbon dioxide in geological formations; and

(C) to use carbon dioxide for—

(i) enhanced oil and natural gas recovery; or

(ii) other large-volume, beneficial uses.

(2) CARBON CAPTURE TECHNOLOGY.—

(A) IN GENERAL.—The term ''carbon capture technology'' means any precombustion technology, post-combustion technology, or oxy-combustion technology or process.

(B) INCLUSION.—The term ''carbon capture technology'' includes carbon dioxide compression technology.

(3) ENHANCED OIL AND NATURAL GAS RECOVERY.—The term ''enhanced oil and natural gas recovery'' means the use of carbon dioxide to improve or enhance the recovery of oil or natural gas from a depleted oil or natural gas field.

(4) PRECOMBUSTION TECHNOLOGY.—The term ''precombustion technology'' means a coal or coal-biomass gasification or integrated gasification combined-cycle process coupled with carbon dioxide storage or reuse.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Energy.

SEC. 3. PURPOSES.

The purposes of this Act are—

(1) to promote the continued responsible use of the abundant, secure, and low-cost coal resources of the United States through the research, development, demonstration, and deployment of—

(A) carbon capture and storage technologies; and

(B) advanced coal power generation technologies;

(2) to promote the exportation of the carbon capture and storage technologies and advanced coal power generation technologies developed by the United States to countries that rely on coal as the dominant energy source of the countries (including China and India); and

(3) to support the deployment of carbon capture and storage technologies by—

(A) quantifying the risks of the technologies; and

(B) helping to establish the most appropriate framework for managing liabilities associated with all phases of carbon capture and storage technology projects, including—

(i) the capture and transportation of carbon dioxide; and

(ii) the siting, design, operation, closure, and long-term stewardship of carbon dioxide storage facilities.

SEC. 4. PROGRAMS.

(a) RESEARCH AND DEVELOPMENT PROGRAM.—

(1) IN GENERAL.—As soon as practicable after the date of enactment of this Act, in accordance with paragraph (2) and subsection (b), the Secretary, acting through the Director of the National Energy Technology Laboratory, shall carry out a research, development, and demonstration program through the National Energy Technology Laboratory to further advance carbon capture and storage and coal power generation technologies.

(2) REQUIRED PROGRAMS.—The program described in paragraph (1) shall include each program described in paragraphs (3) through (6).

(3) COMMERCIAL DEMONSTRATION PROGRAM.—As soon as practicable after the date of enactment of this Act, the Secretary, acting through the Director of the National Energy Technology Laboratory, shall carry out a large-scale commercial demonstration program to evaluate the most promising carbon capture and storage technologies.

(4) RESEARCH AND DEVELOPMENT PROGRAM REGARDING CARBON CAPTURE TECHNOLOGIES.—As soon as practicable after the date of enactment of this Act, the Secretary shall carry out a research and development program under which the Secretary shall evaluate carbon capture technologies to decrease the cost, and increase the performance, of carbon capture technologies.

(5) RESEARCH AND DEVELOPMENT PROGRAM REGARDING CARBON DIOXIDE STORAGE.—As soon as practicable after the date of enactment of this Act, the Secretary shall carry out a research and development program under which the Secretary shall evaluate options for carbon dioxide storage in geological formations—

(A) for enhanced oil and natural gas recovery; and

(B) to decrease the cost, and increase the performance, of carbon capture and storage technologies in existence as of the date of enactment of this Act.

(6) RESEARCH AND DEVELOPMENT PROGRAM REGARDING ADVANCED CLEAN COAL POWER GENERATION TECHNOLOGIES.—As soon as practicable after the date of enactment of this Act, the Secretary shall carry out a research and development program under which the Secretary shall evaluate advanced clean coal power generation technologies to make practicable—

(A) the capture and storage of carbon dioxide; and

(B) highly efficient power generation (including advanced turbines, fuel cells, hydrogen production, and advanced gasification).

(b) COST-SHARING REQUIREMENTS.—

(1) COMMERCIAL DEMONSTRATION PROGRAM.—The Federal share of the cost of any competitively procured project carried out using funds provided under the commercial demonstration program described in subsection (a)(3) shall be not more than 50 percent.

(2) OTHER PROGRAMS.—The Federal share of the cost of any competitively procured project carried out using funds provided under a program described in paragraph (4), (5), or (6) of subsection (a) shall be not more than 80 percent.

SEC. 5. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to the Secretary—

(1) to carry out the commercial demonstration program under section 4(a)(3)—

(A) $300,000,000 for fiscal year 2010;

(B) $350,000,000 for fiscal year 2011;

(C) $400,000,000 for fiscal year 2012; and

(D) $400,000,000 for fiscal year 2013;

(2) to carry out the research and development program under section 4(a)(4)—

(A) $80,000,000 for fiscal year 2010;

(B) $100,000,000 for fiscal year 2011;

(C) $120,000,000 for fiscal year 2012; and

(D) $120,000,000 for fiscal year 2013;

(3) to carry out the research and development program under section 4(a)(5)—

(A) $170,000,000 for fiscal year 2010;

(B) $200,000,000 for fiscal year 2011;

(C) $225,000,000 for fiscal year 2012; and

(D) $225,000,000 for fiscal year 2013; and

(4) to carry out the research and development program under section 4(a)(6)—

(A) $250,000,000 for fiscal year 2010;

(B) $270,000,000 for fiscal year 2011;

(C) $300,000,000 for fiscal year 2012; and

(D) $300,000,000 for fiscal year 2013.

By Ms. STABENOW (for herself, Mr. BROWNBACK, Mr. DURBIN, Mr. VOINOVICH, Mr. LEVIN, Mr. BROWN, Ms. MIKULSKI, and Mr. LIEBERMAN):

S. 1135. A bill to establish a voluntary program in the National Highway Traffic Safety Administration to encourage consumers to trade-in older vehicles for more fuel efficient vehicles, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Ms. STABENOW. 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. 1135

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 ''Drive America Forward Act of 2009''.

SEC. 2. DRIVE AMERICA FORWARD PROGRAM.

(a) ESTABLISHMENT.—There is established in the National Highway Traffic Safety Administration a voluntary program to be known as the ''Drive America Forward Program'' through which the Secretary, in accordance with this section and the regulations promulgated under subsection (d), shall—

(1) authorize the issuance of an electronic voucher, subject to the specifications set forth in subsection (c), to offset the purchase price or lease price for a qualifying lease of a new fuel efficient automobile upon the surrender of an eligible trade-in vehicle to a dealer participating in the Program;

(2) certify dealers for participation in the Program—

(A) to accept vouchers as provided in this section as partial payment or down payment for the purchase or qualifying lease of any new fuel efficient automobile offered for sale or lease by that dealer; and

(B) in accordance with subsection (c)(2), to transfer each eligible trade-in vehicle surrendered to the dealer under the Program to an entity for disposal;

(3) in consultation with the Secretary of the Treasury, make electronic payments to dealers for vouchers accepted by such dealers, in accordance with the regulations issued under subsection (d);

(4) in consultation with the Secretary of the Treasury, provide for the payment of rebates to persons who qualify for a rebate under subsection (c)(3); and

(5) in consultation with the Secretary of the Treasury and the Inspector General of the Department of Transportation, establish and provide for the enforcement of measures to prevent and penalize fraud under the Program.

(b) QUALIFICATIONS FOR AND VALUE OF VOUCHERS.—A voucher issued under the Program shall have a value that may be applied to offset the purchase price or lease price for a qualifying lease of a new fuel efficient automobile as follows:

(1) $3,500 VALUE.—The voucher may be used to offset the purchase price or lease price of the new fuel efficient automobile by $3,500 if—

(A) the new fuel efficient automobile is a passenger automobile and the combined fuel economy value of such automobile is at least 4 miles per gallon higher than the combined fuel economy value of the eligible trade-in vehicle;

(B) the new fuel efficient automobile is a category 1 truck and the combined fuel economy value of such truck is at least 2 miles per gallon higher than the combined fuel economy value of the eligible trade-in vehicle;

(C) the new fuel efficient automobile is a category 2 truck that has a combined fuel economy value of at least 15 miles per gallon and—

(i) the eligible trade-in vehicle is a category 2 truck and the combined fuel economy value of the new fuel efficient automobile is at least 1 mile per gallon higher than the combined fuel economy value of the eligible trade-in vehicle; or

(ii) the eligible trade-in vehicle is a category 3 truck of model year 2001 or earlier; or

(D) the new fuel efficient automobile is a category 3 truck and the eligible trade-in vehicle is a category 3 truck of model year of 2001 or earlier and is of similar size or larger than the new fuel efficient automobile as determined in a manner prescribed by the Secretary.

(2) $4,500 VALUE.—The voucher may be used to offset the purchase price or lease price of the new fuel efficient automobile by $4,500 if—

(A) the new fuel efficient automobile is a passenger automobile and the combined fuel economy value of such automobile is at least 10 miles per gallon higher than the combined fuel economy value of the eligible trade-in vehicle;

(B) the new fuel efficient automobile is a category 1 truck and the combined fuel economy value of such truck is at least 5 miles per gallon higher than the combined fuel economy value of the eligible trade-in vehicle; or

(C) the new fuel efficient automobile is a category 2 truck that has a combined fuel economy value of at least 15 miles per gallon and the combined fuel economy value of such truck is 2 miles per gallon higher than the combined fuel economy value of the eligible trade-in vehicle and the eligible trade-in vehicle is a category 2 truck.

(c) PROGRAM SPECIFICATIONS.—

(1) LIMITATIONS.—

(A) GENERAL PERIOD OF ELIGIBILITY.—A voucher issued under the Program shall be used only for the purchase or qualifying lease of new fuel efficient automobiles that occur between—

(i) March 30, 2009; and

(ii) the day that is 1 year after the date on which the regulations promulgated under subsection (d) are implemented.

(B) NUMBER OF VOUCHERS PER PERSON AND PER TRADE-IN VEHICLE.—Not more than 1 voucher may be issued for a single person and not more than 1 voucher may be issued for the joint registered owners of a single eligible trade-in vehicle.

(C) NO COMBINATION OF VOUCHERS.—Only 1 voucher issued under the Program may be applied toward the purchase or qualifying lease of a single new fuel efficient automobile.

(D) CAP ON FUNDS FOR CATEGORY 3 TRUCKS.—Not more than 7.5 percent of the total funds made available for the Program shall be used for vouchers for the purchase or qualifying lease of category 3 trucks.

(E) COMBINATION WITH OTHER INCENTIVES PERMITTED.—The availability or use of a Federal, State, or local incentive or a State-issued voucher for the purchase or lease of a new fuel efficient automobile shall not limit the value or issuance of a voucher under the Program to any person otherwise eligible to receive such a voucher.

(F) NO ADDITIONAL FEES.—A dealer participating in the program may not charge a person purchasing or leasing a new fuel efficient automobile any additional fees associated with the use of a voucher under the Program.

(G) NUMBER AND AMOUNT.—The total number and value of vouchers issued under the Program may not exceed the amounts appropriated for such purpose.

(2) DISPOSITION OF ELIGIBLE TRADE-IN VEHICLES.—

(A) IN GENERAL.—For each eligible trade-in vehicle surrendered to a dealer under the Program, the dealer shall certify to the Secretary, in such manner as the Secretary shall prescribe by rule, that the dealer—

(i) has not and will not sell, lease, exchange, or otherwise dispose of the vehicle for use as an automobile in the United States or in any other country; and

(ii) will transfer the vehicle (including the engine and drive train), in such manner as the Secretary prescribes, to an entity that will ensure that the vehicle—

(I) will be crushed or shredded within such period and in such manner as the Secretary prescribes; and

(II) has not been, and will not be, sold, leased, exchanged, or otherwise disposed of for use as an automobile in the United States or in any other country.

(B) SAVINGS PROVISION.—Nothing in subparagraph (A) may be construed to preclude a person who dismantles or disposes of the vehicle from—

(i) selling any parts of the disposed vehicle other than the engine block and drive train (unless the engine or drive train has been crushed or shredded); or

(ii) retaining the proceeds from such sale.

(C) COORDINATION.—The Secretary shall coordinate with the Attorney General to ensure that the National Motor Vehicle Title Information System and other publicly accessible systems are appropriately updated on a timely basis to reflect the crushing or shredding of vehicles under this section and appropriate reclassification of the vehicles' titles. The commercial market shall also have electronic and commercial access to the vehicle identification numbers of vehicles that have been disposed of on a timely basis.

(3) ELIGIBLE PURCHASES OR LEASES PRIOR TO DATE OF ENACTMENT.—A person who purchased or leased a new fuel efficient vehicle after March 30, 2009, and before the date of the enactment of this Act is eligible for a cash rebate equivalent to the amount described in subsection (b)(1) if the person provides proof satisfactory to the Secretary that—

(A)(i) the person was the registered owner of an eligible trade-in vehicle; or

(ii) if the person leased the vehicle, the lease was a qualifying lease; and

(B) the vehicle has been disposed of in accordance with clauses (i) and (ii) of paragraph (2)(A).

(d) REGULATIONS.—Notwithstanding the requirements of section 553 of title 5, United States Code, the Secretary shall promulgate final regulations to implement the Program not later than 30 days after the date of the enactment of this Act. Such regulations shall—

(1) provide for a means of certifying dealers for participation in the Program;

(2) establish procedures for the reimbursement of dealers participating in the Program to be made through electronic transfer of funds for both the amount of the vouchers and any reasonable administrative costs incurred by the dealer as soon as practicable but no longer than 10 days after the submission of a voucher for the new fuel efficient automobile to the Secretary;

(3) allow the dealer to use the voucher in addition to any other rebate or discount offered by the dealer or the manufacturer for the new fuel efficient automobile and prohibit the dealer from using the voucher to offset any such other rebate or discount;

(4) require dealers to disclose to the person trading in an eligible trade-in vehicle the best estimate of the scrappage value of such vehicle and to permit the dealer to retain $50 of any amounts paid to the dealer for scrappage of the automobile as payment for any administrative costs to the dealer associated with participation in the Program;

(5) establish a process by which persons who qualify for a rebate under subsection (c)(3) may apply for such rebate;

(6) consistent with subsection (c)(2), establish requirements and procedures for the disposal of eligible trade-in vehicles and provide such information as may be necessary to entities engaged in such disposal to ensure that such vehicles are disposed of in accordance with such requirements and procedures, including—

(A) requirements for the removal and appropriate disposition of refrigerants, antifreeze, lead products, mercury switches, and such other toxic or hazardous vehicle components prior to the crushing or shredding of an eligible trade-in vehicle, in accordance with rules established by the Secretary in consultation with the Administrator of the Environmental Protection Agency, and in accordance with other applicable Federal or State requirements;

(B) a mechanism for dealers to certify to the Secretary that each eligible trade-in vehicle will be transferred to an entity that will ensure that the vehicle is disposed of, in accordance with such requirements and procedures, and to submit the vehicle identification numbers of the vehicles disposed of and the new fuel efficient automobile purchased with each voucher; and

(C) a list of entities to which dealers may transfer eligible trade-in vehicles for disposal;

(7) consistent with subsection (c)(2), establish requirements and procedures for the disposal of eligible trade-in vehicles and provide such information as may be necessary to entities engaged in such disposal to ensure that such vehicles are disposed of in accordance with such requirements and procedures; and

(8) provide for the enforcement of the penalties described in subsection (e).

(e) ANTI-FRAUD PROVISIONS.—

(1) VIOLATION.—It shall be unlawful for any person to knowingly violate any provision under this section or any regulations issued pursuant to subsection (d).

(2) PENALTIES.—Any person who commits a violation described in paragraph (1) shall be liable to the United States Government for a civil penalty of not more than $15,000 for each violation.

(f) INFORMATION TO CONSUMERS AND DEALERS.—Not later than 30 days after the date of the enactment of this Act, and promptly upon the update of any relevant information, the Secretary shall make available on an Internet website and through other means determined by the Secretary information about the Program, including—

(1) how to determine if a vehicle is an eligible trade-in vehicle;

(2) how to participate in the Program, including how to determine participating dealers; and

(3) a comprehensive list, by make and model, of new fuel efficient automobiles meeting the requirements of the Program.

Once such information is available, the Secretary shall conduct a public awareness campaign to inform consumers about the Program and where to obtain additional information.

(g) RECORDKEEPING AND REPORT.—

(1) DATABASE.—The Secretary shall maintain a database of the vehicle identification numbers of all new fuel efficient vehicles purchased or leased and all eligible trade-in vehicles disposed of under the Program.

(2) REPORT.—Not later than 60 days after the termination date described in subsection (c)(1)(A)(ii), the Secretary shall submit a report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate describing the efficacy of the Program, including—

(A) a description of Program results, including—

(i) the total number and amount of vouchers issued for purchase or lease of new fuel efficient automobiles by manufacturer (including aggregate information concerning the make, model, model year) and category of automobile;

(ii) aggregate information regarding the make, model, model year, and manufacturing location of vehicles traded in under the Program; and

(iii) the location of sale or lease;

(B) an estimate of the overall increase in fuel efficiency in terms of miles per gallon, total annual oil savings, and total annual greenhouse gas reductions, as a result of the Program; and

(C) an estimate of the overall economic and employment effects of the Program.

(h) EXCLUSION OF VOUCHERS AND REBATES FROM INCOME.—

(1) FOR PURPOSES OF ALL FEDERAL PROGRAMS.—A voucher issued under the Program or a cash rebate issued under subsection (c)(3) shall not be regarded as income and shall not be regarded as a resource for the month of receipt of the voucher or rebate and the following 12 months, for purposes of determining the eligibility of the recipient of the voucher or rebate (or the recipient's spouse or other family or household members) for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program.

(2) FOR PURPOSES OF TAXATION.—A voucher issued under the Program or a cash rebate issued under subsection (c)(3) shall not be considered as gross income for purposes of the Internal Revenue Code of 1986.

(i) DEFINITIONS.—As used in this section—

(1) the term ''passenger automobile'' means a passenger automobile, as defined in section 32901(a)(18) of title 49, United States Code, that has a combined fuel economy value of at least 22 miles per gallon;

(2) the term ''category 1 truck'' means a nonpassenger automobile, as defined in section 32901(a)(17) of title 49, United States Code, that has a combined fuel economy value of at least 18 miles per gallon, except that such term does not include a category 2 truck;

(3) the term ''category 2 truck'' means a nonpassenger automobile, as defined in section 32901(a)(17) of title 49, United States Code, that is a large van or a large pickup, as categorized by the Secretary using the method used by the Environmental Protection Agency and described in the report entitled ''Light-Duty Automotive Technology and Fuel Economy Trends: 1975 through 2008'';

(4) the term ''category 3 truck'' means a work truck, as defined in section 32901(a)(19) of title 49, United States Code;

(5) the term ''combined fuel economy value'' means—

(A) with respect to a new fuel efficient automobile, the number, expressed in miles per gallon, centered below the words ''Combined Fuel Economy'' on the label required to be affixed or caused to be affixed on a new automobile pursuant to subpart D of part 600 of title 40, Code of Federal Regulations;

(B) with respect to an eligible trade-in vehicle, the equivalent of the number described in subparagraph (A), and posted under the words ''Estimated New EPA MPG'' and above the word ''Combined'' for vehicles of model year 1984 through 2007, or posted under the words ''New EPA MPG'' and above the word ''Combined'' for vehicles of model year 2008 or later on the fueleconomy.gov website of the Environmental Protection Agency for the make, model, and year of such vehicle; or

(C) with respect to an eligible trade-in vehicle manufactured between model years 1978 through 1984, the equivalent of the number described in subparagraph (A) as determined by the Secretary (and posted on the website of the National Highway Traffic Safety Administration) using data maintained by the Environmental Protection Agency for the make, model, and year of such vehicle;

(6) the term ''dealer'' means a person licensed by a State who engages in the sale of new automobiles to ultimate purchasers;

(7) the term ''eligible trade-in vehicle'' means an automobile or a work truck (as such terms are defined in section 32901(a) of title 49, United States Code) that, at the time it is presented for trade-in under this section—

(A) is in drivable condition;

(B) has been continuously insured consistent with the applicable State law and registered to the same owner for a period of not less than 1 year immediately prior to such trade-in;

(C) was manufactured less than 25 years before the date of the trade-in; and

(D) in the case of an automobile, has a combined fuel economy value of 18 miles per gallon or less;

(8) the term ''new fuel efficient automobile'' means an automobile described in paragraph (1), (2), (3), or (4)—

(A) the equitable or legal title of which has not been transferred to any person other than the ultimate purchaser;

(B) that carries a manufacturer's suggested retail price of $45,000 or less;

(C) that—

(i) in the case of passenger automobiles, category 1 trucks, or category 2 trucks, is certified to applicable standards under section 86.1811–04 of title 40, Code of Federal Regulations; or

(ii) in the case of category 3 trucks, is certified to the applicable vehicle or engine standards under section 86.1816–08, 86.007–11, or 86.008–10 of title 40, Code of Federal Regulations; and

(D) that has the combined fuel economy value of—

(i) 22 miles per gallon for a passenger automobile;

(ii) 18 miles per gallon for a category 1 truck; or

(iii) 15 miles per gallon for a category 2 truck;

(9) the term ''Program'' means the Drive America Forward Program established by this section;

(10) the term ''qualifying lease'' means a lease of an automobile for a period of not less than 5 years;

(11) the term ''scrappage value'' means the amount received by the dealer for a vehicle upon transferring title of such vehicle to the person responsible for ensuring the dismantling and destroying the vehicle;

(12) the term ''Secretary'' means the Secretary of Transportation acting through the National Highway Traffic Safety Administration;

(13) the term ''ultimate purchaser'' means, with respect to any new automobile, the first person who in good faith purchases such automobile for purposes other than resale; and

(14) the term ''vehicle identification number'' means the 17-character number used by the automobile industry to identify individual automobiles.

SEC. 3. REALLOCATION OF APPROPRIATIONS.

From the amounts appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the Director of the Office of Management and Budget may allocate such sums as the Director determines to be necessary to carry out the Drive America Forward Program established under this Act.

By Mr. FEINGOLD (for himself, Ms. SNOWE, Mrs. LINCOLN, Mr. SANDERS, and Mr. DODD):

S. 1137. A bill to amend the Elementary and Secondary Education Act of 1965 to establish a Volunteer Teacher Advisory Committee; to the Committee on Health, Education, Labor, and Pensions.

Mr. FEINGOLD. Mr. President, I am today introducing the Teachers at the Table Act of 2009. This bill is the Senate companion to legislation introduced in the House of Representatives by Representative Carolyn McCarthy of New York and Representative LEE Terry of Nebraska and would create a Volunteer Teacher Advisory Committee to advise Congress and the Department of Education on the impact of the Elementary and Secondary Education Act, ESEA, also known as No Child Left Behind, NCLB, on students, their families, and the classroom learning environment. The teachers serving on this committee would be chosen from past or present State or national Teachers of the Year and would be competitively selected by the Secretary of Education and the majority and minority leaders of both the Senate and the House of Representatives.

Every year I travel to each of Wisconsin's 72 counties to hold a listening session to listen to Wisconsinites' concerns and answer their questions. Since NCLB was enacted in early 2002, education has rated as one of the top issues brought up at these listening sessions. I have received feedback from constituents about the noble intentions of NCLB, but I have also heard about the multitude of implementation problems with the law's provisions. The feedback from teachers, parents, school administrators, and school board members has been invaluable over the past 7 years and has guided many of my education policymaking decisions.

As Congress seeks to undertake the reauthorization of ESEA this year, it is my hope that this legislation can be part of the reauthorization. Feedback

from good teachers is absolutely vital to understanding how federal education policy is impacting classroom instruction around the country. This legislation seeks to help ensure that continuous feedback is provided to Congress about how the reauthorized ESEA is impacting student achievement and closing the persistent achievement gap that exists in our Nation.

The Teachers at the Table bill I am introducing today seeks to help ensure that Congress and the Department of Education receive high-quality yearly feedback on how ESEA/NCLB is impacting classroom learning around the country. The teachers who will serve on this committee represent some of the best that teaching has to offer. The bill would create a committee of 20 teachers, with 4 selected by the Secretary of Education and 4 selected by each of the majority and minority leaders in the Senate and House of Representatives. These teachers would serve 2-year terms on the advisory committee and would work to prepare annual reports to Congress as well as quarterly updates on the law's implementation.

Every State and every school district is different and this legislation ensures that the teacher advisory committee will represent a wide range of viewpoints. The bill specifies that the volunteer teacher advisory committee should include teachers from diverse geographic areas, teachers who teach different grade levels, and teachers from a variety of specialty areas. Creating a diverse committee will help ensure that the committee presents a broad range of viewpoints on ESEA/NCLB to Congress and the Department of Education.

Much work needs to be done this year to reform many of the mandates of ESEA/NCLB and I look forward to working with my colleagues during the reauthorization to make those necessary changes. One thing is certain whatever form the reauthorized ESEA takes, there will be a need for consistent feedback from a diverse range of viewpoints.

We need to ensure that the voices of students, educators, parents, and administrators, who are on the frontlines of education reform in our country, are heard during the reauthorization of ESEA and going forward during the reauthorized law's implementation in years to come. This bill seeks to help address that need by enlisting the service of some of America's best teachers in providing information to Federal education policymakers. The advisory committee created by this legislation will provide nationwide feedback and will allow Congress to hear about ESEA/NCLB directly from those who deal with the law and its consequences on a daily basis.

By Mrs. FEINSTEIN (for herself and Mrs. BOXER):

S. 1138. A bill to amend the Reclamation Wastewater and Groundwater Study and Facilities Act to expand the Bay Area Regional Recycling Program, and for other purposes; to the Committee on Energy and Natural Resources.

Mrs. FEINSTEIN. Mr. President, I rise on behalf of myself and Senator BOXER to introduce the Bay Area Regional Water Recycling Program Expansion Act of 2009, which will reduce demand for limited fresh water supplies by providing recycled water to 6 communities across the Bay Area.

It will make 6 additional Bay Area recycled water projects eligible for a 25 percent Federal cost-share, and expand the authorizations for two more, totaling $38,075,000. The activities authorized by the new legislation include installing new piping, storage tanks, and pump stations to convey the recycled water to a number of cities across the Bay Area.

These projects collectively will save 2.6 billion gallons per year of regional water supply by providing a new water supply of clean treated wastewater for irrigation and industrial use. It will free up the amount needed to supply 24,225 households in the growing Bay Area region. And to the regional agencies, over 3,500 local green jobs will be supported by this legislation.

The adoption of water recycling technology is an invaluable conservation method which will result in 8,000 acre-feet of new and reliable water which will reduce demand on fresh water from the Delta.

California is facing phenomenal water supply challenges that are affecting our economy, our communities and our environment.

California's water infrastructure is woefully out of date. Drought, population growth, climate variability, ecosystem needs and a broken Delta are making it even more difficult to manage our water system and deliver reliable supplies.

And unless we take action to address climate change, we could lose a significant portion of the Sierra snowpack, which stores water for 2/3 of California, by 2100.

Increasing the capability for and use of recycled water will help address California's cycles of drought and reduce dependence on water from the troubled Bay-Delta ecosystem.

Water recycling projects are already under way in several local Bay Area communities, and have qualified for Federal funding under the Bay Area Regional Water Recycling Program. This program allows local water managers to treat wastewater and use the clean, recycled water for landscape irrigation and other uses, including at golf courses, schools, city parks and other municipal facilities. Under the new legislation, the six additional Bay Area communities would be allowed to work with the Federal Bureau of Reclamation to use water supplies more efficiently.

With the increasing strain on Bay-Delta and other natural resources, it is vital that we look to adopt innovative water recycling technologies which sustain permanent clean water supplies and support existing water resources and local economies.

Nine Bay Area congressional representatives in the House put this regional approach together, and I'd like to recognize and thank them for their leadership: GEORGE MILLER, D-Martinez, Pete Stark, D-Fremont, ELLEN TAUSCHER, D-Concord, ANNA ESHOO, D-Palo Alto, MIKE HONDA, D-San Jose, LYNN WOOLSEY, D-Petaluma, JERRY MCNERNEY, D-Pleasanton, ZOE LOFGREN, D-San Jose and JACKIE SPEIER, D-San Mateo, worked together to address the Bay Area's water needs.

This bill reflects a federal-local partnership and will provide communities in the San Francisco Bay Area with reliable and sustainable water supplies, and be a benchmark for other major American cities.

Declining water supplies affects people from all across the United States. Now is the time to invest in new water technologies, such as water recycling, to meet increasing needs. Wastewater recycling is an important part of a multifaceted water supply strategy that also includes surface and groundwater storage, improved conveyance, conservation, and desalination.

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. 1138

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 ''Bay Area Regional Water Recycling Program Expansion Act of 2009''.

SEC. 2. PROJECT AUTHORIZATIONS.

(a) IN GENERAL.—The Reclamation Wastewater and Groundwater Study and Facilities Act (43 U.S.C. 390h et seq.) (as amended by section 512(a) of the Consolidated Natural Resources Act of 2008) is amended by adding at the end the following:

''SEC. 1649. CCCSD-CONCORD RECYCLED WATER PROJECT.

''(a) AUTHORIZATION.—The Secretary, in cooperation with the Central Contra Costa Sanitary District, California, is authorized to participate in the design, planning, and construction of recycled water distribution systems.

''(b) COST SHARE.—The Federal share of the cost of the project authorized by this section shall not exceed 25 percent of the total cost of the project.

''(c) LIMITATION.—The Secretary shall not provide funds for the operation and maintenance of the project authorized by this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,800,000.

''SEC. 1650. CENTRAL DUBLIN RECYCLED WATER DISTRIBUTION AND RETROFIT PROJECT.

''(a) AUTHORIZATION.—The Secretary, in cooperation with the Dublin San Ramon Services District, California, is authorized to participate in the design, planning, and construction of recycled water system facilities.

''(b) COST SHARE.—The Federal share of the cost of the project authorized by this section shall not exceed 25 percent of the total cost of the project.

''(c) LIMITATION.—The Secretary shall not provide funds for the operation and maintenance of the project authorized by this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $1,150,000.

''SEC. 1651. PETALUMA RECYCLED WATER PROJECT, PHASES 2A, 2B, AND 3.

''(a) AUTHORIZATION.—The Secretary, in cooperation with the City of Petaluma, California, is authorized to participate in the design, planning, and construction of recycled water system facilities.

''(b) COST SHARE.—The Federal share of the cost of the project authorized by this section shall not exceed 25 percent of the total cost of the project.

''(c) LIMITATION.—The Secretary shall not provide funds for the operation and maintenance of the project authorized by this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $6,000,000.

''SEC. 1652. CENTRAL REDWOOD CITY RECYCLED WATER PROJECT.

''(a) AUTHORIZATION.—The Secretary, in cooperation with the City of Redwood City, California, is authorized to participate in the design, planning, and construction of recycled water system facilities.

''(b) COST SHARE.—The Federal share of the cost of the project authorized by this section shall not exceed 25 percent of the total cost of the project.

''(c) LIMITATION.—The Secretary shall not provide funds for the operation and maintenance of the project authorized by this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $8,000,000.

''SEC. 1653. PALO ALTO RECYCLED WATER PIPELINE PROJECT.

''(a) AUTHORIZATION.—The Secretary, in cooperation with the City of Palo Alto, California, is authorized to participate in the design, planning, and construction of recycled water system facilities.

''(b) COST SHARE.—The Federal share of the cost of the project authorized by this section shall not exceed 25 percent of the total cost of the project.

''(c) LIMITATION.—The Secretary shall not provide funds for the operation and maintenance of the project authorized by this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $8,250,000.

''SEC. 1654. IRONHOUSE SANITARY DISTRICT (ISD) ANTIOCH RECYCLED WATER PROJECT.

''(a) AUTHORIZATION.—The Secretary, in cooperation with the Ironhouse Sanitary District (ISD), California, is authorized to participate in the design, planning, and construction of recycled water distribution systems.

''(b) COST SHARE.—The Federal share of the cost of the project authorized by this section shall not exceed 25 percent of the total cost of the project.

''(c) LIMITATION.—The Secretary shall not provide funds for the operation and maintenance of the project authorized by this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $7,000,000.''.

(b) PROJECT IMPLEMENTATION.—In carrying out sections 1642 through 1648 of the Reclamation Wastewater and Groundwater Study and Facilities Act, and sections 1649 through 1654 of such Act, as added by subsection (a), the Secretary shall enter into individual agreements with the San Francisco Bay Area Regional Water Recycling implementing agencies to fund the projects through the Bay Area Clean Water Agencies (BACWA) or its successor, and shall include in such agreements a provision for the reimbursement of construction costs, including those construction costs incurred prior to the enactment of this Act.

(c) CLERICAL AMENDMENTS.—The table of contents of the Reclamation Projects Authorization and Adjustment Act of 1992 (43 U.S.C. prec. 371) (as amended by section 512(a) of the Consolidated Natural Resources Act of 2008) is amended by inserting after the item relating to section 1648 the following new items:

''Sec. 1649. CCCSD-Concord recycled water project.
''Sec. 1650. Central Dublin recycled water distribution and retrofit project.
''Sec. 1651. Petaluma recycled water project, phases 2a, 2b, and 3.
''Sec. 1652. Central Redwood City recycled water project.
''Sec. 1653. Palo Alto recycled water pipeline project.
''Sec. 1654. Ironhouse Sanitary District (ISD) Antioch recycled water project.''.

SEC. 3. MODIFICATION TO AUTHORIZED PROJECTS.

(a) ANTIOCH RECYCLED WATER PROJECT.—Section 1644(d) of the Reclamation Wastewater and Groundwater Study and Facilities Act (43 U.S.C. 390h–27) (as amended by section 512(a) of the Consolidated Natural Resources Act of 2008) is amended by striking ''$2,250,000'' and inserting ''$3,125,000''.

(b) SOUTH BAY ADVANCED RECYCLED WATER TREATMENT FACILITY.—Section 1648(d) of the Reclamation Wastewater and Groundwater Study and Facilities Act (43 U.S.C. 390h–31) (as amended by section 512(a) of the Consolidated Natural Resources Act of 2008) is amended by striking ''$8,250,000'' and inserting ''$13,250,000''.

By Mr. WYDEN:

S. 1139. A bill to require the Secretary of Agriculture to enter into a property conveyance with the city of Wallowa, Oregon, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. WYDEN. Mr. President, today I am pleased to introduce two bills that will provide two important communities in rural Oregon with the means to promote their cultural history and their economic development opportunities, S. 1139 and S. 1140.

Like anywhere in America, the leaders in rural communities in my state are working every day to build the best place they can. And in many rural communities in my state, that means not much happens without the Federal Government involved. Like many places in the Western United States, the Federal Government owns much of the land surrounding these small communities. To be sure, many of these lands are treasures; they are the source of a vibrant tourism economy; an attraction for individuals and businesses to move to the region; and the daily outlet for the people lucky enough to live there.

By the same token, this high percentage of Federal land ownership sometimes limits the ability of local governments and civic leaders to solve problems and serve the public. The Federal Government can and should be an active partner in advancing communities and improving a region's quality of life.

So today I am introducing legislation that demonstrates the possibilities that can come from a quality Federal Government partnership with a proactive, innovative community that faces challenging economic conditions and a dominant pattern of Federal land ownership.

My first bill, the La Pine Land Conveyance Act, would convey two parcels of property to Deschutes County, Oregon. The bill directs the transfer of Bureau of Land Management BLM, lands to Deschutes County, that will enable the small town of La Pine to develop rodeo and equestrian facilities, public parks, and other recreation facilities.

La Pine has a set of unique challenges well known to the people of Deschutes County. The town recently incorporated, and with incorporation has come a feeling in the community that good things can happen if they work together to make their town as good as it can possibly be.

My bill proposes the transfer of 320 acres of BLM land contiguous to the La Pine city limit, on its western boundary. Ownership of this location will enable construction of public equestrian and rodeo facilities that have become increasingly important in La Pine. The property is within reasonable walking distance of downtown, creating an ideal parade route for the annual 4th of July Frontier Days parade. In addition, the land will provide a location for development of ball fields, parks, and recreation facilities, which can be developed as the town grows and budgets allow.

The La Pine Rodeo and Frontier Days events are currently facing the last year they can hold their events on the currently utilized location because that private property is being developed for other uses. So looking towards the Federal Government, who controls the vast majority of land in the La Pine area, to find a solution provides the right kind of partnership between the federal and local government.

My bill also directs the transfer of approximately 750 acres of BLM lands to Deschutes County for the purpose of expanding the town's wastewater treatment operation.

More than two years ago my office participated in discussions between the La Pine community leaders and the BLM concerning the La Pine community's need for land to serve public purposes. Due to staffing limitations, BLM asked the City to choose one top priority for a land transfer under the Recreation and Public Purposes Act. The La Pine City Council responded immediately that its top priority was

the acquisition of land to enable expansion of their sewer district.

To date, the land has not been transferred, which make this small community unable to be competitive for state and federal economic stimulus funds.

This project is too important to let languish. Perhaps the most important issue affecting water quality in Deschutes County involves the threat to groundwater and the Deschutes River from household septic systems in southern Deschutes County, the region around La Pine. This project directly reduces nitrate loading into south county groundwater in two ways. First, by enabling expansion of the District service boundary to residential areas where septic systems are generating elevated groundwater nitrate levels; and second, by closing the current location for spreading treated effluent, over a relatively high groundwater area, to this new location which is judged not to threaten groundwater. That is why I am introducing legislation today to make sure this transfer moves forward.

My second bill, the Wallowa Forest Service Compound Conveyance Act would convey an old Forest Service Ranger Station compound to the City of Wallowa, Oregon. In Wallowa County, this Forest Service compound was built by the Civilian Conservation Corps in the 1930's. For many years it was the center of town and this site continues to represent the natural and cultural history of one of eastern Oregon's most beautiful communities. The City of Wallowa, along with County Commissioners, the local arts organizations, and a broad group of community leaders intend to restore this important example of Pacific Northwest rustic architecture and tribute to bygone times, making a valuable community interpretive center at this site. The conveyance of this property will allow the community to move forward with this project. The community is currently working to list the Ranger Station on the National Register of Historic Places, and ownership by the City will allow this coalition to restore the buildings and again develop a vibrant community center. Oregon Public Broadcasting aired a segment depicting an early 20th century railroad logging community—a significant part of the rich and diverse history and traditions that will be preserved and celebrated as this Forest Service Compound is developed as an interpretive center.

I want to express my thanks to all the citizens and community leaders that have worked to build their communities and develop these projects. They represent the pioneering spirit and vision that defines my State.

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. 1139

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 ''Wallowa Forest Service Compound Conveyance Act''.

SEC. 2. CONVEYANCE TO CITY OF WALLOWA, OREGON.

(a) DEFINITIONS.—In this Act:

(1) CITY.—The term ''City'' means the city of Wallowa, Oregon.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Agriculture.

(3) WALLOWA FOREST SERVICE COMPOUND.—The term ''Wallowa Forest Service Compound'' means the Wallowa Ranger Station that is—

(A) located at 602 West First Street, Wallowa, Oregon; and

(B) under the jurisdiction of the Secretary.

(b) DUTY OF SECRETARY.—As soon as practicable after the date of enactment of this Act, subject to valid existing rights, the Secretary shall convey to the City, without consideration and by quitclaim deed, all right, title, and interest of the United States, except as provided in subsections (c) and (d), in and to the Wallowa Forest Service Compound.

(c) USE OF WALLOWA FOREST SERVICE COMPOUND.—As a condition of the conveyance under subsection (b), the City shall—

(1) use the Wallowa Forest Service Compound as an interpretive center;

(2) ensure that the Wallowa Forest Service Compound is managed by a nonprofit entity; and

(3) agree to manage the Wallowa Forest Service Compound—

(A) with due consideration and protection for the historic values of the Wallowa Forest Service Compound; and

(B) in accordance with such terms and conditions as are agreed to by the Secretary and the City.

(d) REVERSION.—In the quitclaim deed to the City, the Secretary shall provide that the Wallowa Forest Service Compound shall revert to the Secretary, at the election of the Secretary, if the Wallowa Forest Service Compound is—

(1) used for a purpose other than the purposes described in subsection (c)(1); or

(2) managed by the City in a manner that is inconsistent with subsection(c)(3).

By Mr. WYDEN:

S. 1140. A bill to direct the Secretary of the Interior to convey certain Federal land to Deschutes County, Oregon; to the Committee on Energy and Natural Resources.

Mr. WYDEN. 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. 1140

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 ''La Pine Land Conveyance Act''.

SEC. 2. DEFINITIONS.

In this Act:

(1) COUNTY.—The term ''County'' means the County of Deschutes, Oregon.

(2) MAP.—The term ''map'' means the map entitled ''La Pine Proposed Land Transfer Proposal'' and dated May [____], 2009.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior, acting through the Director of the Bureau of Land Management.

SEC. 3. CONVEYANCE OF LAND TO THE COUNTY OF DESCHUTES, OREGON.

(a) IN GENERAL.—As soon as practicable after the date of enactment of this Act, subject to valid existing rights, and notwithstanding the land use planning requirements of sections 202 and 203 of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1712, 1713), the Secretary shall convey to the County, without consideration, all right, title, and interest of the United States in and to the land described in subsection (b).

(b) DESCRIPTION OF LAND.—The land referred to in subsection (a) consists of—

(1) approximately 320 acres of land managed by the Bureau of Land Management, Prineville District, Oregon, depicted on the map as ''parcel A''; and

(2) approximately 750 acres of land managed by the Bureau of Land Management, Prineville District, Oregon, depicted on the map as ''parcel B''.

(c) MAP ON FILE.—The map shall be on file and available for public inspection in the appropriate offices of the Bureau of Land Management.

(d) USE OF CONVEYED LAND.—

(1) IN GENERAL.—The land conveyed under subsection (a) shall be used as a rodeo ground, public sewer system, or other public purpose consistent with the Act of June 14, 1926 (commonly known as the ''Recreation and Public Purposes Act'') (43 U.S.C. 869 et seq.).

(2) LIMITATIONS.—The land conveyed under subsection (a)—

(A) shall not be used for residential or commercial purposes; and

(B) shall be used consistent with the Act of June 14, 1926 (commonly known as the ''Recreation and Public Purposes Act'') (43 U.S.C. 869 et seq.).

(3) ADDITIONAL TERMS AND CONDITIONS.—The Secretary may require such additional terms and conditions for the conveyance as the Secretary determines to be appropriate to protect the interests of the United States.

(e) ADMINISTRATIVE COSTS.—The Secretary shall require the County to pay all survey costs and other administrative costs necessary for the preparation and completion of any patents for, and transfers of title to, the land under subsection (a).

(f) REVERSION.—

(1) IN GENERAL.—If the land conveyed under subsection (a) ceases to be used for the public purpose for which the land was conveyed, the land shall, at the discretion of the Secretary, revert to the United States.

(2) RESPONSIBILITY OF DISTRICT.—If the Secretary determines under paragraph (1) that the land should revert to the United States and that the land is contaminated with hazardous waste, the County shall be responsible for remediation of the contamination.

By Mrs. FEINSTEIN (for herself and Mr. BOND):

S. 1141. A bill to extend certain trade preferences to certain least-developed countries, and for other purposes; to the Committee on Finance.

Mrs. FEINSTEIN. Mr. President, I rise today with Senator BOND to introduce the Tariff Relief Assistance for Developing Economies Act of 2009 to help some of the world's poorest countries sustain vital export industries and promote economic growth and political stability.

I worked with former senator Gordon Smith on this bill in the past and I am proud to move it forward in the 111th Congress.

This legislation will provide duty free and quota free benefits for garments and other products similar to those afforded to beneficiary countries under the Africa Growth and Opportunity Act, AGOA.

The countries covered by this legislation are the 14 Least Developed Countries, LDCs, as defined by the United Nations and the U.S. State Department, which are not covered by any current U.S. trade preference program: Afghanistan, Bangladesh, Bhutan, Cambodia, Kiribati, Laos, Maldives, Nepal, Samoa, Solomon Islands, East Timor, Tuvalu, Vanuatu, and Yemen.

The bill also includes Sri Lanka as an eligible country.

To be eligible for the benefits provided under our bill, a country must demonstrate that it is making continual progress toward establishing rule of law, political pluralism, the right to due process, and a market-based economy that protects private property rights. Our legislation would help promote democracy while sustaining vital export industries and creating employment opportunities.

The beneficiary countries of this legislation are among the poorest countries in the world.

Nepal has per capita income of $240. Unemployment in Bangladesh stands at 40 percent. Approximately 36 percent of Cambodia's population lives below the poverty line.

Each country faces critical challenges in the years ahead including poor health care, insufficient educational opportunities, high HIV/AIDS rates, and the effects of war and civil strife.

The U.S. must take a leadership role in providing much needed assistance to the people of these countries.

Yet humanitarian and development assistance should not be the sum total of our efforts to put these countries on the road to economic prosperity and political stability.

Indeed, the key for sustained growth and rising standards of living will be the ability of each of these countries to create vital export industries to compete in a free and open global marketplace.

We should help these countries help themselves by opening the U.S. market to their exports.

Success in that endeavor will ultimately allow these countries to become less dependent on foreign aid and allow the U.S. to provide assistance to countries in greater need.

The garment industry is a key part of the manufacturing sector in some of these countries.

In Nepal, the garment industry is entirely export oriented and accounts for 40 percent of foreign exchange earnings. It employs over 100,000 workers—half of them women—and sustains the livelihood of over 350,000 people.

The United States is the largest market for Nepalese garments and accounts for 80–90 percent of Nepal's total exports every year.

In Cambodia, approximately 250,000 Cambodians work in the garment industry supporting approximately one million dependents. The garment industry accounts for more than 90 percent of Cambodia's export earnings.

In Bangladesh, the garment industry accounts for 75 percent of export earnings. The industry employs 1.8 million people, 90 percent of whom are women, and sustains the livelihoods of 10 to 15 million people.

Despite the poverty seen in these countries and the importance of the garment industry and the U.S. market, they face some of the highest U.S. tariffs in the world, averaging over 15 percent. In contrast, countries like Japan and our European partners face tariffs that are nearly zero.

Surely we can do better. This legislation will help these countries compete in the U.S. market and let their citizens know that Americans are committed to helping them realize a better future for themselves and their families.

Doing so is consistent with U.S. goals to combat poverty, instability, and terrorism in a critical part of the world. We should not forget that of the approximately 265 million people that live in the TRADE Act countries, almost 200 million are Muslim.

The impact on U.S. jobs will be minimal. Currently, the beneficiary countries under this legislation account for only 4 percent of U.S. textile and apparel imports, compared to 24 percent for China, and 72 percent for the rest of the world.

These countries will continue to be small players in the U.S. market, but the benefits of this legislation will have a major impact on their export economies.

At a time when we are trying to rebuild the image of the U.S. around the world, we need legislation such as this to show the best of America and American values. It will provide a vital component to our development strategy and add another tool to the war on terror. I urge my colleagues to support this bill.

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. 1141

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 ''Tariff Relief Assistance for Developing Economies Act of 2009'' or the ''TRADE Act of 2009''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) It is in the mutual interest of the United States and least-developed countries to promote stable and sustainable economic growth and development.

(2) Trade and investment are powerful economic tools and can be used to reduce poverty and raise the standard of living in a country.

(3) A country that is open to trade may increase its economic growth.

(4) Trade and investment often lead to employment opportunities and often help alleviate poverty.

(5) Least-developed countries have a particular challenge in meeting the economic requirements and competitiveness of globalization and international markets.

(6) The United States has recognized the benefits that international trade provides to least-developed countries by enacting the Generalized System of Preferences and trade benefits for developing countries in the Caribbean, Andean, and sub-Saharan African regions of the world.

(7) Enhanced trade with least-developed Muslim countries, including Yemen, Afghanistan, and Bangladesh, is consistent with other United States objectives of encouraging a strong private sector and individual economic empowerment in those countries.

(8) Offering least-developed countries enhanced trade preferences will encourage both higher levels of trade and direct investment in support of positive economic and political developments throughout the world.

(9) Encouraging the reciprocal reduction of trade and investment barriers will enhance the benefits of trade and investment as well as enhance commercial and political ties between the United States and the countries designated for benefits under this Act.

(10) Economic opportunity and engagement in the global trading system together with support for democratic institutions and a respect for human rights are mutually reinforcing objectives and key elements of a policy to confront and defeat global terrorism.

SEC. 3. DEFINITIONS.

In this Act:

(1) BENEFICIARY TRADE ACT OF 2009 COUNTRY.—The term ''beneficiary TRADE Act of 2009 country'' means a TRADE Act of 2009 country that the President has determined is eligible for preferential treatment under section 5.

(2) FORMER TRADE ACT OF 2009 BENEFICIARY COUNTRY.—The term ''former TRADE Act of 2009 beneficiary country'' means a country that, after being designated as a beneficiary TRADE Act of 2009 country under this Act, ceased to be designated as such a country by reason of its entering into a free trade agreement with the United States.

(3) TRADE ACT OF 2009 COUNTRY.—The term ''TRADE Act of 2009 country'' means a country listed in subsection (b) or (c) of section 4.

SEC. 4. AUTHORITY TO DESIGNATE; ELIGIBILITY REQUIREMENTS.

(a) AUTHORITY TO DESIGNATE.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the President is authorized to designate a TRADE Act of 2009 country as a beneficiary TRADE Act of 2009 country eligible for benefits described in section 5—

(A) if the President determines that the country meets the requirements set forth in section 104 of the African Growth and Opportunity Act (19 U.S.C. 3703); and

(B) subject to the authority granted to the President under subsections (a), (d), and (e) of section 502 of the Trade Act of 1974 (19 U.S.C. 2462 (a), (d), and (e)), if the country otherwise meets the eligibility criteria set forth in such section 502.

(2) APPLICATION OF SECTION 104.—Section 104 of the African Growth and Opportunity Act shall be applied for purposes of paragraph (1) by substituting ''TRADE Act of 2009 country'' for ''sub-Saharan African country'' each place it appears.

(b) COUNTRIES ELIGIBLE FOR DESIGNATION.—For purposes of this Act, the term ''TRADE Act of 2009 country'' refers to the following or their successor political entities:

(1) Afghanistan.
(2) Bangladesh.
(3) Bhutan.
(4) Cambodia.
(5) Kiribati.
(6) Lao People's Democratic Republic.
(7) Maldives.
(8) Nepal.
(9) Samoa.
(10) Solomon Islands.
(11) Timor-Leste (East Timor).
(12) Tuvalu.
(13) Vanuatu.
(14) Yemen.

(c) SRI LANKA ECONOMIC EMERGENCY SUPPORT.—For purposes of this Act, the President may also designate Sri Lanka as beneficiary TRADE Act of 2009 country eligible for benefits described in section 5.

SEC. 5. TRADE ENHANCEMENT.

The preferential treatment described in this section includes the following:

(1) PREFERENTIAL TARIFF TREATMENT FOR CERTAIN ARTICLES.—

(A) IN GENERAL.—The President may provide duty-free treatment for any article described in section 503(b)(1) (B) through (G) of the Trade Act of 1974 (19 U.S.C. 2463(b)(1) (B) through (G)) that is the growth, product, or manufacture of a beneficiary TRADE Act of 2009 country, if, after receiving the advice of the International Trade Commission in accordance with section 503(e) of the Trade Act of 1974 (19 U.S.C. 2463(e)), the President determines that such article is not import-sensitive in the context of imports from beneficiary TRADE Act of 2009 countries.

(B) RULES OF ORIGIN.—The duty-free treatment provided under subparagraph (A) shall apply to any article described in that subparagraph that meets the requirements of section 503(a)(2) of the Trade Act of 1974 (19 U.S.C. 2463(a)(2)), except that—

(i) if the cost or value of materials produced in the customs territory of the United States is included with respect to that article, an amount not to exceed 15 percent of the appraised value of the article at the time it is entered that is attributed to such United States cost or value may be applied toward determining the percentage referred to in subparagraph (A) of section 503(a)(2) of the Trade Act of 1974 (19 U.S.C. 2463(a)(2)); and

(ii) the cost or value of the materials included with respect to that article that are produced in one or more beneficiary TRADE Act of 2009 countries or former beneficiary TRADE Act of 2009 countries shall be applied in determining such percentage.

(2) TEXTILE AND APPAREL ARTICLES.—

(A) IN GENERAL.—The preferential treatment relating to textile and apparel articles described in section 112 (a) and (b) (1) and (2) of the African Growth and Opportunity Act (19 U.S.C. 3721 (a) and (b) (1) and (2)) shall apply to textile and apparel articles imported directly into the customs territory of the United States from a beneficiary TRADE Act of 2009 country and such section shall be applied for purposes of this subparagraph by substituting ''beneficiary TRADE Act of 2009 country'' and ''beneficiary TRADE Act of 2009 countries'' for ''beneficiary sub-Saharan African country'' and ''beneficiary sub-Saharan African countries'', respectively, each place such terms appear.

(B) APPAREL ARTICLES ASSEMBLED FROM REGIONAL AND OTHER FABRIC.—In applying such section 112, apparel articles wholly assembled in one or more beneficiary TRADE Act of 2009 countries or former beneficiary TRADE Act of 2009 countries, or both, from fabric wholly formed in one or more beneficiary TRADE Act of 2009 countries or former beneficiary TRADE Act of 2009 countries, or both, from yarn originating either in the United States or one or more beneficiary TRADE Act of 2009 countries or former beneficiary TRADE Act of 2009 countries, or both (including fabrics not formed from yarns, if such fabrics are classifiable under heading 5602 or 5603 of the Harmonized Tariff Schedule of the United States and are wholly formed and cut in the United States, in one or more beneficiary TRADE Act of 2009 countries or former beneficiary TRADE Act of 2009 countries, or any combination thereof), whether or not the apparel articles are also made from any of the fabrics, fabric components formed, or components knit-to-shape described in section 112(b) (1) or (2) of the African Growth and Opportunity Act (19 U.S.C. 3721(b) (1) and (2)) (unless the apparel articles are made exclusively from any of the fabrics, fabric components formed, or components knit-to-shape described in such section 112(b) (1) or (2)) subject to the following:

(i) LIMITATIONS ON BENEFITS.—

(I) IN GENERAL.—Preferential treatment under this subparagraph shall be extended in the 1-year period beginning January 1, 2009, and in each of the succeeding 10 1-year periods, to imports of apparel articles described in this subparagraph in an amount not to exceed the applicable percentage of the aggregate square meter equivalents of all apparel articles imported into the United States in the most recent 12-month period for which data are available.

(II) APPLICABLE PERCENTAGE.—For purposes of this clause, the term ''applicable percentage'' means 11 percent for the 1-year period beginning January 1, 2009, increased in each of the 10 succeeding 1-year period by equal increments, so that for the period beginning January 1, 2019, the applicable percentage does not exceed 14 percent.

(ii) SPECIAL RULE.—

(I) IN GENERAL.—Subject to clause (i), preferential treatment described in this subparagraph shall be extended through December 31, 2016, for apparel articles wholly assembled in one or more beneficiary TRADE Act of 2009 countries or former beneficiary TRADE Act of 2009 countries, or both, regardless of the country of origin of the yarn or fabric used to make such articles.

(II) COUNTRY LIMITATIONS.—

(aa) SMALL SUPPLIERS.—If, during the preceding 1-year period beginning on January 1 for which data are available, imports from a beneficiary TRADE Act of 2009 country are less than 1 percent of the aggregate square meter equivalents of all apparel articles imported into the United States during such period, such imports may increase to an amount that is equal to not more than 1.5 percent of the aggregate square meter equivalents of all apparel articles imported into the United States during such period.

(bb) OTHER SUPPLIERS.—If during the preceding 1-year period beginning on January 1 for which data are available, imports from a beneficiary TRADE Act of 2009 country are at least 1 percent of the aggregate square meter equivalents of all apparel articles imported into the United States during such period, such imports may increase, during each subsequent 12-month period, by an amount that is equal to not more than one-third of 1 percent of the aggregate square meter equivalents of all apparel articles imported into the United States.

(cc) AGGREGATE COUNTRY LIMIT.—In no case may the aggregate quantity of textile and apparel articles imported into the United States under this subparagraph exceed the applicable percentage set forth in clause (i).

(C) TECHNICAL AMENDMENT.—Section 6002(a)(2)(B) of the Africa Investment Incentive Act of 2006 (Public Law 109–432) is amended by inserting before ''by striking'' the following: ''in paragraph (3),''.

(D) OTHER RESTRICTIONS.—The provisions of section 112 (b) (3)(B), (4), (5), (6), (7), and (8), and (e), and section 113 of the African Growth and Opportunity Act (19 U.S.C. 3721 (b) (3)(B), (4), (5), (6), (7), and (8), and (e), and 3722) shall apply with respect to the preferential treatment extended under this Act to a beneficiary TRADE Act of 2009 country by substituting ''beneficiary TRADE Act of 2009 country'' for ''beneficiary sub-Saharan African country'' and ''beneficiary TRADE Act of 2009 countries'' and ''former beneficiary TRADE Act of 2009 countries'' for ''beneficiary sub-Saharan African countries'' and ''former sub-Saharan African countries'', respectively, wherever appropriate.

SEC. 6. REPORTING REQUIREMENT.

The President shall monitor, review, and report to Congress, not later than 1 year after the date of the enactment of this Act, and annually thereafter, on the implementation of this Act and on the trade and investment policy of the United States with respect to the TRADE Act of 2009 countries.

SEC. 7. TERMINATION OF PREFERENTIAL TREATMENT.

No duty-free treatment or other preferential treatment extended to a beneficiary TRADE Act of 2009 country under this Act shall remain in effect after December 31, 2019.

SEC. 8. EFFECTIVE DATE.

The provisions of this Act shall take effect on January 1, 2009.

By Mr. REED (for himself and Ms. MIKULSKI):

S. 1142. A bill to amend the Federal Food, Drug, and Cosmetic Act with respect to inclusion of effectiveness information in drug and device labeling and advertising; to the Committee on Health, Education, Labor, and Pensions.

Mr. REED. Mr. President, today I introduce the Informed Health Care Decision Making Act of 2009. I am introducing this legislation along with my colleague Senator MIKULSKI because every American deserves to have the full information regarding drugs and devices prescribed by their provider.

Even though the amount of money spent to reach the public about drugs and devices is greater than five billion dollars annually, the most fundamental information—information about how well the drug or device actually works—is generally absent. In 2007, the Institute of Medicine conducted a workshop regarding the public's understanding of drugs and confirmed the importance for patients and physicians of having standardized and quantitative information about the product before making health care decisions.

Researchers at Dartmouth University have documented that replacing the current narrative information contained in drug advertisements with simplified, factual information, will enable patients to play an active role in health care decision making. In fact, similar to the nutrition facts boxes that are required on our Nation's packaged food supply, this research demonstrated that a drug facts box will actually help physicians make better health care choices.

If the research is not enough proof that this type of streamlined information will be beneficial, the Food and

Drug Administration's, FDA, Risk Communications Advisory Committee, a committee specifically designed to counsel the agency on how to strengthen the communication of risks and benefits of FDA-regulated products to the public, unanimously recommended that the FDA adopt standardized, quantitative summaries of risks and benefits in a drug facts box format.

As such, the Informed Health Care Decision Making Act of 2009 would require the FDA to determine if the information provided in a drug facts box, or a similar format, would improve health care decision making by clinicians and patients, and report to Congress on that determination. If the report determines that a specific standardized, quantitative format would be beneficial, the FDA must issue regulations to implement the format.

Regardless of the FDA's determination, it is important for clinicians and patients to be able to compare the similarities, differences, benefits, and risks of drugs and devices. As such, the legislation would require the Agency for Healthcare Research and Quality to establish a multi-stakeholder process for developing and periodically updating methodological standards and criteria for comparative clinical effectiveness research. This would include standards and criteria for the sources of evidence and the adequacy of evidence that are appropriate for the inclusion of comparative clinical effectiveness information in labeling and print advertisements.

Upon completion of these standards, the legislation requires drug labels and print advertisements to include information on the clinical effectiveness of a product—compared to other products approved for the same health condition for the same patient demographic subpopulation—or a disclosure that there is no such information, if another product has not been approved for the same use. The potential of such a disclosure should be a powerful incentive for manufacturers to fund comparative effectiveness research.

It is my hope that as we embark upon meaningful health care reform, my colleagues will join me in supporting this bill and other initiatives to improve the health care decision making of both patients and clinicians.

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. 1142

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 ''Informed Health Care Decision Making Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) National randomized controlled trials have found that replacing the brief summary of drug advertisements with a drug facts box improved consumer knowledge and judgments. In such trials, consumers who were presented with a drug facts box more accurately perceived the side effects and benefits of a drug, and were more than twice as likely to choose the superior drug.

(2)(A) In 2007, the Institute of Medicine conducted a workshop that highlighted that the public has a limited understanding of the benefits and risks of drugs. The workshop also highlighted that it is important to—

(i) provide patients and physicians with the best possible information for making informed decisions about the use of pharmaceuticals;

(ii) employ quantitative and standardized approaches when trying to evaluate pharmaceutical benefit-risk; and

(iii) develop and validate improved tools for communicating pharmaceutical benefit-risk information to patients and physicians.

(B) The general agreement of the workshop was that the Food and Drug Administration should pilot test a drug facts box.

(3) On February 27, 2009, the Food and Drug Administration's Risk Communication Advisory Committee made the following unanimous recommendations:

(A) The Food and Drug Administration should adopt a single standard document for communicating essential information about pharmaceuticals.

(B) That standard document should include quantitative summaries of risks and benefits, along with use and precaution information.

(C) The Food and Drug Administration should adopt the drug facts box format as its standard.

SEC. 3. PRESENTATION OF DRUG BENEFIT AND RISK INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this Act as the ''Secretary''), acting through the Commissioner of Food and Drugs, shall determine whether standardized, quantitative summaries of the benefits and risks of drugs in a tabular or drug facts box format, or any alternative format, in the labeling and print advertising of such drugs would improve health care decision making by clinicians and patients and consumers.

(b) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall review all available scientific evidence and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, and representatives of racial and ethnic minorities.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the Congress a report that provides—

(1) the determination by the Secretary under subsection (a); and

(2) the reasoning and analysis underlying that determination.

(d) AUTHORITY.—

(1) IN GENERAL.—If the Secretary determines under subsection (a) that standardized, quantitative summaries of the benefits and risks of drugs in a tabular or drug facts box format, or any alternative format, in the labeling and print advertising of such drugs would improve health care decision making by clinicians and patients and consumers, then the Secretary, not later than 1 year after the date of submission of the report under subsection (c), shall promulgate regulations as necessary to implement such format.

(2) OBJECTIVE AND UP-TO-DATE INFORMATION.—In carrying out paragraph (1), the Secretary shall ensure that the information presented in a summary described under such paragraph is objective and up-to-date, and is the result of a review process that considers the totality of published and unpublished data.

(3) POSTING OF INFORMATION.—In carrying out paragraph (1), the Secretary shall post the information presented in a summary described under such paragraph on the Internet Web site of the Food and Drug Administration.

SEC. 4. STANDARDS FOR COMPARATIVE CLINICAL EFFECTIVENESS INFORMATION.

(a) IN GENERAL.—The Secretary, acting through the Commissioner of Food and Drugs, shall establish and periodically update methodological standards and criteria for the sources of evidence and the adequacy and degree of evidence that are appropriate for inclusion of comparative clinical effectiveness information in labeling and advertisements under subsections (f), (n)(3), and (r) of section 502 of the Federal Food, Drug, and Cosmetic Act (as amended by section 5).

(b) REQUIREMENTS.—The standards and criteria established under subsection (a) shall ensure that comparative clinical effectiveness information provides reliable and useful information that improves health care decision making, adheres to rigorous scientific standards, and is produced through a transparent process that includes consultation with stakeholders.

(c) CONSULTATION.—In carrying out subsection (a), the Secretary shall consult with manufacturers of drugs and devices, clinicians, patients and consumers, experts in health literacy, and representatives of racial and ethnic minorities.

(d) DEFINITION.—For purposes of this section, the term ''comparative clinical effectiveness'' means the clinical outcomes, effectiveness, safety, and clinical appropriateness of a drug or device in comparison to 1 or more drugs or devices, respectively, approved to prevent, diagnose, or treat the same health condition for the same patient demographic subpopulation.

SEC. 5. DISCLOSURE OF COMPARATIVE CLINICAL EFFECTIVENESS INFORMATION.

(a) COMPARATIVE CLINICAL EFFECTIVENESS.—Section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321) is amended by adding at the end the following:

''(rr) The term 'comparative clinical effectiveness' means the clinical outcomes, effectiveness, safety, and clinical appropriateness of a drug or device in comparison to 1 or more drugs or devices, respectively, approved to prevent, diagnose, or treat the same health condition for the same patient demographic subpopulation, on the basis of research that meets standards adopted by the Secretary under section 4 of the Informed Health Care Decision Making Act.''.

(b) LABELING AND ADVERTISING INFORMATION.—Section 502 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352) is amended—

(1) in subsection (f), by striking ''for use; and (2)'' and inserting ''for use; (2) such information in brief summary relating to comparative clinical effectiveness as shall be required in regulations which shall be issued by the Secretary in accordance with the procedure specified in section 701(a); and (3)'';

(2) in subsection (n)(3), by striking ''and effectiveness'' and inserting ''effectiveness, and comparative clinical effectiveness (or a disclosure that there is no such information relating to comparative clinical effectiveness if another drug has been approved for the same use),''; and

(3) in subsection (r)—

(A) by striking ''In the case of any'' and inserting ''(1) In the case of any'';

(B) by striking ''(1) a true'' and inserting ''(A) a true'';

(C) by striking ''(2) a brief'' and inserting ''(B) a brief''; and

(D) by striking ''and contraindications'' and inserting ''contraindications, and, if appropriate after taking into consideration the type of device, effectiveness and comparative clinical effectiveness (or a disclosure that there is no such information relating to comparative clinical effectiveness if another device has been approved for the same use)''.

By Mr. DURBIN:

S. 1143. A bill to amend the Public Health Service Act to establish various programs for the recruitment and retention of public health workers and to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies and health centers; to the Committee on Health, Education, Labor, and Pensions.

Mr. DURBIN. Mr. President, the people who work in public health are responsible for some of the most important jobs that protect the lives and health of ordinary Americans. The scope of public health includes preventing the spread of communicable diseases and pandemics, managing the health system's response to biological and chemical attacks, fighting foodborne illnesses, assisting communities in preparing for disasters, and promoting best health practices.

The recent outbreak of Influenza A H1N1 virus reminds us how much we depend on the people who work in public health. This virus has infected thousands of people and caused nearly a hundred deaths worldwide. The American people have looked to the Centers for Disease Control and Prevention and their State and local health departments to collect data, monitor the threat, provide accurate information, and prepare to respond if the situation worsens. But even when a pandemic or other widespread threat is not imminent, the public health workforce remains on the front lines in promoting healthy lifestyles and preventing chronic disease.

Our ability to prevent, respond to, and recover from a pandemic or other health challenges depends largely on a strong pipeline of public health professionals. Unfortunately, a critical—and growing—shortage of public health workers is putting our nation at risk.

The Association of Schools of Public Health recently reported that there were 50,000 fewer public health workers in 2000 than there were in 1980. In my home State of Illinois, the average Illinois Department of Public Health worker is 48 years old, and 39 percent of the staff will be eligible to retire within 5 years. Compounding this problem is the fact that 13 percent of agency positions are vacant, and when a new hire is found, the average age is 41. The ''graying'' workforce and weak pipeline of new public health graduates are problems across all levels of government. Nearly half of the federal employees in occupations critical to U.S. biodefense will be eligible to retire by 2012.

We cannot stay on the same trajectory in the future. We are not educating enough people in public health to replace retiring public health workers, and the salaries for those who do work in public health disciplines are not competitive with comparable employment in the private sector. The Association of State and Territorial Health Officials reports that in 2004, most of the approximately 6,400 graduates from accredited schools of public health took jobs in the private sector.

I am pleased to introduce the Public Health Workforce Development Act of 2009 today to help address this challenge. This legislation provides several common-sense solutions to develop a strong pipeline of public health professionals. This bill would provide scholarships to students going into public health and provide loan repayment for current public health workers in exchange for a commitment to additional years of service in public health.

The legislation also encourages states to set up their own public health training programs and creates a scholarship program for mid-career professionals to maintain or upgrade their training. Finally, it creates an online clearinghouse of public health jobs available in the Federal Government. Together, these programs will help attract young people to a career in public health and give current public health professionals incentives to remain in the field in the long-term

Our health care system today focuses too much on treating sickness, at the expense of preserving wellness. As the process of health reform moves forward, two key concerns are improving health care quality, while holding health care costs down. To do this, we need to focus on wellness, preventive care, and effective management of chronic conditions, all of which are hallmarks of the public health system. This bill will help maintain a strong and effective public health system by alleviating the dangerous shortage of public health workers

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. 1143

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 ''Public Health Workforce Development Act of 2009''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The ability of the public health system to prevent, respond to, and recover from bioterrorism, acute outbreaks of infectious diseases, or other health threats and emergencies, and to prevent and reduce chronic disease, depends upon the existence of adequate numbers of well-trained public health professionals in Federal, State, local, and tribal public health departments and health centers.

(2) The public health system has an aging staff nearing retirement with no clear pipeline of highly-skilled and capable employees to fill the void, with the average age of the State public health workforce at 47 years.

(3) Retirement rates in some State public health agencies were as high as 20 percent as of June 2007, and projected to be as high as 45 percent in 2009.

(4) The ratio of public health workers to the population has dropped from 219 per 100,000 in 1980 to 158 per 100,000 in 2000, while responsibilities of such workers have continued to expand.

(5) Public health nurses comprise the largest segment of the public health workforce. A study by the Institute of Medicine in 2003 identified nursing as facing one of the most severe shortages of public health workers. The average age of public health nurses is nearly 50 years, with the leaders of State public health nursing averaging more than 30 years of service. In one State nearly 40 percent of the public health nursing workforce was eligible for retirement as of June 2007.

(6) According to the Association of State and Territorial Health Officials, most of the approximately 6,400 graduates from accredited schools of public health took jobs in the private sector in 2004. The Bureau of Labor Statistics projects that there will be an increase in private sector demand for highly-educated graduates in scientific fields during the 10-year period ending in 2017. Public health agencies will have difficulty competing for those highly-skilled scientists.

(7) As of June 2007, approximately 42 percent of the epidemiology workforce in State and territorial health departments lacked formal academic training in epidemiology. States have reported that approximately 47 percent more epidemiologists are needed to adequately prevent and control avian influenza and other emerging diseases.

(8) The Partnership for Public Service reports that in the field of microbiology, there are more than 4 times as many full-time permanent employees over age 40 as under age 40 at the Centers for Disease Control and Prevention. Among full-time permanent employees with medical backgrounds at the Centers for Disease Control and Prevention and the Food and Drug Administration, there are 3 times as many employees over 40 years of age as under 40.

(9) More than 50 percent of States cite the lack of qualified individuals or individuals willing to relocate as being a major barrier to preparedness. A study conducted by the Health Resources and Services Association reported difficulty with recruiting more educated, skilled public health providers to work in traditionally medically underserved areas, such as rural populations. Public health agencies continue to face an unmet need for public health workers who are bilingual and culturally competent.

(10) Lack of access to advanced education, including baccalaureate nursing and graduate studies, is a significant barrier to upgrading the existing public health workforce, particularly in rural areas.

SEC. 3. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

"Subpart 3—Public Health Workforce Recruitment and Retention Programs

"SEC. 780. PUBLIC HEALTH WORKFORCE SCHOLARSHIP PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the 'Program') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies and health centers.

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1) be accepted for enrollment, or be enrolled, as a full-time student—

''(A) in an accredited (as determined by the Secretary) educational institution in a State or territory; and

''(B) in a course of study or program, offered by such institution and approved by the Secretary, leading to a health professions degree (graduate, undergraduate, or associate) or certificate, which may include public health, laboratory sciences, epidemiology, environmental health, health communications, health education and behavioral sciences, information sciences, or public administration;

''(2) be a United States citizen;

''(3) submit an application to the Secretary to participate in the Program; and

''(4) sign and submit to the Secretary, at the time of the submission of such application, a written contract (described in subsection (d)) to serve, upon the completion of the course of study or program involved, for the applicable period of obligated service in the full-time employment of a Federal, State, local, or tribal public health agency or a health center.

''(c) DISSEMINATION OF INFORMATION.—

''(1) APPLICATION AND CONTRACT FORMS.—The Secretary shall disseminate application forms and contract forms to individuals desiring to participate in the Program. The Secretary shall include with such forms—

''(A) 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 in the case of the individual's breach of the contract; and

''(B) information relating to the service obligation and such other information as may be necessary for the individual to understand the individual's prospective participation in the Program.

''(2) INFORMATION FOR SCHOOLS.—The Secretary shall distribute to health professions schools and other appropriate accredited academic institutions and relevant Federal, State, local, and tribal public health agencies, materials providing information on the Program and shall encourage such schools, institutions, and agencies to disseminate such materials to potentially eligible students.

''(3) UNDERSTANDABILITY AND TIMING.—The application form, contract form, and all other information furnished by the Secretary under this section shall—

''(A) be written in a manner calculated to be understood by the average individual applying to participate in the Program; and

''(B) be made available by the Secretary on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

''(d) CONTRACT.—The written contract between the Secretary and an individual shall contain—

''(1) an agreement on the part of the Secretary that the Secretary will provide the individual with a scholarship for a period of years (not to exceed 4 academic years) during which the individual shall pursue an approved course of study or program to prepare the individual to serve in the public health workforce;

''(2) an agreement on the part of the individual that the individual will—

''(A) maintain full-time enrollment in the approved course of study or program described in subsection (b)(1) until the individual completes that course of study or program;

''(B) while enrolled in the course of study or program, maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or program); and

''(C) immediately upon graduation, serve in the full-time employment of a Federal, State, local, or tribal public health agency or a health center in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the 'period of obligated service') equal to the greater of—

''(i) 1 year for each academic year for which the individual was provided a scholarship under the Program; or

''(ii) 2 years;

''(3) an agreement by both parties as to the nature and extent of the scholarship assistance, which may include—

''(A) payment of the tuition expenses of the individual;

''(B) payment of all other reasonable educational expenses of the individual including fees, books, equipment, and laboratory expenses; and

''(C) payment of a stipend of not more than $1,200 per month for each month of the academic year involved (indexed to account for increases in the Consumer Price Index);

''(4) a provision that any financial obligation of the United States arising out of a contract entered into under this subsection and any obligation of the individual which is conditioned thereon, is contingent upon funds being appropriated for scholarships under this section;

''(5) a statement of the damages to which the United States is entitled for the individual's breach of the contract; and

''(6) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this section.

''(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a school of medicine, public health, nursing, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, psychology, or social work under a scholarship under the Program, the date of the initiation of the period of obligated service may be postponed, upon the submission by the individual of a petition for such postponement and approval by the Secretary, to the date on which the individual completes an approved internship, residency, or other relevant public health advanced training program.

''(f) ADMINISTRATIVE PROVISIONS.—

''(1) CONTRACTS WITH INSTITUTIONS.—The Secretary may contract with an educational institution in which a participant in the Program is enrolled, for the payment to the educational institution of the amounts of tuition and other reasonable educational expenses described in subsection (d)(3).

''(2) EMPLOYMENT CEILINGS.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic training, shall not be counted against any employment ceiling affecting the Department or any other Federal agency.

''(g) BREACH OF CONTRACT.—An individual who fails to comply with the contract entered into under subsection (d) shall be subject to the same financial penalties as provided for under section 338E for breaches of scholarship contracts under sections 338A.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $35,000,000 for each of the fiscal years 2010 through 2015.

''(i) DEFINITION.—For purposes of this subpart, the term 'health center' has the meaning given such term in section 330(a).

''SEC. 781. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies and in health centers.

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) be accepted for enrollment, or be enrolled, as a full-time or part-time student in an accredited academic educational institution in a State or territory in the final year of a course of study or program offered by that institution leading to a health professions degree or certificate, which may include a degree (graduate, undergraduate, or associate) or certificate relating to public health, laboratory sciences, epidemiology, environmental health, health communications, health education and behavioral sciences, information sciences, or public administration; or

''(B) have graduated, within 10 years, from an accredited educational institution in a State or territory and received a health professions degree (graduate, undergraduate, or associate) or certificate, which may include a degree (graduate, undergraduate, or associate) or certificate relating to public health, laboratory sciences, epidemiology, environmental health, health communications, health education and behavioral sciences, information sciences, or public administration;

''(2)(A) in the case of an individual described in paragraph (1)(A), have accepted employment with a Federal, State, local, or tribal public health agency or a health center, as recognized by the Secretary, to commence upon graduation; or

''(B) in the case of an individual described in paragraph (1)(B), be employed by, or have accepted employment with, a Federal, State, local, or tribal public health agency or a health center, as recognized by the Secretary;

''(3) be a United States citizen;

''(4) submit an application to the Secretary to participate in the Program; and

''(5) sign and submit to the Secretary, at the time of the submission of such application, a written contract (described in subsection (d)) to serve for the applicable period of obligated service in the full-time employment of a Federal, State, local, or tribal public health agency or a health center.

''(c) DISSEMINATION OF INFORMATION.—

''(1) APPLICATION AND CONTRACT FORMS.—The Secretary shall disseminate application forms and contract forms to individuals desiring to participate in the Program. The Secretary shall include with such forms—

''(A) 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 to recover in the case of the individual's breach of the contract; and

''(B) information relating to the service obligation and such other information as may be necessary for the individual to understand the individual's prospective participation in the Program.

''(2) INFORMATION FOR SCHOOLS.—The Secretary shall distribute to health professions schools and other appropriate accredited academic institutions and relevant Federal, State, local, and tribal public health agencies and health centers, materials providing information on the Program and shall encourage such schools, institutions, and agencies to disseminate such materials to potentially eligible students.

''(3) UNDERSTANDABILITY AND TIMING.—The application form, contract form, and all

other information furnished by the Secretary under this section shall—

''(A) be written in a manner calculated to be understood by the average individual applying to participate in the Program; and

''(B) be made available by the Secretary on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

''(d) CONTRACT.—The written contract (referred to in this section) between the Secretary and an individual shall contain—

''(1) an agreement on the part of the Secretary that the Secretary will repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant public health workforce educational degree or certificate in accordance with the terms of the contract;

''(2) an agreement on the part of the individual that the individual will serve, immediately upon graduation in the case of an individual described in subsection (b)(1)(A) service, or in the case of an individual described in subsection (b)(1)(B) continue to serve, in the full-time employment of a Federal, State, local, or tribal public health agency or health center in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the 'period of obligated service') equal to the greater of—

''(A) 3 years; or

''(B) such longer period of time as determined appropriate by the Secretary and the individual;

''(3) an agreement, as appropriate, on the part of the individual to relocate for the entire period of obligated service to a political jurisdiction designated by the Secretary to be a priority service area in exchange for an additional loan repayment incentive amount that does not exceed 20 percent of the individual's eligible loan repayment award per academic year such that the total of the loan repayment and the incentive amount shall not exceed ⅓ of the eligible loan balance per year;

''(4) in the case of an individual described in subsection (b)(1)(A) who is in the final year of study and who has accepted employment with a Federal, State, local, or tribal public health agency or a health center upon graduation, an agreement on the part of the individual to complete the education or training, maintain an acceptable level of academic standing (as determined by the education institution offering the course of study or training), and agree to the period of obligated service;

''(5) 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 that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

''(6) a statement of the damages to which the United States is entitled, under this section for the individual's breach of the contract; and

''(7) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

''(e) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

''(A) tuition expenses; or

''(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual.

''(2) PAYMENTS FOR YEARS SERVED.—

''(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (d) the Secretary may pay up to $35,000 on behalf of the individual for loans described in paragraph (1). With respect to participants under the Program whose total eligible loans are less than $105,000, the Secretary shall pay an amount that does not exceed ⅓ of the eligible loan balance for each year of obligated service of the individual.

''(B) REPAYMENT SCHEDULE.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

''(3) TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual—

''(A) the Secretary shall, in addition to such payments, make payments to the individual in an amount not to exceed 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.

''(4) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Program to establish a schedule for the making of such payments.

''(f) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a school of medicine, public health, nursing, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, psychology, or social work, the date of the initiation of the period of obligated service may be postponed, upon the submission by the individual of a petition for such postponement and approval by the Secretary, to the date on which the individual completes an approved internship, residency, or other relevant public health advanced training program.

''(g) ADMINISTRATIVE PROVISIONS.—

''(1) HIRING PRIORITY.—Notwithstanding any other provision of law, Federal, State, local, and tribal public health agencies and health centers may give hiring priority to any individual who has qualified for and is willing to execute a contract to participate in the Program.

''(2) EMPLOYMENT CEILINGS.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, who are serving as full-time employees of a State, local, or tribal public health agency or a health center, or who are in the last year of public health workforce academic preparation, shall not be counted against any employment ceiling affecting the Department or any other Federal agency.

''(h) BREACH OF CONTRACT.—An individual who fails to comply with the contract entered into under subsection (d) shall be subject to the same financial penalties as provided for under section 338E for breaches of loan repayment contracts under section 338B.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $195,000,000 for each of the fiscal years 2010 through 2015.

"SEC. 782. GRANTS FOR STATE AND LOCAL PROGRAMS.

''(a) IN GENERAL.—For the purpose of operating State, local, tribal, and health center public health workforce loan repayment programs under this subpart, the Secretary shall award a grant to any public health agency that receives public health preparedness cooperative agreements, or other successor cooperative agreements, from the Department of Health and Human Services.

''(b) REQUIREMENTS.—A State or local loan repayment program operated with a grant under subsection (a) shall incorporate all provisions of the Public Health Workforce Loan Repayment Program under section 781, including the ability to designate priority service areas within the relevant political jurisdiction.

''(c) ADMINISTRATION.—The head of the State or local office that receives a grant under subsection (a) shall be responsible for contracting and operating the loan repayment program under the grant.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to obligate or limit any State, local, or tribal government entity from implementing independent or supplemental public health workforce development programs within their borders.

"SEC. 783. TRAINING FOR MID-CAREER PUBLIC HEALTH PROFESSIONALS.

''(a) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, any eligible entity to award scholarships to eligible individuals to enroll in degree or professional training programs for the purpose of enabling mid-career professionals in the public health workforce to receive additional training in the field of public health.

''(b) ELIGIBILITY.—

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' indicates an accredited educational institution that offers a course of study, certificate program, or professional training program in infectious disease science, medicine, public health, veterinary medicine, or other discipline impacting or influenced by bioterrorism or emerging infectious diseases.

''(2) ELIGIBLE INDIVIDUALS.—The term 'eligible individuals' includes those individuals employed in public health positions at the Federal, State, tribal, or local level or a health center who are interested in retaining or upgrading their education.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $30,000,000 for each of the fiscal years 2010 through 2015.

"SEC. 784. CATALOGUE OF FEDERAL PUBLIC HEALTH WORKFORCE EMPLOYMENT OPPORTUNITIES.

''(a) IN GENERAL.—The Director of the Office of Personnel Management, in cooperation with the Secretary, shall ensure that, included in the Internet website of the Office of Personnel Management, there is an online catalogue, or link to an online catalogue, of public health workforce employment opportunities in the Federal Government.

''(b) REQUIREMENTS.—To the extent practicable, the catalogue described in subsection (a) shall include—

''(1) existing and projected job openings in the Federal public health workforce; and

''(2) a general discussion of the occupations that comprise the Federal public health workforce.

''(c) INFORMATION.—The Secretary shall include a copy of the catalogue described in subsection (a), or a prominent reference to the catalogue, in—

''(1) the application forms provided under section 780(c)(1); and

''(2) the information for schools provided under section 780(c)(2).''.

By Mr. KOHL (for himself and Mr. LEAHY):

S. 1147. A bill to prevent tobacco smuggling, to ensure the collection of

all tobacco taxes, and for other purposes; to the Committee on the Judiciary.

Mr. KOHL. Mr. President, I rise today with Senator LEAHY to introduce the Prevent All Cigarette Trafficking, PACT, Act of 2009. As the problem of cigarette trafficking continues to worsen, we must provide law enforcement officials with the tools they need to crack down on cigarette trafficking. The PACT Act closes loopholes in current tobacco trafficking laws, enhances penalties for violations, and provides law enforcement with new tools to combat the innovative new methods being used by cigarette traffickers to distribute their products. Each day we delay passage of this important legislation, terrorists and criminals raise more money, States lose significant amounts of tax revenue, and kids have easy access to tobacco products over the internet.

The cost to Americans is not merely financial. Tobacco smuggling also poses a significant threat to innocent people around the world. It has developed into a popular, and highly profitable, means of generating revenue for criminal and terrorist organizations. Hezbollah, for example, earned $1.5 million between 1996 and 2000 by engaging in tobacco trafficking in the U.S. Al Qaeda and Hamas have also generated significant revenue from the sale of counterfeit cigarettes. That money is often raised right here in the U.S. and it is then funneled back to these international terrorist groups. Cutting off financial support to terrorist groups is an integral part of the protecting this country against future attacks. We can no longer continue to let terrorist organizations exploit weaknesses in our tobacco laws to generate significant amounts of money. The cost of doing nothing is too great.

This is not a minor problem. Cigarette smuggling is a multibillion dollar a year phenomenon, and it is getting worse. In 1998, the Bureau of Alcohol, Tobacco, Firearms and Explosives (BATFE) had six active tobacco smuggling investigations. In 2005, that number swelled to 452. Today there are more than 400 open cases.

The number of cases alone, however, does not sufficiently put this problem into perspective. The amount of money involved is truly astonishing. Cigarette trafficking, including the illegal sale of tobacco products over the internet, costs States billions of dollars in lost tax revenue each year. It is estimated that we lose $5 billion in state revenues due to illegal tobacco sales. As lost tobacco tax revenue lines the pockets of criminals and terrorist groups, states are being forced to college tuition and restrict access to other public programs. Tobacco smuggling may provide some with cheap access to cigarettes, but those cheap cigarettes are coming at a significant cost to the rest of us.

According to the Government Accountability Office, each year, cigarette trafficking investigations are growing more and more complex, and take longer to resolve. More people are selling cigarettes illegally, and they are getting better at it. As these cases get tougher to solve, we owe it to law enforcement officials to do our part to lend a helping hand. The PACT Act enhances BATFE's authority to enter premises to investigate and enforce cigarette trafficking laws, and increasing penalties for violations. Unless these existing laws are strengthened, traffickers will continue to operate with near impunity.

Just as important, though, we must provide law enforcement with new enforcement tools—tools that enable them to combat the cigarette smugglers of the 21st century. The internet represents one of those new obstacles to enforcement. Illegal tobacco vendors around the world evade detection by conducting transactions over the internet, and then employing the services of common carriers and the U.S. Postal Service to deliver their illegal products around the country. Just a few years ago, there were less than 100 vendors selling cigarettes online. Today, we estimate that approximately 500 vendors sell illegal tobacco products over the internet.

Without new and innovative enforcement methods, law enforcement will not be able to effectively address the growing challenges facing them today. The PACT Act sets out to do just that by cutting off the delivery. A significant part of this problem involves the shipment of contraband cigarettes through the U.S. Postal Service, USPS. This bill would cut off access to the USPS by making tobacco products non-mailable. We would treat cigarettes just like we treat alcohol, making it illegal to ship them through the U.S. mails and cutting off a large portion of the delivery system.

It also employs a novel approach, one being used in some of our States today, to combat illegal sales of tobacco over the internet. Specifically, it will allow the Attorney General, in collaboration with State and local law enforcement, to create a list of companies that are illegally selling tobacco products. That list will then be distributed to legitimate businesses whose services are indispensable to illegal internet vendors—common carriers. Once a common carrier knows which customers are breaking the law, this bill will ensure that they take appropriate action to prevent their companies from being exploited by terrorists and other criminals.

It is important to point out that this bill has been carefully negotiated with the common carriers, including UPS, to ensure that it does not place any unreasonable burdens on these businesses. In recognition of UPS and other common carriers' agreements to not deliver cigarettes to individual consumers on a nationwide basis, pursuant to agreements with the State of New York, we have exempted them from the bill provided this agreement remains in effect.

In addition to these important law enforcement needs, it is important to mention another aspect of this legislation that is equally important. One of the primary ways children get access to cigarettes today is on the internet and through the mails. The PACT Act now contains a strong age verification section that will ensure that online vendors are not selling cigarettes to our children. This provision would prohibit the sale of tobacco products to children, and it would also require sellers to use a method of shipment that requires a signature and photo ID check upon delivery. Most States already have similar laws on the books, and this would simply make sure that we have a national standard to ensure that the internet is not being used to evade similar ID checks we require at our grocery and convenience stores.

The recognition that this is a significant problem, along with the commonsense approach taken in the PACT Act to combat it, has brought together a coalition of strange bedfellows. The legislation has not just garnered the support of the law enforcement community, including the National Association of Attorneys General, and public health advocates, such as the Campaign for Tobacco Free Kids. It also has the strong support of tobacco companies like Altria. These groups, who sometimes find themselves on opposite sides of these issues, all agree that this is an issue begging to be addressed. They all recognize the urgent need to provide our law enforcement officials with the tools they need to combat a very serious threat to our security and protect public health.

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. 1147

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

SECTION 1. SHORT TITLE; FINDINGS; PURPOSES.

(a) SHORT TITLE.—This Act may be cited as the ''Prevent All Cigarette Trafficking Act of 2009'' or ''PACT Act''.

(b) FINDINGS.—Congress finds that—

(1) the sale of illegal cigarettes and smokeless tobacco products significantly reduces Federal, State, and local government revenues, with Internet sales alone accounting for billions of dollars of lost Federal, State, and local tobacco tax revenue each year;

(2) Hezbollah, Hamas, al Qaeda, and other terrorist organizations have profited from trafficking in illegal cigarettes or counterfeit cigarette tax stamps;

(3) terrorist involvement in illicit cigarette trafficking will continue to grow because of the large profits such organizations can earn;

(4) the sale of illegal cigarettes and smokeless tobacco over the Internet, and through mail, fax, or phone orders, makes it cheaper and easier for children to obtain tobacco products;

(5) the majority of Internet and other remote sales of cigarettes and smokeless tobacco are being made without adequate precautions to protect against sales to children,

without the payment of applicable taxes, and without complying with the nominal registration and reporting requirements in existing Federal law;

(6) unfair competition from illegal sales of cigarettes and smokeless tobacco is taking billions of dollars of sales away from law-abiding retailers throughout the United States;

(7) with rising State and local tobacco tax rates, the incentives for the illegal sale of cigarettes and smokeless tobacco have increased;

(8) the number of active tobacco investigations being conducted by the Bureau of Alcohol, Tobacco, Firearms, and Explosives rose to 452 in 2005;

(9) the number of Internet vendors in the United States and in foreign countries that sell cigarettes and smokeless tobacco to buyers in the United States increased from only about 40 in 2000 to more than 500 in 2005; and

(10) the intrastate sale of illegal cigarettes and smokeless tobacco over the Internet has a substantial effect on interstate commerce.

(c) PURPOSES.—It is the purpose of this Act to—

(1) require Internet and other remote sellers of cigarettes and smokeless tobacco to comply with the same laws that apply to law-abiding tobacco retailers;

(2) create strong disincentives to illegal smuggling of tobacco products;

(3) provide government enforcement officials with more effective enforcement tools to combat tobacco smuggling;

(4) make it more difficult for cigarette and smokeless tobacco traffickers to engage in and profit from their illegal activities;

(5) increase collections of Federal, State, and local excise taxes on cigarettes and smokeless tobacco; and

(6) prevent and reduce youth access to inexpensive cigarettes and smokeless tobacco through illegal Internet or contraband sales.

SEC. 2. COLLECTION OF STATE CIGARETTE AND SMOKELESS TOBACCO TAXES.

(a) DEFINITIONS.—The Act of October 19, 1949 (15 U.S.C. 375 et seq.; commonly referred to as the ''Jenkins Act'') (referred to in this Act as the ''Jenkins Act''), is amended by striking the first section and inserting the following:

''SECTION 1. DEFINITIONS.

''As used in this Act, the following definitions apply:

''(1) ATTORNEY GENERAL.—The term 'attorney general', with respect to a State, means the attorney general or other chief law enforcement officer of the State.

''(2) CIGARETTE.—

''(A) IN GENERAL.—The term 'cigarette'—

''(i) has the meaning given that term in section 2341 of title 18, United States Code; and

''(ii) includes roll-your-own tobacco (as defined in section 5702 of the Internal Revenue Code of 1986).

''(B) EXCEPTION.—The term 'cigarette' does not include a cigar (as defined in section 5702 of the Internal Revenue Code of 1986).

''(3) COMMON CARRIER.—The term 'common carrier' means any person (other than a local messenger service or the United States Postal Service) that holds itself out to the general public as a provider for hire of the transportation by water, land, or air of merchandise (regardless of whether the person actually operates the vessel, vehicle, or aircraft by which the transportation is provided) between a port or place and a port or place in the United States.

''(4) CONSUMER.—The term 'consumer'—

''(A) means any person that purchases cigarettes or smokeless tobacco; and

''(B) does not include any person lawfully operating as a manufacturer, distributor, wholesaler, or retailer of cigarettes or smokeless tobacco.

''(5) DELIVERY SALE.—The term 'delivery sale' means any sale of cigarettes or smokeless tobacco to a consumer if—

''(A) the consumer submits the order for the sale by means of a telephone or other method of voice transmission, the mails, or the Internet or other online service, or the seller is otherwise not in the physical presence of the buyer when the request for purchase or order is made; or

''(B) the cigarettes or smokeless tobacco are delivered to the buyer by common carrier, private delivery service, or other method of remote delivery, or the seller is not in the physical presence of the buyer when the buyer obtains possession of the cigarettes or smokeless tobacco.

''(6) DELIVERY SELLER.—The term 'delivery seller' means a person who makes a delivery sale.

''(7) INDIAN COUNTRY.—The term 'Indian country'—

''(A) has the meaning given that term in section 1151 of title 18, United States Code, except that within the State of Alaska that term applies only to the Metlakatla Indian Community, Annette Island Reserve; and

''(B) includes any other land held by the United States in trust or restricted status for one or more Indian tribes.

''(8) INDIAN TRIBE.—The term 'Indian tribe', 'tribe', or 'tribal' refers to an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) or as listed pursuant to section 104 of the Federally Recognized Indian Tribe List Act of 1994 (25 U.S.C. 479a–1).

''(9) INTERSTATE COMMERCE.—The term 'interstate commerce' means commerce between a State and any place outside the State, commerce between a State and any Indian country in the State, or commerce between points in the same State but through any place outside the State or through any Indian country.

''(10) PERSON.—The term 'person' means an individual, corporation, company, association, firm, partnership, society, State government, local government, Indian tribal government, governmental organization of such a government, or joint stock company.

''(11) STATE.—The term 'State' means each of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or any territory or possession of the United States.

''(12) SMOKELESS TOBACCO.—The term 'smokeless tobacco' means any finely cut, ground, powdered, or leaf tobacco, or other product containing tobacco, that is intended to be placed in the oral or nasal cavity or otherwise consumed without being combusted.

''(13) TOBACCO TAX ADMINISTRATOR.—The term 'tobacco tax administrator' means the State, local, or tribal official duly authorized to collect the tobacco tax or administer the tax law of a State, locality, or tribe, respectively.

''(14) USE.—The term 'use' includes the consumption, storage, handling, or disposal of cigarettes or smokeless tobacco.''.

(b) REPORTS TO STATE TOBACCO TAX ADMINISTRATORS.—Section 2 of the Jenkins Act (15 U.S.C. 376) is amended—

(1) by striking ''cigarettes'' each place it appears and inserting ''cigarettes or smokeless tobacco'';

(2) in subsection (a)—

(A) in the matter preceding paragraph (1)—

(i) by inserting ''CONTENTS.—'' after ''(a)'';

(ii) by striking ''or transfers'' and inserting '', transfers, or ships'';

(iii) by inserting '', locality, or Indian country of an Indian tribe'' after ''a State'';

(iv) by striking ''to other than a distributor licensed by or located in such State,''; and

(v) by striking ''or transfer and shipment'' and inserting '', transfer, or shipment'';

(B) in paragraph (1)—

(i) by striking ''with the tobacco tax administrator of the State'' and inserting ''with the Attorney General of the United States and with the tobacco tax administrators of the State and place''; and

(ii) by striking ''; and'' and inserting the following: '', as well as telephone numbers for each place of business, a principal electronic mail address, any website addresses, and the name, address, and telephone number of an agent in the State authorized to accept service on behalf of the person;'';

(C) in paragraph (2), by striking ''and the quantity thereof.'' and inserting ''the quantity thereof, and the name, address, and phone number of the person delivering the shipment to the recipient on behalf of the delivery seller, with all invoice or memoranda information relating to specific customers to be organized by city or town and by zip code; and''; and

(D) by adding at the end the following:

''(3) with respect to each memorandum or invoice filed with a State under paragraph (2), also file copies of the memorandum or invoice with the tobacco tax administrators and chief law enforcement officers of the local governments and Indian tribes operating within the borders of the State that apply their own local or tribal taxes on cigarettes or smokeless tobacco.'';

(3) in subsection (b)—

(A) by inserting ''PRESUMPTIVE EVIDENCE.—'' after ''(b)'';

(B) by striking ''(1) that'' and inserting ''that''; and

(C) by striking '', and (2)'' and all that follows and inserting a period; and

(4) by adding at the end the following:

''(c) USE OF INFORMATION.—A tobacco tax administrator or chief law enforcement officer who receives a memorandum or invoice under paragraph (2) or (3) of subsection (a) shall use the memorandum or invoice solely for the purposes of the enforcement of this Act and the collection of any taxes owed on related sales of cigarettes and smokeless tobacco, and shall keep confidential any personal information in the memorandum or invoice except as required for such purposes.''.

(c) REQUIREMENTS FOR DELIVERY SALES.—The Jenkins Act is amended by inserting after section 2 the following:

''SEC. 2A. DELIVERY SALES.

''(a) IN GENERAL.—With respect to delivery sales into a specific State and place, each delivery seller shall comply with—

''(1) the shipping requirements set forth in subsection (b);

''(2) the recordkeeping requirements set forth in subsection (c);

''(3) all State, local, tribal, and other laws generally applicable to sales of cigarettes or smokeless tobacco as if the delivery sales occurred entirely within the specific State and place, including laws imposing—

''(A) excise taxes;

''(B) licensing and tax-stamping requirements;

''(C) restrictions on sales to minors; and

''(D) other payment obligations or legal requirements relating to the sale, distribution, or delivery of cigarettes or smokeless tobacco; and

''(4) the tax collection requirements set forth in subsection (d).

''(b) SHIPPING AND PACKAGING.—

''(1) REQUIRED STATEMENT.—For any shipping package containing cigarettes or smokeless tobacco, the delivery seller shall include on the bill of lading, if any, and on

the outside of the shipping package, on the same surface as the delivery address, a clear and conspicuous statement providing as follows: 'CIGARETTES/SMOKELESS TOBACCO: FEDERAL LAW REQUIRES THE PAYMENT OF ALL APPLICABLE EXCISE TAXES, AND COMPLIANCE WITH APPLICABLE LICENSING AND TAX–STAMPING OBLIGATIONS'.

''(2) FAILURE TO LABEL.—Any shipping package described in paragraph (1) that is not labeled in accordance with that paragraph shall be treated as nondeliverable matter by a common carrier or other delivery service, if the common carrier or other delivery service knows or should know the package contains cigarettes or smokeless tobacco. If a common carrier or other delivery service believes a package is being submitted for delivery in violation of paragraph (1), it may require the person submitting the package for delivery to establish that it is not being sent in violation of paragraph (1) before accepting the package for delivery. Nothing in this paragraph shall require the common carrier or other delivery service to open any package to determine its contents.

''(3) WEIGHT RESTRICTION.—A delivery seller shall not sell, offer for sale, deliver, or cause to be delivered in any single sale or single delivery any cigarettes or smokeless tobacco weighing more than 10 pounds.

''(4) AGE VERIFICATION.—

''(A) IN GENERAL.—A delivery seller who mails or ships tobacco products—

''(i) shall not sell, deliver, or cause to be delivered any tobacco products to a person under the minimum age required for the legal sale or purchase of tobacco products, as determined by the applicable law at the place of delivery;

''(ii) shall use a method of mailing or shipping that requires—

''(I) the purchaser placing the delivery sale order, or an adult who is at least the minimum age required for the legal sale or purchase of tobacco products, as determined by the applicable law at the place of delivery, to sign to accept delivery of the shipping container at the delivery address; and

''(II) the person who signs to accept delivery of the shipping container to provide proof, in the form of a valid, government-issued identification bearing a photograph of the individual, that the person is at least the minimum age required for the legal sale or purchase of tobacco products, as determined by the applicable law at the place of delivery; and

''(iii) shall not accept a delivery sale order from a person without—

''(I) obtaining the full name, birth date, and residential address of that person; and

''(II) verifying the information provided in subclause (I), through the use of a commercially available database or aggregate of databases, consisting primarily of data from government sources, that are regularly used by government and businesses for the purpose of age and identity verification and authentication, to ensure that the purchaser is at least the minimum age required for the legal sale or purchase of tobacco products, as determined by the applicable law at the place of delivery.

''(B) LIMITATION.—No database being used for age and identity verification under subparagraph (A)(iii) shall be in the possession or under the control of the delivery seller, or be subject to any changes or supplementation by the delivery seller.

''(c) RECORDS.—

''(1) IN GENERAL.—Each delivery seller shall keep a record of any delivery sale, including all of the information described in section 2(a)(2), organized by the State, and within the State, by the city or town and by zip code, into which the delivery sale is so made.

''(2) RECORD RETENTION.—Records of a delivery sale shall be kept as described in paragraph (1) until the end of the 4th full calendar year that begins after the date of the delivery sale.

''(3) ACCESS FOR OFFICIALS.—Records kept under paragraph (1) shall be made available to tobacco tax administrators of the States, to local governments and Indian tribes that apply local or tribal taxes on cigarettes or smokeless tobacco, to the attorneys general of the States, to the chief law enforcement officers of the local governments and Indian tribes, and to the Attorney General of the United States in order to ensure the compliance of persons making delivery sales with the requirements of this Act.

''(d) DELIVERY.—

''(1) IN GENERAL.—Except as provided in paragraph (2), no delivery seller may sell or deliver to any consumer, or tender to any common carrier or other delivery service, any cigarettes or smokeless tobacco pursuant to a delivery sale unless, in advance of the sale, delivery, or tender—

''(A) any cigarette or smokeless tobacco excise tax that is imposed by the State in which the cigarettes or smokeless tobacco are to be delivered has been paid to the State;

''(B) any cigarette or smokeless tobacco excise tax that is imposed by the local government of the place in which the cigarettes or smokeless tobacco are to be delivered has been paid to the local government; and

''(C) any required stamps or other indicia that the excise tax has been paid are properly affixed or applied to the cigarettes or smokeless tobacco.

''(2) EXCEPTION.—Paragraph (1) does not apply to a delivery sale of smokeless tobacco if the law of the State or local government of the place where the smokeless tobacco is to be delivered requires or otherwise provides that delivery sellers collect the excise tax from the consumer and remit the excise tax to the State or local government, and the delivery seller complies with the requirement.

''(e) LIST OF UNREGISTERED OR NONCOMPLIANT DELIVERY SELLERS.—

''(1) IN GENERAL.—

''(A) INITIAL LIST.—Not later than 90 days after this subsection goes into effect under the Prevent All Cigarette Trafficking Act of 2009, the Attorney General of the United States shall compile a list of delivery sellers of cigarettes or smokeless tobacco that have not registered with the Attorney General of the United States pursuant to section 2(a), or that are otherwise not in compliance with this Act, and—

''(i) distribute the list to—

''(I) the attorney general and tax administrator of every State;

''(II) common carriers and other persons that deliver small packages to consumers in interstate commerce, including the United States Postal Service; and

''(III) any other person that the Attorney General of the United States determines can promote the effective enforcement of this Act; and

''(ii) publicize and make the list available to any other person engaged in the business of interstate deliveries or who delivers cigarettes or smokeless tobacco in or into any State.

''(B) LIST CONTENTS.—To the extent known, the Attorney General of the United States shall include, for each delivery seller on the list described in subparagraph (A)—

''(i) all names the delivery seller uses or has used in the transaction of its business or on packages delivered to customers;

''(ii) all addresses from which the delivery seller does or has done business, or ships or has shipped cigarettes or smokeless tobacco;

''(iii) the website addresses, primary e-mail address, and phone number of the delivery seller; and

''(iv) any other information that the Attorney General of the United States determines would facilitate compliance with this subsection by recipients of the list.

''(C) UPDATING.—The Attorney General of the United States shall update and distribute the list described in subparagraph (A) at least once every 4 months, and may distribute the list and any updates by regular mail, electronic mail, or any other reasonable means, or by providing recipients with access to the list through a nonpublic website that the Attorney General of the United States regularly updates.

''(D) STATE, LOCAL, OR TRIBAL ADDITIONS.—The Attorney General of the United States shall include in the list described in subparagraph (A) any noncomplying delivery sellers identified by any State, local, or tribal government under paragraph (6), and shall distribute the list to the attorney general or chief law enforcement official and the tax administrator of any government submitting any such information, and to any common carriers or other persons who deliver small packages to consumers identified by any government pursuant to paragraph (6).

''(E) ACCURACY AND COMPLETENESS OF LIST OF NONCOMPLYING DELIVERY SELLERS.—In preparing and revising the list described in subparagraph (A), the Attorney General of the United States shall—

''(i) use reasonable procedures to ensure maximum possible accuracy and completeness of the records and information relied on for the purpose of determining that a delivery seller is not in compliance with this Act;

''(ii) not later than 14 days before including a delivery seller on the list, make a reasonable attempt to send notice to the delivery seller by letter, electronic mail, or other means that the delivery seller is being placed on the list, which shall cite the relevant provisions of this Act and the specific reasons for which the delivery seller is being placed on the list;

''(iii) provide an opportunity to the delivery seller to challenge placement on the list;

''(iv) investigate each challenge described in clause (iii) by contacting the relevant Federal, State, tribal, and local law enforcement officials, and provide the specific findings and results of the investigation to the delivery seller not later than 30 days after the date on which the challenge is made; and

''(v) if the Attorney General of the United States determines that the basis for including a delivery seller on the list is inaccurate, based on incomplete information, or cannot be verified, promptly remove the delivery seller from the list as appropriate and notify each appropriate Federal, State, tribal, and local authority of the determination.

''(F) CONFIDENTIALITY.—The list described in subparagraph (A) shall be confidential, and any person receiving the list shall maintain the confidentiality of the list and may deliver the list, for enforcement purposes, to any government official or to any common carrier or other person that delivers tobacco products or small packages to consumers. Nothing in this section shall prohibit a common carrier, the United States Postal Service, or any other person receiving the list from discussing with a listed delivery seller the inclusion of the delivery seller on the list and the resulting effects on any services requested by the listed delivery seller.

''(2) PROHIBITION ON DELIVERY.—

''(A) IN GENERAL.—Commencing on the date that is 60 days after the date of the initial distribution or availability of the list

described in paragraph (1)(A), no person who receives the list under paragraph (1), and no person who delivers cigarettes or smokeless tobacco to consumers, shall knowingly complete, cause to be completed, or complete its portion of a delivery of any package for any person whose name and address are on the list, unless—

''(i) the person making the delivery knows or believes in good faith that the item does not include cigarettes or smokeless tobacco;

''(ii) the delivery is made to a person lawfully engaged in the business of manufacturing, distributing, or selling cigarettes or smokeless tobacco; or

''(iii) the package being delivered weighs more than 100 pounds and the person making the delivery does not know or have reasonable cause to believe that the package contains cigarettes or smokeless tobacco.

''(B) IMPLEMENTATION OF UPDATES.—Commencing on the date that is 30 days after the date of the distribution or availability of any updates or corrections to the list described in paragraph (1)(A), all recipients and all common carriers or other persons that deliver cigarettes or smokeless tobacco to consumers shall be subject to subparagraph (A) in regard to the corrections or updates.

''(3) EXEMPTIONS.—

''(A) IN GENERAL.—Subsection (b)(2) and any requirements or restrictions placed directly on common carriers under this subsection, including subparagraphs (A) and (B) of paragraph (2), shall not apply to a common carrier that—

''(i) is subject to a settlement agreement described in subparagraph (B); or

''(ii) if a settlement agreement described in subparagraph (B) to which the common carrier is a party is terminated or otherwise becomes inactive, is administering and enforcing policies and practices throughout the United States that are at least as stringent as the agreement.

''(B) SETTLEMENT AGREEMENT.—A settlement agreement described in this subparagraph—

''(i) is a settlement agreement relating to tobacco product deliveries to consumers; and

''(ii) includes—

''(I) the Assurance of Discontinuance entered into by the Attorney General of New York and DHL Holdings USA, Inc. and DHL Express (USA), Inc. on or about July 1, 2005, the Assurance of Discontinuance entered into by the Attorney General of New York and United Parcel Service, Inc. on or about October 21, 2005, and the Assurance of Compliance entered into by the Attorney General of New York and Federal Express Corporation and FedEx Ground Package Systems, Inc. on or about February 3, 2006, if each of those agreements is honored throughout the United States to block illegal deliveries of cigarettes or smokeless tobacco to consumers; and

''(II) any other active agreement between a common carrier and a State that operates throughout the United States to ensure that no deliveries of cigarettes or smokeless tobacco shall be made to consumers or illegally operating Internet or mail-order sellers and that any such deliveries to consumers shall not be made to minors or without payment to the States and localities where the consumers are located of all taxes on the tobacco products.

''(4) SHIPMENTS FROM PERSONS ON LIST.—

''(A) IN GENERAL.—If a common carrier or other delivery service delays or interrupts the delivery of a package in the possession of the common carrier or delivery service because the common carrier or delivery service determines or has reason to believe that the person ordering the delivery is on a list described in paragraph (1)(A) and that the package contains cigarettes or smokeless tobacco—

''(i) the person ordering the delivery shall be obligated to pay—

''(I) the common carrier or other delivery service as if the delivery of the package had been timely completed; and

''(II) if the package is not deliverable, any reasonable additional fee or charge levied by the common carrier or other delivery service to cover any extra costs and inconvenience and to serve as a disincentive against such noncomplying delivery orders; and

''(ii) if the package is determined not to be deliverable, the common carrier or other delivery service shall offer to provide the package and its contents to a Federal, State, or local law enforcement agency.

''(B) RECORDS.—A common carrier or other delivery service shall maintain, for a period of 5 years, any records kept in the ordinary course of business relating to any delivery interrupted under this paragraph and provide that information, upon request, to the Attorney General of the United States or to the attorney general or chief law enforcement official or tax administrator of any State, local, or tribal government.

''(C) CONFIDENTIALITY.—Any person receiving records under subparagraph (B) shall—

''(i) use the records solely for the purposes of the enforcement of this Act and the collection of any taxes owed on related sales of cigarettes and smokeless tobacco; and

''(ii) keep confidential any personal information in the records not otherwise required for such purposes.

''(5) PREEMPTION.—

''(A) IN GENERAL.—No State, local, or tribal government, nor any political authority of 2 or more State, local, or tribal governments, may enact or enforce any law or regulation relating to delivery sales that restricts deliveries of cigarettes or smokeless tobacco to consumers by common carriers or other delivery services on behalf of delivery sellers by—

''(i) requiring that the common carrier or other delivery service verify the age or identity of the consumer accepting the delivery by requiring the person who signs to accept delivery of the shipping container to provide proof, in the form of a valid, government-issued identification bearing a photograph of the individual, that the person is at least the minimum age required for the legal sale or purchase of tobacco products, as determined by either State or local law at the place of delivery;

''(ii) requiring that the common carrier or other delivery service obtain a signature from the consumer accepting the delivery;

''(iii) requiring that the common carrier or other delivery service verify that all applicable taxes have been paid;

''(iv) requiring that packages delivered by the common carrier or other delivery service contain any particular labels, notice, or markings; or

''(v) prohibiting common carriers or other delivery services from making deliveries on the basis of whether the delivery seller is or is not identified on any list of delivery sellers maintained and distributed by any entity other than the Federal Government.

''(B) RELATIONSHIP TO OTHER LAWS.—Except as provided in subparagraph (C), nothing in this paragraph shall be construed to nullify, expand, restrict, or otherwise amend or modify—

''(i) section 14501(c)(1) or 41713(b)(4) of title 49, United States Code;

''(ii) any other restrictions in Federal law on the ability of State, local, or tribal governments to regulate common carriers; or

''(iii) any provision of State, local, or tribal law regulating common carriers that is described in section 14501(c)(2) or 41713(b)(4)(B) of title 49 of the United States Code.

''(C) STATE LAWS PROHIBITING DELIVERY SALES.—

''(i) IN GENERAL.—Except as provided in clause (ii), nothing in the Prevent All Cigarette Trafficking Act of 2009, the amendments made by that Act, or in any other Federal statute shall be construed to preempt, supersede, or otherwise limit or restrict State laws prohibiting the delivery sale, or the shipment or delivery pursuant to a delivery sale, of cigarettes or other tobacco products to individual consumers or personal residences.

''(ii) EXEMPTIONS.—No State may enforce against a common carrier a law prohibiting the delivery of cigarettes or other tobacco products to individual consumers or personal residences without proof that the common carrier is not exempt under paragraph (3) of this subsection.

''(6) STATE, LOCAL, AND TRIBAL ADDITIONS.—

''(A) IN GENERAL.—Any State, local, or tribal government shall provide the Attorney General of the United States with—

''(i) all known names, addresses, website addresses, and other primary contact information of any delivery seller that—

''(I) offers for sale or makes sales of cigarettes or smokeless tobacco in or into the State, locality, or tribal land; and

''(II) has failed to register with or make reports to the respective tax administrator as required by this Act, or that has been found in a legal proceeding to have otherwise failed to comply with this Act; and

''(ii) a list of common carriers and other persons who make deliveries of cigarettes or smokeless tobacco in or into the State, locality, or tribal land.

''(B) UPDATES.—Any government providing a list to the Attorney General of the United States under subparagraph (A) shall also provide updates and corrections every 4 months until such time as the government notifies the Attorney General of the United States in writing that the government no longer desires to submit information to supplement the list described in paragraph (1)(A).

''(C) REMOVAL AFTER WITHDRAWAL.—Upon receiving written notice that a government no longer desires to submit information under subparagraph (A), the Attorney General of the United States shall remove from the list described in paragraph (1)(A) any persons that are on the list solely because of the prior submissions of the government of the list of the government of noncomplying delivery sellers of cigarettes or smokeless tobacco or a subsequent update or correction by the government.

''(7) DEADLINE TO INCORPORATE ADDITIONS.—The Attorney General of the United States shall—

''(A) include any delivery seller identified and submitted by a State, local, or tribal government under paragraph (6) in any list or update that is distributed or made available under paragraph (1) on or after the date that is 30 days after the date on which the information is received by the Attorney General of the United States; and

''(B) distribute any list or update described in subparagraph (A) to any common carrier or other person who makes deliveries of cigarettes or smokeless tobacco that has been identified and submitted by a government pursuant to paragraph (6).

''(8) NOTICE TO DELIVERY SELLERS.—Not later than 14 days before including any delivery seller on the initial list described in paragraph (1)(A), or on an update to the list for the first time, the Attorney General of the United States shall make a reasonable attempt to send notice to the delivery seller by letter, electronic mail, or other means that the delivery seller is being placed on the

list or update, with that notice citing the relevant provisions of this Act.

''(9) LIMITATIONS.—

''(A) IN GENERAL.—Any common carrier or other person making a delivery subject to this subsection shall not be required or otherwise obligated to—

''(i) determine whether any list distributed or made available under paragraph (1) is complete, accurate, or up-to-date;

''(ii) determine whether a person ordering a delivery is in compliance with this Act; or

''(iii) open or inspect, pursuant to this Act, any package being delivered to determine its contents.

''(B) ALTERNATE NAMES.—Any common carrier or other person making a delivery subject to this subsection—

''(i) shall not be required to make any inquiries or otherwise determine whether a person ordering a delivery is a delivery seller on the list described in paragraph (1)(A) who is using a different name or address in order to evade the related delivery restrictions; and

''(ii) shall not knowingly deliver any packages to consumers for any delivery seller on the list described in paragraph (1)(A) who the common carrier or other delivery service knows is a delivery seller who is on the list and is using a different name or address to evade the delivery restrictions of paragraph (2).

''(C) PENALTIES.—Any common carrier or person in the business of delivering packages on behalf of other persons shall not be subject to any penalty under section 14101(a) of title 49, United States Code, or any other provision of law for—

''(i) not making any specific delivery, or any deliveries at all, on behalf of any person on the list described in paragraph (1)(A);

''(ii) refusing, as a matter of regular practice and procedure, to make any deliveries, or any deliveries in certain States, of any cigarettes or smokeless tobacco for any person or for any person not in the business of manufacturing, distributing, or selling cigarettes or smokeless tobacco; or

''(iii) delaying or not making a delivery for any person because of reasonable efforts to comply with this Act.

''(D) OTHER LIMITS.—Section 2 and subsections (a), (b), (c), and (d) of this section shall not be interpreted to impose any responsibilities, requirements, or liability on common carriers.

''(f) PRESUMPTION.—For purposes of this Act, a delivery sale shall be deemed to have occurred in the State and place where the buyer obtains personal possession of the cigarettes or smokeless tobacco, and a delivery pursuant to a delivery sale is deemed to have been initiated or ordered by the delivery seller.''.

(d) PENALTIES.—The Jenkins Act is amended by striking section 3 and inserting the following:

''SEC. 3. PENALTIES.

''(a) CRIMINAL PENALTIES.—

''(1) IN GENERAL.—Except as provided in paragraph (2), whoever knowingly violates this Act shall be imprisoned for not more than 3 years, fined under title 18, United States Code, or both.

''(2) EXCEPTIONS.—

''(A) GOVERNMENTS.—Paragraph (1) shall not apply to a State, local, or tribal government.

''(B) DELIVERY VIOLATIONS.—A common carrier or independent delivery service, or employee of a common carrier or independent delivery service, shall be subject to criminal penalties under paragraph (1) for a violation of section 2A(e) only if the violation is committed knowingly—

''(i) as consideration for the receipt of, or as consideration for a promise or agreement to pay, anything of pecuniary value; or

''(ii) for the purpose of assisting a delivery seller to violate, or otherwise evading compliance with, section 2A.

''(b) CIVIL PENALTIES.—

''(1) IN GENERAL.—Except as provided in paragraph (3), whoever violates this Act shall be subject to a civil penalty in an amount not to exceed—

''(A) in the case of a delivery seller, the greater of—

''(i) $5,000 in the case of the first violation, or $10,000 for any other violation; or

''(ii) for any violation, 2 percent of the gross sales of cigarettes or smokeless tobacco of the delivery seller during the 1-year period ending on the date of the violation.

''(B) in the case of a common carrier or other delivery service, $2,500 in the case of a first violation, or $5,000 for any violation within 1 year of a prior violation.

''(2) RELATION TO OTHER PENALTIES.—A civil penalty imposed under paragraph (1) for a violation of this Act shall be imposed in addition to any criminal penalty under subsection (a) and any other damages, equitable relief, or injunctive relief awarded by the court, including the payment of any unpaid taxes to the appropriate Federal, State, local, or tribal governments.

''(3) EXCEPTIONS.—

''(A) DELIVERY VIOLATIONS.—An employee of a common carrier or independent delivery service shall be subject to civil penalties under paragraph (1) for a violation of section 2A(e) only if the violation is committed intentionally—

''(i) as consideration for the receipt of, or as consideration for a promise or agreement to pay, anything of pecuniary value; or

''(ii) for the purpose of assisting a delivery seller to violate, or otherwise evading compliance with, section 2A.

''(B) OTHER LIMITATIONS.—No common carrier or independent delivery service shall be subject to civil penalties under paragraph (1) for a violation of section 2A(e) if—

''(i) the common carrier or independent delivery service has implemented and enforces effective policies and practices for complying with that section; or

''(ii) the violation consists of an employee of the common carrier or independent delivery service who physically receives and processes orders, picks up packages, processes packages, or makes deliveries, taking actions that are outside the scope of employment of the employee, or that violate the implemented and enforced policies of the common carrier or independent delivery service described in clause (i).''.

(e) ENFORCEMENT.—The Jenkins Act is amended by striking section 4 and inserting the following:

''SEC. 4. ENFORCEMENT.

''(a) IN GENERAL.—The United States district courts shall have jurisdiction to prevent and restrain violations of this Act and to provide other appropriate injunctive or equitable relief, including money damages, for the violations.

''(b) AUTHORITY OF THE ATTORNEY GENERAL.—The Attorney General of the United States shall administer and enforce this Act.

''(c) STATE, LOCAL, AND TRIBAL ENFORCEMENT.—

''(1) IN GENERAL.—

''(A) STANDING.—A State, through its attorney general, or a local government or Indian tribe that levies a tax subject to section 2A(a)(3), through its chief law enforcement officer, may bring an action in a United States district court to prevent and restrain violations of this Act by any person or to obtain any other appropriate relief from any person for violations of this Act, including civil penalties, money damages, and injunctive or other equitable relief.

''(B) SOVEREIGN IMMUNITY.—Nothing in this Act shall be deemed to abrogate or constitute a waiver of any sovereign immunity of a State or local government or Indian tribe against any unconsented lawsuit under this Act, or otherwise to restrict, expand, or modify any sovereign immunity of a State or local government or Indian tribe.

''(2) PROVISION OF INFORMATION.—A State, through its attorney general, or a local government or Indian tribe that levies a tax subject to section 2A(a)(3), through its chief law enforcement officer, may provide evidence of a violation of this Act by any person not subject to State, local, or tribal government enforcement actions for violations of this Act to the Attorney General of the United States or a United States attorney, who shall take appropriate actions to enforce this Act.

''(3) USE OF PENALTIES COLLECTED.—

''(A) IN GENERAL.—There is established a separate account in the Treasury known as the 'PACT Anti-Trafficking Fund'. Notwithstanding any other provision of law and subject to subparagraph (B), an amount equal to 50 percent of any criminal and civil penalties collected by the Federal Government in enforcing this Act shall be transferred into the PACT Anti-Trafficking Fund and shall be available to the Attorney General of the United States for purposes of enforcing this Act and other laws relating to contraband tobacco products.

''(B) ALLOCATION OF FUNDS.—Of the amount available to the Attorney General of the United States under subparagraph (A), not less than 50 percent shall be made available only to the agencies and offices within the Department of Justice that were responsible for the enforcement actions in which the penalties concerned were imposed or for any underlying investigations.

''(4) NONEXCLUSIVITY OF REMEDY.—

''(A) IN GENERAL.—The remedies available under this section and section 3 are in addition to any other remedies available under Federal, State, local, tribal, or other law.

''(B) STATE COURT PROCEEDINGS.—Nothing in this Act shall be construed to expand, restrict, or otherwise modify any right of an authorized State official to proceed in State court, or take other enforcement actions, on the basis of an alleged violation of State or other law.

''(C) TRIBAL COURT PROCEEDINGS.—Nothing in this Act shall be construed to expand, restrict, or otherwise modify any right of an authorized Indian tribal government official to proceed in tribal court, or take other enforcement actions, on the basis of an alleged violation of tribal law.

''(D) LOCAL GOVERNMENT ENFORCEMENT.—Nothing in this Act shall be construed to expand, restrict, or otherwise modify any right of an authorized local government official to proceed in State court, or take other enforcement actions, on the basis of an alleged violation of local or other law.

''(d) PERSONS DEALING IN TOBACCO PRODUCTS.—Any person who holds a permit under section 5712 of the Internal Revenue Code of 1986 (regarding permitting of manufacturers and importers of tobacco products and export warehouse proprietors) may bring an action in an appropriate United States district court to prevent and restrain violations of this Act by any person other than a State, local, or tribal government.

''(e) NOTICE.—

''(1) PERSONS DEALING IN TOBACCO PRODUCTS.—Any person who commences a civil action under subsection (d) shall inform the Attorney General of the United States of the action.

''(2) STATE, LOCAL, AND TRIBAL ACTIONS.—It is the sense of Congress that the attorney general of any State, or chief law enforcement officer of any locality or tribe, that commences a civil action under this section should inform the Attorney General of the United States of the action.

''(f) PUBLIC NOTICE.—

''(1) IN GENERAL.—The Attorney General of the United States shall make available to the public, by posting information on the Internet and by other appropriate means, information regarding all enforcement actions brought by the United States, or reported to the Attorney General of the United States, under this section, including information regarding the resolution of the enforcement actions and how the Attorney General of the United States has responded to referrals of evidence of violations pursuant to subsection (c)(2).

''(2) REPORTS TO CONGRESS.—Not later than 1 year after the date of enactment of the Prevent All Cigarette Trafficking Act of 2009, and every year thereafter until the date that is 5 years after such date of enactment, the Attorney General of the United States shall submit to Congress a report containing the information described in paragraph (1).''.

SEC. 3. TREATMENT OF CIGARETTES AND SMOKELESS TOBACCO AS NONMAILABLE MATTER.

(a) IN GENERAL.—Chapter 83 of title 18, United States Code, is amended by inserting after section 1716D the following:

''§ 1716E. Tobacco products as nonmailable

''(a) PROHIBITION.—

''(1) IN GENERAL.—All cigarettes and smokeless tobacco (as those terms are defined in section 1 of the Act of October 19, 1949, commonly referred to as the Jenkins Act) are nonmailable and shall not be deposited in or carried through the mails. The United States Postal Service shall not accept for delivery or transmit through the mails any package that it knows or has reasonable cause to believe contains any cigarettes or smokeless tobacco made nonmailable by this paragraph.

''(2) REASONABLE CAUSE.—For the purposes of this subsection reasonable cause includes—

''(A) a statement on a publicly available website, or an advertisement, by any person that the person will mail matter which is nonmailable under this section in return for payment; or

''(B) the fact that the person is on the list created under section 2A(e) of the Jenkins Act.

''(b) EXCEPTIONS.—

''(1) CIGARS.—Subsection (a) shall not apply to cigars (as defined in section 5702(a) of the Internal Revenue Code of 1986).

''(2) GEOGRAPHIC EXCEPTION.—Subsection (a) shall not apply to mailings within the State of Alaska or within the State of Hawaii.

''(3) BUSINESS PURPOSES.—

''(A) IN GENERAL.—Subsection (a) shall not apply to tobacco products mailed only—

''(i) for business purposes between legally operating businesses that have all applicable State and Federal Government licenses or permits and are engaged in tobacco product manufacturing, distribution, wholesale, export, import, testing, investigation, or research; or

''(ii) for regulatory purposes between any business described in clause (i) and an agency of the Federal Government or a State government.

''(B) RULES.—

''(i) IN GENERAL.—Not later than 180 days after the date of enactment of the Prevent All Cigarette Trafficking Act of 2009, the Postmaster General shall issue a final rule which shall establish the standards and requirements that apply to all mailings described in subparagraph (A).

''(ii) CONTENTS.—The final rule issued under clause (i) shall require—

''(I) the United States Postal Service to verify that any person submitting an otherwise nonmailable tobacco product into the mails as authorized under this paragraph is a business or government agency permitted to make a mailing under this paragraph;

''(II) the United States Postal Service to ensure that any recipient of an otherwise nonmailable tobacco product sent through the mails under this paragraph is a business or government agency that may lawfully receive the product;

''(III) that any mailing described in subparagraph (A) shall be sent through the systems of the United States Postal Service that provide for the tracking and confirmation of the delivery;

''(IV) that the identity of the business or government entity submitting the mailing containing otherwise nonmailable tobacco products for delivery and the identity of the business or government entity receiving the mailing are clearly set forth on the package;

''(V) the United States Postal Service to maintain identifying information described in subclause (IV) during the 3-year period beginning on the date of the mailing and make the information available to the Postal Service, the Attorney General of the United States, and to persons eligible to bring enforcement actions under section 3(d) of the Prevent All Cigarette Trafficking Act of 2009;

''(VI) that any mailing described in subparagraph (A) be marked with a United States Postal Service label or marking that makes it clear to employees of the United States Postal Service that it is a permitted mailing of otherwise nonmailable tobacco products that may be delivered only to a permitted government agency or business and may not be delivered to any residence or individual person; and

''(VII) that any mailing described in subparagraph (A) be delivered only to a verified employee of the recipient business or government agency, who is not a minor and who shall be required to sign for the mailing.

''(C) DEFINITION.—In this paragraph, the term 'minor' means an individual who is less than the minimum age required for the legal sale or purchase of tobacco products as determined by applicable law at the place the individual is located.

''(4) CERTAIN INDIVIDUALS.—

''(A) IN GENERAL.—Subsection (a) shall not apply to tobacco products mailed by individuals who are not minors for noncommercial purposes, including the return of a damaged or unacceptable tobacco product to the manufacturer.

''(B) RULES.—

''(i) IN GENERAL.—Not later than 180 days after the date of enactment of the Prevent All Cigarette Trafficking Act of 2009, the Postmaster General shall issue a final rule which shall establish the standards and requirements that apply to all mailings described in subparagraph (A).

''(ii) CONTENTS.—The final rule issued under clause (i) shall require—

''(I) the United States Postal Service to verify that any person submitting an otherwise nonmailable tobacco product into the mails as authorized under this paragraph is the individual identified on the return address label of the package and is not a minor;

''(II) for a mailing to an individual, the United States Postal Service to require the person submitting the otherwise nonmailable tobacco product into the mails as authorized by this paragraph to affirm that the recipient is not a minor;

''(III) that any package mailed under this paragraph shall weigh not more than 10 ounces;

''(IV) that any mailing described in subparagraph (A) shall be sent through the systems of the United States Postal Service that provide for the tracking and confirmation of the delivery;

''(V) that a mailing described in subparagraph (A) shall not be delivered or placed in the possession of any individual who has not been verified as not being a minor;

''(VI) for a mailing described in subparagraph (A) to an individual, that the United States Postal Service shall deliver the package only to a recipient who is verified not to be a minor at the recipient address or transfer it for delivery to an Air/Army Postal Office or Fleet Postal Office number designated in the recipient address; and

''(VII) that no person may initiate more than 10 mailings described in subparagraph (A) during any 30-day period.

''(C) DEFINITION.—In this paragraph, the term 'minor' means an individual who is less than the minimum age required for the legal sale or purchase of tobacco products as determined by applicable law at the place the individual is located.

''(5) EXCEPTION FOR MAILINGS FOR CONSUMER TESTING BY MANUFACTURERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), subsection (a) shall not preclude a legally operating cigarette manufacturer or a legally authorized agent of a legally operating cigarette manufacturer from using the United States Postal Service to mail cigarettes to verified adult smoker solely for consumer testing purposes, if—

''(i) the cigarette manufacturer has a permit, in good standing, issued under section 5713 of the Internal Revenue Code of 1986;

''(ii) the package of cigarettes mailed under this paragraph contains not more than 12 packs of cigarettes (240 cigarettes);

''(iii) the recipient does not receive more than 1 package of cigarettes from any 1 cigarette manufacturer under this paragraph during any 30-day period;

''(iv) all taxes on the cigarettes mailed under this paragraph levied by the State and locality of delivery are paid to the State and locality before delivery, and tax stamps or other tax-payment indicia are affixed to the cigarettes as required by law; and

''(v)(I) the recipient has not made any payments of any kind in exchange for receiving the cigarettes;

''(II) the recipient is paid a fee by the manufacturer or agent of the manufacturer for participation in consumer product tests; and

''(III) the recipient, in connection with the tests, evaluates the cigarettes and provides feedback to the manufacturer or agent.

''(B) LIMITATIONS.—Subparagraph (A) shall not—

''(i) permit a mailing of cigarettes to an individual located in any State that prohibits the delivery or shipment of cigarettes to individuals in the State, or preempt, limit, or otherwise affect any related State laws; or

''(ii) permit a manufacturer, directly or through a legally authorized agent, to mail cigarettes in any calendar year in a total amount greater than 1 percent of the total cigarette sales of the manufacturer in the United States during the calendar year before the date of the mailing.

''(C) RULES.—

''(i) IN GENERAL.—Not later than 180 days after the date of enactment of the Prevent All Cigarette Trafficking Act of 2009, the Postmaster General shall issue a final rule which shall establish the standards and requirements that apply to all mailings described in subparagraph (A).

''(ii) CONTENTS.—The final rule issued under clause (i) shall require—

''(I) the United States Postal Service to verify that any person submitting a tobacco product into the mails under this paragraph is a legally operating cigarette manufacturer permitted to make a mailing under this paragraph, or an agent legally authorized by the legally operating cigarette manufacturer to submit the tobacco product into the mails on behalf of the manufacturer;

''(II) the legally operating cigarette manufacturer submitting the cigarettes into the mails under this paragraph to affirm that—

''(aa) the manufacturer or the legally authorized agent of the manufacturer has verified that the recipient is an adult established smoker;

''(bb) the recipient has not made any payment for the cigarettes;

''(cc) the recipient has signed a written statement that is in effect indicating that the recipient wishes to receive the mailings; and

''(dd) the manufacturer or the legally authorized agent of the manufacturer has offered the opportunity for the recipient to withdraw the written statement described in item (cc) not less frequently than once in every 3-month period;

''(III) the legally operating cigarette manufacturer or the legally authorized agent of the manufacturer submitting the cigarettes into the mails under this paragraph to affirm that any package mailed under this paragraph contains not more than 12 packs of cigarettes (240 cigarettes) on which all taxes levied on the cigarettes by the State and locality of delivery have been paid and all related State tax stamps or other tax-payment indicia have been applied;

''(IV) that any mailing described in subparagraph (A) shall be sent through the systems of the United States Postal Service that provide for the tracking and confirmation of the delivery;

''(V) the United States Postal Service to maintain records relating to a mailing described in subparagraph (A) during the 3-year period beginning on the date of the mailing and make the information available to persons enforcing this section;

''(VI) that any mailing described in subparagraph (A) be marked with a United States Postal Service label or marking that makes it clear to employees of the United States Postal Service that it is a permitted mailing of otherwise nonmailable tobacco products that may be delivered only to the named recipient after verifying that the recipient is an adult; and

''(VII) the United States Postal Service shall deliver a mailing described in subparagraph (A) only to the named recipient and only after verifying that the recipient is an adult.

''(D) DEFINITIONS.—In this paragraph—

''(i) the term 'adult' means an individual who is not less than 21 years of age; and

''(ii) the term 'consumer testing' means testing limited to formal data collection and analysis for the specific purpose of evaluating the product for quality assurance and benchmarking purposes of cigarette brands or sub-brands among existing adult smokers.

''(6) FEDERAL GOVERNMENT AGENCIES.—An agency of the Federal Government involved in the consumer testing of tobacco products solely for public health purposes may mail cigarettes under the same requirements, restrictions, and rules and procedures that apply to consumer testing mailings of cigarettes by manufacturers under paragraph (5), except that the agency shall not be required to pay the recipients for participating in the consumer testing.

''(c) SEIZURE AND FORFEITURE.—Any cigarettes or smokeless tobacco made nonmailable by this subsection that are deposited in the mails shall be subject to seizure and forfeiture, pursuant to the procedures set forth in chapter 46 of this title. Any tobacco products seized and forfeited under this subsection shall be destroyed or retained by the Federal Government for the detection or prosecution of crimes or related investigations and then destroyed.

''(d) ADDITIONAL PENALTIES.—In addition to any other fines and penalties under this title for violations of this section, any person violating this section shall be subject to an additional civil penalty in the amount equal to 10 times the retail value of the nonmailable cigarettes or smokeless tobacco, including all Federal, State, and local taxes.

''(e) CRIMINAL PENALTY.—Whoever knowingly deposits for mailing or delivery, or knowingly causes to be delivered by mail, according to the direction thereon, or at any place at which it is directed to be delivered by the person to whom it is addressed, anything that is nonmailable matter under this section shall be fined under this title, imprisoned not more than 1 year, or both.

''(f) USE OF PENALTIES.—There is established a separate account in the Treasury, to be known as the 'PACT Postal Service Fund'. Notwithstanding any other provision of law, an amount equal to 50 percent of any criminal fines, civil penalties, or other monetary penalties collected by the Federal Government in enforcing this section shall be transferred into the PACT Postal Service Fund and shall be available to the Postmaster General for the purpose of enforcing this subsection.

''(g) COORDINATION OF EFFORTS.—The Postmaster General shall cooperate and coordinate efforts to enforce this section with related enforcement activities of any other Federal agency or agency of any State, local, or tribal government, whenever appropriate.

''(h) ACTIONS BY STATE, LOCAL, OR TRIBAL GOVERNMENTS RELATING TO CERTAIN TOBACCO PRODUCTS.—

''(1) IN GENERAL.—A State, through its attorney general, or a local government or Indian tribe that levies an excise tax on tobacco products, through its chief law enforcement officer, may in a civil action in a United States district court obtain appropriate relief with respect to a violation of this section. Appropriate relief includes injunctive and equitable relief and damages equal to the amount of unpaid taxes on tobacco products mailed in violation of this section to addressees in that State, locality, or tribal land.

''(2) SOVEREIGN IMMUNITY.—Nothing in this subsection shall be deemed to abrogate or constitute a waiver of any sovereign immunity of a State or local government or Indian tribe against any unconsented lawsuit under paragraph (1), or otherwise to restrict, expand, or modify any sovereign immunity of a State or local government or Indian tribe.

''(3) ATTORNEY GENERAL REFERRAL.—A State, through its attorney general, or a local government or Indian tribe that levies an excise tax on tobacco products, through its chief law enforcement officer, may provide evidence of a violation of this section for commercial purposes by any person not subject to State, local, or tribal government enforcement actions for violations of this section to the Attorney General of the United States, who shall take appropriate actions to enforce this section.

''(4) NONEXCLUSIVITY OF REMEDIES.—The remedies available under this subsection are in addition to any other remedies available under Federal, State, local, tribal, or other law. Nothing in this subsection shall be construed to expand, restrict, or otherwise modify any right of an authorized State, local, or tribal government official to proceed in a State, tribal, or other appropriate court, or take other enforcement actions, on the basis of an alleged violation of State, local, tribal, or other law.

''(5) OTHER ENFORCEMENT ACTIONS.—Nothing in this subsection shall be construed to prohibit an authorized State official from proceeding in State court on the basis of an alleged violation of any general civil or criminal statute of the State.

''(i) DEFINITION.—In this section, the term 'State' has the meaning given that term in section 1716(k).''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 83 of title 18 is amended by inserting after the item relating to section 1716D the following:

''1716E. Tobacco products as nonmailable.''.

SEC. 4. COMPLIANCE WITH MODEL STATUTE OR QUALIFYING STATUTE.

(a) IN GENERAL.—A Tobacco Product Manufacturer or importer may not sell in, deliver to, or place for delivery sale, or cause to be sold in, delivered to, or placed for delivery sale in a State that is a party to the Master Settlement Agreement, any cigarette manufactured by a Tobacco Product Manufacturer that is not in full compliance with the terms of the Model Statute or Qualifying Statute enacted by the State requiring funds to be placed into a qualified escrow account under specified conditions, and with any regulations promulgated pursuant to the statute.

(b) JURISDICTION TO PREVENT AND RESTRAIN VIOLATIONS.—

(1) IN GENERAL.—The United States district courts shall have jurisdiction to prevent and restrain violations of subsection (a) in accordance with this subsection.

(2) INITIATION OF ACTION.—A State, through its attorney general, may bring an action in an appropriate United States district court to prevent and restrain violations of subsection (a) by any person.

(3) ATTORNEY FEES.—In any action under paragraph (2), a State, through its attorney general, shall be entitled to reasonable attorney fees from a person found to have knowingly violated subsection (a).

(4) NONEXCLUSIVITY OF REMEDIES.—The remedy available under paragraph (2) is in addition to any other remedies available under Federal, State, or other law. No provision of this Act or any other Federal law shall be held or construed to prohibit or preempt the Master Settlement Agreement, the Model Statute (as defined in the Master Settlement Agreement), any legislation amending or complementary to the Model Statute in effect as of June 1, 2006, or any legislation substantially similar to such existing, amending, or complementary legislation enacted after the date of enactment of this Act.

(5) OTHER ENFORCEMENT ACTIONS.—Nothing in this subsection shall be construed to prohibit an authorized State official from proceeding in State court or taking other enforcement actions on the basis of an alleged violation of State or other law.

(6) AUTHORITY OF THE ATTORNEY GENERAL.—The Attorney General of the United States may bring an action in an appropriate United States district court to prevent and restrain violations of subsection (a) by any person.

(c) DEFINITIONS.—In this section the following definitions apply:

(1) DELIVERY SALE.—The term ''delivery sale'' means any sale of cigarettes or smokeless tobacco to a consumer if—

(A) the consumer submits the order for the sale by means of a telephone or other method of voice transmission, the mails, or the Internet or other online service, or the seller is otherwise not in the physical presence of the buyer when the request for purchase or order is made; or

(B) the cigarettes or smokeless tobacco are delivered to the buyer by common carrier,

private delivery service, or other method of remote delivery, or the seller is not in the physical presence of the buyer when the buyer obtains possession of the cigarettes or smokeless tobacco.

(2) IMPORTER.—The term ''importer'' means each of the following:

(A) SHIPPING OR CONSIGNING.—Any person in the United States to whom nontaxpaid tobacco products manufactured in a foreign country, Puerto Rico, the Virgin Islands, or a possession of the United States are shipped or consigned.

(B) MANUFACTURING WAREHOUSES.—Any person who removes cigars or cigarettes for sale or consumption in the United States from a customs-bonded manufacturing warehouse.

(C) UNLAWFUL IMPORTING.—Any person who smuggles or otherwise unlawfully brings tobacco products into the United States.

(3) MASTER SETTLEMENT AGREEMENT.—The term ''Master Settlement Agreement'' means the agreement executed November 23, 1998, between the attorneys general of 46 States, the District of Columbia, the Commonwealth of Puerto Rico, and 4 territories of the United States and certain tobacco manufacturers.

(4) MODEL STATUTE; QUALIFYING STATUTE.—The terms ''Model Statute'' and ''Qualifying Statute'' means a statute as defined in section IX(d)(2)(e) of the Master Settlement Agreement.

(5) TOBACCO PRODUCT MANUFACTURER.—The term ''Tobacco Product Manufacturer'' has the meaning given that term in section II(uu) of the Master Settlement Agreement.

SEC. 5. INSPECTION BY BUREAU OF ALCOHOL, TOBACCO, FIREARMS, AND EXPLOSIVES OF RECORDS OF CERTAIN CIGARETTE AND SMOKELESS TOBACCO SELLERS; CIVIL PENALTY.

Section 2343(c) of title 18, United States Code, is amended to read as follows:

''(c)(1) Any officer of the Bureau of Alcohol, Tobacco, Firearms, and Explosives may, during normal business hours, enter the premises of any person described in subsection (a) or (b) for the purposes of inspecting—

''(A) any records or information required to be maintained by the person under this chapter; or

''(B) any cigarettes or smokeless tobacco kept or stored by the person at the premises.

''(2) The district courts of the United States shall have the authority in a civil action under this subsection to compel inspections authorized by paragraph (1).

''(3) Whoever denies access to an officer under paragraph (1), or who fails to comply with an order issued under paragraph (2), shall be subject to a civil penalty in an amount not to exceed $10,000.''.

SEC. 6. EXCLUSIONS REGARDING INDIAN TRIBES AND TRIBAL MATTERS.

(a) IN GENERAL.—Nothing in this Act or the amendments made by this Act shall be construed to amend, modify, or otherwise affect—

(1) any agreements, compacts, or other intergovernmental arrangements between any State or local government and any government of an Indian tribe (as that term is defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) relating to the collection of taxes on cigarettes or smokeless tobacco sold in Indian country;

(2) any State laws that authorize or otherwise pertain to any such intergovernmental arrangements or create special rules or procedures for the collection of State, local, or tribal taxes on cigarettes or smokeless tobacco sold in Indian country;

(3) any limitations under Federal or State law, including Federal common law and treaties, on State, local, and tribal tax and regulatory authority with respect to the sale, use, or distribution of cigarettes and smokeless tobacco by or to Indian tribes, tribal members, tribal enterprises, or in Indian country;

(4) any Federal law, including Federal common law and treaties, regarding State jurisdiction, or lack thereof, over any tribe, tribal members, tribal enterprises, tribal reservations, or other lands held by the United States in trust for one or more Indian tribes; or

(5) any State or local government authority to bring enforcement actions against persons located in Indian country.

(b) COORDINATION OF LAW ENFORCEMENT.—Nothing in this Act or the amendments made by this Act shall be construed to inhibit or otherwise affect any coordinated law enforcement effort by 1 or more States or other jurisdictions, including Indian tribes, through interstate compact or otherwise, that—

(1) provides for the administration of tobacco product laws or laws pertaining to interstate sales or other sales of tobacco products;

(2) provides for the seizure of tobacco products or other property related to a violation of such laws; or

(3) establishes cooperative programs for the administration of such laws.

(c) TREATMENT OF STATE AND LOCAL GOVERNMENTS.—Nothing in this Act or the amendments made by this Act shall be construed to authorize, deputize, or commission States or local governments as instrumentalities of the United States.

(d) ENFORCEMENT WITHIN INDIAN COUNTRY.—Nothing in this Act or the amendments made by this Act shall prohibit, limit, or restrict enforcement by the Attorney General of the United States of this Act or an amendment made by this Act within Indian country.

(e) AMBIGUITY.—Any ambiguity between the language of this section or its application and any other provision of this Act shall be resolved in favor of this section.

(f) DEFINITIONS.—In this section—

(1) the term ''Indian country'' has the meaning given that term in section 1 of the Jenkins Act, as amended by this Act; and

(2) the term ''tribal enterprise'' means any business enterprise, regardless of whether incorporated or unincorporated under Federal or tribal law, of an Indian tribe or group of Indian tribes.

SEC. 7. ENHANCED CONTRABAND TOBACCO ENFORCEMENT.

(a) REQUIREMENTS.—The Director of the Bureau of Alcohol, Tobacco, Firearms, and Explosives shall—

(1) not later than the end of the 3-year period beginning on the effective date of this Act, create a regional contraband tobacco trafficking team in each of New York, New York, the District of Columbia, Detroit, Michigan, Los Angeles, California, Seattle, Washington, and Miami, Florida;

(2) create a Tobacco Intelligence Center to oversee investigations and monitor and coordinate ongoing investigations and to serve as the coordinator for all ongoing tobacco diversion investigations within the Bureau of Alcohol, Tobacco, Firearms, and Explosives, in the United States and, where applicable, with law enforcement organizations around the world;

(3) establish a covert national warehouse for undercover operations; and

(4) create a computer database that will track and analyze information from retail sellers of tobacco products that sell through the Internet or by mail order or make other non-face-to-face sales.

(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (a) $8,500,000 for each of fiscal years 2010 through 2014.

SEC. 8. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in subsection (b), this Act shall take effect on the date that is 90 days after the date of enactment of this Act.

(b) BATFE AUTHORITY.—The amendments made by section 5 shall take effect on the date of enactment of this Act.

SEC. 9. SEVERABILITY.

If any provision of this Act, or any amendment made by this Act, or the application thereof to any person or circumstance, is held invalid, the remainder of the Act and the application of the Act to any other person or circumstance shall not be affected thereby.

SEC. 10. SENSE OF CONGRESS CONCERNING THE PRECEDENTIAL EFFECT OF THIS ACT.

It is the sense of Congress that unique harms are associated with online cigarette sales, including problems with verifying the ages of consumers in the digital market and the long-term health problems associated with the use of certain tobacco products. This Act was enacted recognizing the longstanding interest of Congress in urging compliance with States' laws regulating remote sales of certain tobacco products to citizens of those States, including the passage of the Jenkins Act over 50 years ago, which established reporting requirements for out-of-State companies that sell certain tobacco products to citizens of the taxing States, and which gave authority to the Department of Justice and the Bureau of Alcohol, Tobacco, Firearms, and Explosives to enforce the Jenkins Act. In light of the unique harms and circumstances surrounding the online sale of certain tobacco products, this Act is intended to help collect cigarette excise taxes, to stop tobacco sales to underage youth, and to help the States enforce their laws that target the online sales of certain tobacco products only. This Act is in no way meant to create a precedent regarding the collection of State sales or use taxes by, or the validity of efforts to impose other types of taxes on, out-of-State entities that do not have a physical presence within the taxing State.

By Mr. GRASSLEY (for himself, Mrs. MCCASKILL, Mr. BOND, and Mr. THUNE):

S. 1148. A bill to amend the Clean Air Act to modify a provision relating to the renewable fuel program; to the Committee on Environment and Public Works.

Mr. GRASSLEY. Mr. President, I am pleased to be joined today in introducing commonsense legislation with Senators MCCASKILL and BOND. The Renewable Fuel Standard Improvement Act, seeks to improve a number of provisions included in the expanded Renewable Fuels Standard that was enacted in the Energy Independence and Security Act of 2007, EISA.

Just a week ago, the Chairman of the House Agriculture Committee, Representative COLLIN PETERSON, introduced this legislation in the House of Representatives. It now has more than 44 bipartisan cosponsors. Because Chairman PETERSON crafted such thoughtful modifications to the Renewable Fuel Standard, I want to give my Senate colleagues an opportunity to consider the bill. So, today I am introducing companion legislation in the Senate.

A component of the new Renewable Fuels Standard was a requirement that various biofuels meet specified lifecycle greenhouse gas emission reduction targets. The law specified that lifecycle greenhouse gas emissions are to include direct emissions and significant indirect emissions from indirect land use changes. In the Notice of Proposed Rulemaking released by the Environmental Protection Agency earlier this month, the EPA relies on incomplete science and inaccurate assumptions to penalize U.S. biofuels for so-called ''indirect land use changes.'' So, this bill ensures that the greenhouse gas calculations are based on proven science by removing the requirement to include indirect land use changes.

The bill also includes a number of other commonsense fixes to the expanded Renewable Fuels Standard. Under EISA, the life-cycle greenhouse gas reduction requirements do not apply to corn ethanol plants that were in operation or under construction prior to the date of enactment. This grandfather provision does not apply to biodiesel facilities, however. The legislation I am introducing today would extend the same grandfathered treatment to biodiesel facilities.

Finally, the bill includes a more inclusive definition of renewable biomass, and it expands the role of the U.S. Departments of Agriculture and Energy in administering the program.

This bill goes a long way to rectifying a few provisions that are undermining and harming our efforts toward energy independence. I do not think it makes sense to impose hurdles on our domestic renewable fuels industry, particularly if it prolongs our dependence on dirtier fossil fuels, or increases our dependence on energy from countries like Iran and Venezuela.

I would like to thank the cosponsors for their support. I look forward to Senate consideration of this important legislation.

By Mr. REID (for Mr. ROCKEFELLER):

S. 1149. A bill to eliminate annual and lifetime aggregate limits imposed by health plans; to the Committee on Health, Education, Labor, and Pensions.

Mr. ROCKEFELLER. Mr. President, I rise today to introduce the Annual and Lifetime Health Care Limit Elimination Act of 2009, legislation that would prohibit insurance companies from imposing any annual or lifetime limit on any individual or group health insurance policy, thus providing continuity and affordability of health care coverage for those with serious chronic conditions.

Each year, thousands of insured Americans face daunting medical expenses and challenges when they reach the annual or lifetime limit on their individual or employer-sponsored health insurance plan. Once a beneficiary's medical costs have exceeded the annual or lifetime limit of their plan, the insurance company no longer pays for the medical costs incurred by that individual.

In April, I held a roundtable discussion on health care in Raleigh County. There, I met a woman who had myelodysplastic syndrome, which is a non-curable pre-leukemia type disease. Unfortunately, her husband's insurance policy had a lifetime limit of $300,000, which she had reached. Another young West Virginian, born with serious congenital heart defects, reached the $1 million limit on his mother's insurance policy within the first nine months of his life. The limits on their health insurance plans have left these families struggling to find a way to pay for the expensive and life-sustaining treatments their loved ones desperately need.

Unfortunately, these two West Virginia families are not alone. In 2007, it was estimated that 55 percent of all people who obtain health benefits from their employer have some type of lifetime limit on their plan, an increase of approximately 4 percent since 2004. More than 23 percent of people have health insurance plans that impose limits of $2 million or less. Also, some health insurance policies renew less frequently than annually and contain annual limits to reduce the medical expenses paid by insurance companies. It is estimated that approximately 20,000 to 25,000 people no longer have health care benefits through their employers because of lifetime limits on their employer-sponsored health care plans.

When individuals with serious chronic conditions—such as transplant recipients, patients living with hemophilia, and newborns with life-threatening illnesses—hit the annual or lifetime limits on their policies, they are often left with very few options to meet their health care needs. Individuals and families that can afford it can try to pay for their health care costs completely out-of-pocket. However, this is rarely financially feasible; therefore, many people are forced to leave good, stable jobs and seek different employment in an effort to obtain new employer-sponsored coverage. Unfortunately, new enrollees are often subject to a waiting period for coverage if there was any break in their previous health care coverage.

Should an individual try to find health insurance in the individual market, coverage is likely to be prohibitively expensive. More often then not, these individuals are denied coverage altogether because of the insurer's preexisting condition exclusion. Annual or lifetime limits can force people to turn to public programs such as Medicaid, or spend down their savings to meet the financial restrictions of the program. Others are forced to forgo treatment altogether, which can lead to serious complications and greater long-term health care costs.

It is time to stop health insurance companies from imposing annual or lifetime limits on health insurance policies. The beneficiaries affected by these limits have paid their premiums, deductibles, and copays faithfully, only to lose access to life-saving treatment when they need care the most. This is unacceptable and I encourage my colleagues to join me in supporting the Annual and Lifetime Health Care Limit Elimination Act.

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. 1149

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 ''Annual and Lifetime Health Care Limit Elimination Act of 2009''.

SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

''SEC. 715. ELIMINATION OF ANNUAL OR LIFETIME AGGREGATE LIMITS.

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

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

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act, is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Elimination of annual or lifetime aggregate limits.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after the date that is 1 year after the date of enactment of this Act.

SEC. 3. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

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

''SEC. 2708. ELIMINATION OF ANNUAL OR LIFETIME AGGREGATE LIMITS.

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

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

or other coverage unit on an annual or lifetime basis.''.

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

''SEC. 2754. ELIMINATION OF ANNUAL OR LIFETIME AGGREGATE LIMITS.

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

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after the date that is 1 year after the date of enactment of this Act.

By Mr. REID (for Mr. ROCKEFELLER (for himself, Ms. COLLINS, Mr. KOHL, Mr. WYDEN, and Mr. CARPER)):

S. 1150. A bill to improve end-of-life care; to the Committee on Finance.

Mr. ROCKEFELLER. Mr. President, I rise today with my friends and colleagues—Senators COLLINS, KOHL, WYDEN and CARPER—to introduce the Advance Planning and Compassionate Care Act of 2009, comprehensive legislation that recognizes the critical importance of advance care planning and quality end-of-life care. Senator COLLINS and I have worked on this legislation for over a decade—with the ultimate goal of one day passing comprehensive end-of-life care legislation. We are encouraged by the prospect of comprehensive health reform this year and believe that it is absolutely critical that end-of-life care provisions be included.

In preparation for the impending health reform debate, Senator COLLINS and I decided last year that it was time to update our Advance Planning and Compassionate Care Act to incorporate all of the best ideas out there on improving end-of-life care—including new and innovative approaches being implemented in the states, approaches suggested by scholars in this field, and recommendations based on our own experiences with loved ones facing the end of life. This new and improved bill is truly a labor of love and we are certainly hopeful that we can finally get something comprehensive and meaningful done for the millions of individuals and families faced with the agonizing issues surrounding the end of life.

A modern health care delivery system is well within our reach and something that we can start to achieve this year. A critical component of a modernized health system is the ability to address the health care needs of patients across the life-span—especially at the end of life. Death is a serious, personal, and complicated part of the life cycle. Yet, care at the end of life is eventually relevant to everyone. Americans deserve end-of-life care that is effective in providing information about diagnosis and prognosis, integrating appropriate support services, fulfilling individual wishes, and avoiding unnecessary disputes.

The bitter dispute that played out publicly for Terri Schiavo and her family is an agonizing experience that countless other families quietly face over the care of a loved one because clear advance directives are not in place. End-of-life care is a very delicate, yet important, issue and we must act to ensure that all Americans have the dignity and comfort they deserve at the end of life. Services should be available to help patients and their families with the medical, psychological, spiritual, and practical issues surrounding death.

Most people want to discuss advance directives when they are healthy and they want their families involved in the process. Yet, the vast majority of Americans have not completed an advance directive expressing their final wishes. In 2007, RAND conducted a comprehensive review of academic literature relating to end-of-life decision-making. This review found that only 18 to 30 percent of Americans have completed some type of advance directive expressing their end-of-life wishes. RAND also found that acutely ill individuals, for whom these decisions are particularly relevant, complete advance directives at only slightly higher rates—35 percent of dialysis patients and 32 percent of Chronic Obstructive Pulmonary Disease, COPD, patients. Perhaps most alarmingly, between 65 and 76 percent of physicians whose patients had an advance directive were unaware of its existence.

In its present form, end-of-life planning and care for most Americans is perplexing, disjointed, and lacking an active dialogue. In its 1997 report entitled Approaching Death: Improving Care at the End of Life, the Institute of Medicine found several barriers to effective advance planning and end-of-life care that still persist today.

In addition to the substantial burden of suffering experienced by many at the end of life, there are also significant financial consequences for family members and society as a whole that stem from ineffective end-of-life care. According to one Federal evaluation, 80 percent of all deaths occur in hospitals—the most costly setting to deliver care—even though most people would prefer to die at home. Current studies indicate that around 25 percent of all Medicare spending occurs in the last year of life. Largely because of their poorer health status, dually eligible beneficiaries have Medicare costs that are about 1.5 times that of other Medicare beneficiaries. Research also shows significant variation in expenditures at the end-of-life by geography and hospital, without evidence that greater expenditures are associated with better outcomes or satisfaction.

We must find ways to improve the quality of end-of-life care. Quality measures provide not only information for oversight, but data with which to improve care practices and models. No core sets of end-of-life quality measures are required across provider settings. Even for certified hospices, reporting of quality measures has only recently been required, with each hospice deciding its own indicators. Hospice surveys are behind schedule and not conducted frequently enough.

Facilitating greater advance planning and improving care at the end of life also requires an adequate workforce. Unfortunately, there is a substantial shortage of health professionals who specialize in palliative care. There is a severe shortage of physicians and advance practice nurses trained in palliative medicine. Contributing to these shortages is a shortage of medical and nursing school faculty in palliative medicine and care. There is also a lack of content about end-of-life care in medical school curricula. Medical students in general receive very little formal end-of-life education. Almost half of medical residents in a survey felt unprepared to address patients' fears of dying. For Americans to have a full range of choices in end-of-life care, we must strengthen our health care workforce, including palliative care education of physicians and other health professionals.

Care at the end-of-life can, and should, be better and more consistent with what Americans want. The Advance Planning and Compassionate Care Act takes enormous steps forward to fully inform consumers of their treatment options at the end of life and to actually address patient end-of-life care needs when the time comes. To promote advance care planning, this legislation provides both patients and their physicians with the information and tools to help them in this most personal and often difficult discussion.

Last year's Medicare Improvements for Patients and Providers Act, PL 110–275, took a significant step forward toward improving advance care planning. MIPPA included a provision that I authored, requiring physicians to provide an advance care planning consultation as part of the Welcome to Medicare physical exam. Unfortunately, less than 10 percent of new enrollees use the Welcome to Medicare visit. The MIPPA provision also does not address the advance care planning needs of existing Medicare enrollees.

The legislation we are introducing today establishes physician payment under Medicare, Medicaid, and CHIP for vital patient advance care planning conversations. It provides help in documenting decisions from these conversations in the form of advance directives and in the form of actionable orders for life sustaining treatment. It also takes steps to address the problem of accessing advance directives when needed, including state grants for electronic registries.

This legislation establishes a National Geriatric and Palliative Care Service Corps, modeled after the National Health Service Corps, to increase the woefully inadequate supply

of geriatric and palliative specialists and to even out their geographic distribution. It adopts MedPAC's 2009 hospice payment reforms aimed at aligning payment with the actual trajectory of resources expended over hospice episodes of care, while remaining within the constraints of current reimbursement. Demonstration projects are funded to explore ways to better meet the needs of patients over longer time periods than the 6-month prognoses inherent in the hospice benefit.

Certification standards and processes are developed for hospital-based palliative care teams. Such teams are critical to providing consultation and care to dying patients. Quality measurement and oversight are strengthened, with development of end-of-life measures across care settings and greater data reporting requirements of hospices—so that we can make sure the hospice benefit is keeping pace with the changing diagnostic mix of patients that hospice serves.

Finally, this bill takes the important step of establishing a National Center on Palliative and End-of-Life Care within the NIH. This is a vital step toward prioritizing biomedical research in the areas of palliative and end-of-life care. It will also serve as a symbol to remind us that, as in other phases of life, we need care at the end of life that addresses our individual needs and circumstances.

Death is a serious, personal, and complicated issue that is eventually relevant to each and every one of us. Americans deserve end-of-life care that is effective in fulfilling individual wishes, avoiding unnecessary disputes, and, most importantly, providing quality end-of-life care. Therefore, I urge my colleagues to join us in improving end-of-life care and reducing the amount of grief that inevitably comes with losing those who we hold dear.

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. 1150

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Advance Planning and Compassionate Care Act of 2009''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Definitions.

TITLE I—ADVANCE CARE PLANNING

Subtitle A—Consumer and Provider Education

PART I—CONSUMER EDUCATION

SUBPART A—NATIONAL INITIATIVES

Sec. 101. Advance care planning telephone hotline.
Sec. 102. Advance care planning information clearinghouses.
Sec. 103. Advance care planning toolkit.
Sec. 104. National public education campaign.
Sec. 105. Update of Medicare and Social Security handbooks.
Sec. 106. Authorization of appropriations.

SUBPART B—STATE AND LOCAL INITIATIVES

Sec. 111. Financial assistance for advance care planning.
Sec. 112. Grants for programs for orders regarding life sustaining treatment.

PART II—PROVIDER EDUCATION

Sec. 121. Public provider advance care planning website.
Sec. 122. Continuing education for physicians and nurses.

Subtitle B—Portability of Advance Directives; Health Information Technology

Sec. 131. Portability of advance directives.
Sec. 132. State advance directive registries; driver's license advance directive notation.
Sec. 133. GAO study and report on establishment of national advance directive registry.

Subtitle C—National Uniform Policy on Advance Care Planning

Sec. 141. Study and report by the Secretary regarding the establishment and implementation of a national uniform policy on advance directives.

TITLE II—COMPASSIONATE CARE

Subtitle A—Workforce Development

PART I—EDUCATION AND TRAINING

Sec. 201. National Geriatric and Palliative Care Services Corps.
Sec. 202. Exemption of palliative medicine fellowship training from Medicare graduate medical education caps.
Sec. 203. Medical school curricula.

Subtitle B—Coverage Under Medicare, Medicaid, and CHIP

PART I—COVERAGE OF ADVANCE CARE PLANNING

Sec. 211. Medicare, Medicaid, and CHIP coverage.

PART II—HOSPICE

Sec. 221. Adoption of MedPAC hospice payment methodology recommendations.
Sec. 222. Removing hospice inpatient days in setting per diem rates for critical access hospitals.
Sec. 223. Hospice payments for dual eligible individuals residing in long-term care facilities.
Sec. 224. Delineation of respective care responsibilities of hospice programs and long-term care facilities.
Sec. 225. Adoption of MedPAC hospice program eligibility certification and recertification recommendations.
Sec. 226. Concurrent care for children.
Sec. 227. Making hospice a required benefit under Medicaid and CHIP.
Sec. 228. Medicare Hospice payment model demonstration projects.
Sec. 229. MedPAC studies and reports.
Sec. 230. HHS Evaluations.

Subtitle C—Quality Improvement

Sec. 241. Patient satisfaction surveys.
Sec. 242. Development of core end-of-life care quality measures across each relevant provider setting.
Sec. 243. Accreditation of hospital-based palliative care programs.
Sec. 244. Survey and data requirements for all Medicare participating hospice programs.

Subtitle D—Additional Reports, Research, and Evaluations

Sec. 251. National Center On Palliative and End-Of-Life Care.
Sec. 252. National Mortality Followback Survey.
Sec. 253. Demonstration projects for use of telemedicine services in advance care planning.
Sec. 254. Inspector General investigation of raud and abuse.
Sec. 255. GAO study and report on provider adherence to advance directives.

SEC. 2. DEFINITIONS.

In this Act:

(1) ADVANCE CARE PLANNING.—The term ''advance care planning'' means the process of—

(A) determining an individual's priorities, values and goals for care in the future when the individual is no longer able to express his or her wishes;

(B) engaging family members, health care proxies, and health care providers in an ongoing dialogue about—

(i) the individual's wishes for care;

(ii) what the future may hold for people with serious illnesses or injuries;

(iii) how individuals, their health care proxies, and family members want their beliefs and preferences to guide care decisions; and

(iv) the steps that individuals and family members can take regarding, and the resources available to help with, finances, family matters, spiritual questions, and other issues that impact seriously ill or dying patients and their families; and

(C) executing and updating advance directives and appointing a health care proxy.

(2) ADVANCE DIRECTIVE.—The term ''advance directive'' means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.

(3) CHIP.—The term ''CHIP'' means the program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(4) END-OF-LIFE-CARE.—The term ''end-of-life care'' means all aspects of care of a patient with a potentially fatal condition, and includes care that is focused on specific preparations for an impending death.

(5) HEALTH CARE POWER OF ATTORNEY.—The term ''health care power of attorney'' means a legal document that identifies a health care proxy or decisionmaker for a patient who has the authority to act on the patient's behalf when the patient is unable to communicate his or her wishes for medical care on matters that the patient specifies when he or she is competent. Such term includes a durable power of attorney that relates to medical care.

(6) LIVING WILL.—The term ''living will'' means a legal document—

(A) used to specify the type of medical care (including any type of medical treatment, including life-sustaining procedures if that person becomes permanently unconscious or is otherwise dying) that an individual wants provided or withheld in the event the individual cannot speak for himself or herself and cannot express his or her wishes; and

(B) that requires a physician to honor the provisions of upon receipt or to transfer the care of the individual covered by the document to another physician that will honor such provisions.

(7) MEDICAID.—The term ''Medicaid'' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(8) MEDICARE.—The term ''Medicare'' means the program established under title

XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(9) ORDERS FOR LIFE-SUSTAINING TREATMENT.—The term ''orders for life-sustaining treatment'' means a process for focusing a patients' values, goals, and preferences on current medical circumstances and to translate such into visible and portable medical orders applicable across care settings, including home, long-term care, emergency medical services, and hospitals.

(10) PALLIATIVE CARE.—The term ''palliative care'' means interdisciplinary care for individuals with a life-threatening illness or injury relating to pain and symptom management and psychological, social, and spiritual needs and that seeks to improve the quality of life for the individual and the individual's family.

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

TITLE I—ADVANCE CARE PLANNING

Subtitle A—Consumer and Provider Education

PART I—CONSUMER EDUCATION

Subpart A—National Initiatives

SEC. 101. ADVANCE CARE PLANNING TELEPHONE HOTLINE.

(a) IN GENERAL.—Not later than January 1, 2011, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and operate directly, or by grant, contract, or interagency agreement, a 24-hour toll-free telephone hotline to provide consumer information regarding advance care planning, including—

(1) an explanation of advanced care planning and its importance;

(2) issues to be considered when developing an individual's advance care plan;

(3) how to establish an advance directive;

(4) procedures to help ensure that an individual's directives for end-of-life care are followed;

(5) Federal and State-specific resources for assistance with advance care planning; and

(6) hospice and palliative care (including their respective purposes and services).

(b) ESTABLISHMENT.—In carrying out the requirements under subsection (a), the Director of the Centers for Disease Control and Prevention may designate an existing 24-hour toll-free telephone hotline or, if no such service is available or appropriate, establish a new 24-hour toll-free telephone hotline.

SEC. 102. ADVANCE CARE PLANNING INFORMATION CLEARINGHOUSES.

(a) EXPANSION OF NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—

(1) DEVELOPMENT.—Not later than January 1, 2010, the Secretary shall develop an online clearinghouse to provide comprehensive information regarding advance care planning.

(2) MAINTENANCE.—The advance care planning clearinghouse, which shall be clearly identifiable and available on the homepage of the Department of Health and Human Service's National Clearinghouse for Long-Term Care Information website, shall be maintained and publicized by the Secretary on an ongoing basis.

(3) CONTENT.—The advance care planning clearinghouse shall include—

(A) any relevant content contained in the national public education campaign required under section 104;

(B) content addressing—

(i) an explanation of advanced care planning and its importance;

(ii) issues to be considered when developing an individual's advance care plan;

(iii) how to establish an advance directive;

(iv) procedures to help ensure that an individual's directives for end-of-life care are followed; and

(v) hospice and palliative care (including their respective purposes and services); and

(C) available Federal and State-specific resources for assistance with advance care planning, including—

(i) contact information for any State public health departments that are responsible for issues regarding end-of-life care;

(ii) contact information for relevant legal service organizations, including those funded under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(iii) advance directive forms for each State; and

(D) any additional information, as determined by the Secretary.

(b) ESTABLISHMENT OF PEDIATRIC ADVANCE CARE PLANNING CLEARINGHOUSE.—

(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary, in consultation with the Assistant Secretary for Children and Families of the Department of Health and Human Services, shall develop an online clearinghouse to provide comprehensive information regarding pediatric advance care planning.

(2) MAINTENANCE.—The pediatric advance care planning clearinghouse, which shall be clearly identifiable on the homepage of the Administration for Children and Families website, shall be maintained and publicized by the Secretary on an ongoing basis.

(3) CONTENT.—The pediatric advance care planning clearinghouse shall provide advance care planning information specific to children with life-threatening illnesses or injuries and their families.

SEC. 103. ADVANCE CARE PLANNING TOOLKIT.

(a) DEVELOPMENT.—Not later than July 1, 2010, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop an online advance care planning toolkit.

(b) MAINTENANCE.—The advance care planning toolkit, which shall be available in English, Spanish, and any other languages that the Secretary deems appropriate, shall be maintained and publicized by the Secretary on an ongoing basis and made available on the following websites:

(1) The Centers for Disease Control and Prevention.

(2) The Department of Health and Human Service's National Clearinghouse for Long-Term Care Information.

(3) The Administration for Children and Families.

(c) CONTENT.—The advance care planning toolkit shall include content addressing—

(1) common issues and questions regarding advance care planning, including individuals and resources to contact for further inquiries;

(2) advance directives and their uses, including living wills and durable powers of attorney;

(3) the roles and responsibilities of a health care proxy;

(4) Federal and State-specific resources to assist individuals and their families with advance care planning, including—

(A) the advance care planning toll-free telephone hotline established under section 101;

(B) the advance care planning clearinghouses established under section 102;

(C) the advance care planning toolkit established under this section;

(D) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(E) website links or addresses for State-specific advance directive forms; and

(5) any additional information, as determined by the Secretary.

SEC. 104. NATIONAL PUBLIC EDUCATION CAMPAIGN.

(a) NATIONAL PUBLIC EDUCATION CAMPAIGN.—

(1) IN GENERAL.—Not later than January 1, 2011, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, directly or through grants, contracts, or interagency agreements, develop and implement a national campaign to inform the public of the importance of advance care planning and of an individual's right to direct and participate in their health care decisions.

(2) CONTENT OF EDUCATIONAL CAMPAIGN.—The national public education campaign established under paragraph (1) shall—

(A) employ the use of various media, including regularly televised public service announcements;

(B) provide culturally and linguistically appropriate information;

(C) be conducted continuously over a period of not less than 5 years;

(D) identify and promote the advance care planning information available on the Department of Health and Human Service's National Clearinghouse for Long-Term Care Information website and Administration for Children and Families website, as well as any other relevant Federal or State-specific advance care planning resources;

(E) raise public awareness of the consequences that may result if an individual is no longer able to express or communicate their health care decisions;

(F) address the importance of individuals speaking to family members, health care proxies, and health care providers as part of an ongoing dialogue regarding their health care choices;

(G) address the need for individuals to obtain readily available legal documents that express their health care decisions through advance directives (including living wills, comfort care orders, and durable powers of attorney for health care);

(H) raise public awareness regarding the availability of hospice and palliative care; and

(I) encourage individuals to speak with their physicians about their options and intentions for end-of-life care.

(3) EVALUATION.—

(A) IN GENERAL.—Not later than July 1, 2013, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a nationwide survey to evaluate whether the national campaign conducted under this subsection has achieved its goal of changing public awareness, attitudes, and behaviors regarding advance care planning.

(B) BASELINE SURVEY.—In order to evaluate the effectiveness of the national campaign, the Secretary shall conduct a baseline survey prior to implementation of the campaign.

(C) REPORTING REQUIREMENT.—Not later than December 31, 2013, the Secretary shall report the findings of such survey, as well as any recommendations that the Secretary determines appropriate regarding the need for continuation or legislative or administrative changes to facilitate changing public awareness, attitudes, and behaviors regarding advance care planning, to the appropriate committees of the Congress.

(b) REPEAL.—Section 4751(d) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note; Public Law 101–508) is repealed.

SEC. 105. UPDATE OF MEDICARE AND SOCIAL SECURITY HANDBOOKS.

(a) MEDICARE & YOU HANDBOOK.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall update the online version of

the ''Planning Ahead'' section of the Medicare & You Handbook to include—

(A) an explanation of advance care planning and advance directives, including—

(i) living wills;

(ii) health care proxies; and

(iii) after-death directives;

(B) Federal and State-specific resources to assist individuals and their families with advance care planning, including—

(i) the advance care planning toll-free telephone hotline established under section 101;

(ii) the advance care planning clearinghouses established under section 102;

(iii) the advance care planning toolkit established under section 103;

(iv) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and

(v) website links or addresses for State-specific advance directive forms; and

(C) any additional information, as determined by the Secretary.

(2) UPDATE OF PAPER AND SUBSEQUENT VERSIONS.—The Secretary shall include the information described in paragraph (1) in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 60 days after the date of enactment of this Act.

(b) SOCIAL SECURITY HANDBOOK.—The Commissioner of Social Security shall—

(1) not later than 60 days after the date of enactment of this Act, update the online version of the Social Security Handbook for beneficiaries to include the information described in subsection (a)(1); and

(2) include such information in all paper and online versions of such handbook that are published on or after the date that is 60 days after the date of enactment of this Act.

SEC. 106. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated for the period of fiscal years 2010 through 2014—

(1) $195,000,000 to the Secretary to carry out sections 101, 102, 103, 104 and 105(a); and

(2) $5,000,000 to the Commissioner of Social Security to carry out section 105(b).

Subpart B—State and Local Initiatives

SEC. 111. FINANCIAL ASSISTANCE FOR ADVANCE CARE PLANNING.

(a) LEGAL ASSISTANCE FOR ADVANCE CARE PLANNING.—

(1) DEFINITION OF RECIPIENT.—Section 1002(6) of the Legal Services Corporation Act (42 U.S.C. 2996a(6)) is amended by striking ''clause (A) of'' and inserting ''subparagraph (A) or (B) of''.

(2) ADVANCE CARE PLANNING.—Section 1006 of the Legal Services Corporation Act (42 U.S.C. 2996e) is amended—

(A) in subsection (a)(1)—

(i) by striking ''title, and (B) to make'' and inserting the following: ''title;

''(C) to make''; and

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

''(B) to provide financial assistance, and make grants and contracts, as described in subparagraph (A), on a competitive basis for the purpose of providing legal assistance in the form of advance care planning (as defined in section 3 of the Advance Planning and Compassionate Care Act of 2009, and including providing information about State-specific advance directives, as defined in that section) for eligible clients under this title, including providing such planning to the family members of eligible clients and persons with power of attorney to make health care decisions for the clients; and''; and

(B) in subsection (b), by adding at the end the following:

''(2) Advance care planning provided in accordance with subsection (a)(1)(B) shall not be construed to violate the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14401 et seq.).''.

(3) REPORTS.—Section 1008(a) of the Legal Services Corporation Act (42 U.S.C. 2996g(a)) is amended by adding at the end the following: ''The Corporation shall require such a report, on an annual basis, from each grantee, contractor, or other recipient of financial assistance under section 1006(a)(1)(B).''.

(4) AUTHORIZATION OF APPROPRIATIONS.—Section 1010 of the Legal Services Corporation Act (42 U.S.C. 2996i) is amended—

(A) in subsection (a)—

(i) by striking ''(a)'' and inserting ''(a)(1)'';

(ii) in the last sentence, by striking ''Appropriations for that purpose'' and inserting the following:

''(3) Appropriations for a purpose described in paragraph (1) or (2)''; and

(iii) by inserting before paragraph (3) (as designated by clause (ii)) the following:

''(2) There are authorized to be appropriated to carry out section 1006(a)(1)(B), $10,000,000 for each of fiscal years 2010, 2011, 2012, 2013, and 2014.''; and

(B) in subsection (d), by striking ''subsection (a)'' and inserting ''subsection (a)(1)''.

(5) EFFECTIVE DATE.—This subsection and the amendments made by this subsection take effect July 1, 2010.

(b) STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (3) to award grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990 to provide advance care planning services to Medicare beneficiaries, personal representatives of such beneficiaries, and the families of such beneficiaries. Such services shall include information regarding State-specific advance directives and ways to discuss individual care wishes with health care providers.

(2) REQUIREMENTS.—

(A) AWARD OF GRANTS.—In making grants under this subsection for a fiscal year, the Secretary shall satisfy the following requirements:

(i) Two-thirds of the total amount of funds available under paragraph (3) for a fiscal year shall be allocated among those States approved for a grant under this section that have adopted the Uniform Health-Care Decisions Act drafted by the National Conference of Commissioners on Uniform State Laws and approved and recommended for enactment by all States at the annual conference of such commissioners in 1993.

(ii) One-third of the total amount of funds available under paragraph (3) for a fiscal year shall be allocated among those States approved for a grant under this section that have adopted a uniform form for orders regarding life sustaining treatment as defined in section 1861(hhh)(5) of the Social Security Act (as amended by section 211 of this Act) or a comparable approach to advance care planning.

(B) WORK PLAN; REPORT.—As a condition of being awarded a grant under this subsection, a State shall submit the following to the Secretary:

(i) An approved plan for expending grant funds.

(ii) For each fiscal year for which the State is paid grant funds under this subsection, an annual report regarding the use of the funds, including the number of Medicare beneficiaries served and their satisfaction with the services provided.

(C) LIMITATION.—No State shall be paid funds from a grant made under this subsection prior to July 1, 2010.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to the Centers for Medicare & Medicaid Services Program Management Account, $12,000,000 for each of fiscal years 2010 through 2014 for purposes of awarding grants to States under paragraph (1).

(c) MEDICAID TRANSFORMATION GRANTS FOR ADVANCE CARE PLANNING.—Section 1903(z) of the Social Security Act (42 U.S.C. 1396b(z)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(G) Methods for improving the effectiveness and efficiency of medical assistance provided under this title by making available to individuals enrolled in the State plan or under a waiver of such plan information regarding advance care planning (as defined in section 3 of the Advance Planning and Compassionate Care Act of 2009), including at time of enrollment or renewal of enrollment in the plan or waiver, through providers, and through such other innovative means as the State determines appropriate.'';

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(D) WORK PLAN REQUIRED FOR AWARD OF ADVANCE CARE PLANNING GRANTS.—Payment to a State under this subsection to adopt the innovative methods described in paragraph (2)(G) is conditioned on the State submitting to the Secretary an approved plan for expending the funds awarded to the State under this subsection.''; and

(3) in paragraph (4)—

(A) in subparagraph (A)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period at the end and inserting ''; and''; and

(iii) by inserting after clause (ii), the following new clause:

''(iii) $20,000,000 for each of fiscal years 2010 through 2014.''; and

(B) by striking subparagraph (B), and inserting the following:

''(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States awarded a grant for fiscal year 2010, 2011, 2012, 2013, or 2014. Such method shall provide that—

''(i) 100 percent of such funds for each of fiscal years 2010 through 2014 shall be awarded to States that design programs to adopt the innovative methods described in paragraph (2)(G); and

''(ii) in no event shall a payment to a State awarded a grant under this subsection for fiscal year 2010 be made prior to July 1, 2010.''.

(d) ADVANCE CARE PLANNING COMMUNITY TRAINING GRANTS.—

(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (3) to award grants to area agencies on aging (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)).

(2) REQUIREMENTS.—

(A) USE OF FUNDS.—Funds awarded to an area agency on aging under this subsection shall be used to provide advance care planning education and training opportunities for local aging service providers and organizations.

(B) WORK PLAN; REPORT.—As a condition of being awarded a grant under this subsection, an area agency on aging shall submit the following to the Secretary:

(i) An approved plan for expending grant funds.

(ii) For each fiscal year for which the agency is paid grant funds under this subsection, an annual report regarding the use of the funds, including the number of Medicare beneficiaries served and their satisfaction with the services provided.

(C) LIMITATION.—No area agency on aging shall be paid funds from a grant made under this subsection prior to July 1, 2010.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to the Centers for Medicare & Medicaid Services Program Management Account, $12,000,000 for each of fiscal years 2010 through 2014 for purposes of awarding grants to area agencies on aging under paragraph (1).

(e) NONDUPLICATION OF ACTIVITIES.—The Secretary shall establish procedures to ensure that funds made available under grants awarded under this section or pursuant to amendments made by this section supplement, not supplant, existing Federal funding, and that such funds are not used to duplicate activities carried out under such grants or under other Federally funded programs.

SEC. 112. GRANTS FOR PROGRAMS FOR ORDERS REGARDING LIFE SUSTAINING TREATMENT.

(a) IN GENERAL.—The Secretary shall make grants to eligible entities for the purpose of—

(1) establishing new programs for orders regarding life sustaining treatment in States or localities;

(2) expanding or enhancing an existing program for orders regarding life sustaining treatment in States or localities; or

(3) providing a clearinghouse of information on programs for orders for life sustaining treatment and consultative services for the development or enhancement of such programs.

(b) AUTHORIZED ACTIVITIES.—Activities funded through a grant under this section for an area may include—

(1) developing such a program for the area that includes home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services within the area;

(2) securing consultative services and advice from institutions with experience in developing and managing such programs; and

(3) expanding an existing program for orders regarding life sustaining treatment to serve more patients or enhance the quality of services, including educational services for patients and patients' families or training of health care professionals.

(c) DISTRIBUTION OF FUNDS.—In funding grants under this section, the Secretary shall ensure that, of the funds appropriated to carry out this section for each fiscal year—

(1) at least two-thirds are used for establishing or developing new programs for orders regarding life sustaining treatment; and

(2) one-third is used for expanding or enhancing existing programs for orders regarding life sustaining treatment.

(d) DEFINITIONS.—In this section:

(1) The term ''eligible entity'' includes—

(A) an academic medical center, a medical school, a State health department, a State medical association, a multi-State taskforce, a hospital, or a health system capable of administering a program for orders regarding life sustaining treatment for a State or locality; or

(B) any other health care agency or entity as the Secretary determines appropriate.

(2) The term ''order regarding life sustaining treatment'' has the meaning given such term in section 1861(hhh)(5) of the Social Security Act, as added by section 211.

(3) The term ''program for orders regarding life sustaining treatment'' means, with respect to an area, a program that supports the active use of orders regarding life sustaining treatment in the area.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2009 through 2014.

PART II—PROVIDER EDUCATION

SEC. 121. PUBLIC PROVIDER ADVANCE CARE PLANNING WEBSITE.

(a) DEVELOPMENT.—Not later than January 1, 2010, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Agency for Healthcare Research and Quality, shall establish a website for providers under Medicare, Medicaid, the Children's Health Insurance Program, the Indian Health Service (include contract providers) and other public health providers on each individual's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(b) MAINTENANCE.—The website, shall be maintained and publicized by the Secretary on an ongoing basis.

(c) CONTENT.—The website shall include content, tools, and resources necessary to do the following:

(1) Inform providers about the advance directive requirements under the health care programs described in subsection (a) and other State and Federal laws and regulations related to advance care planning.

(2) Educate providers about advance care planning quality improvement activities.

(3) Provide assistance to providers to—

(A) integrate advance directives into electronic health records, including oral directives; and

(B) develop and disseminate advance care planning informational materials for their patients.

(4) Inform providers about advance care planning continuing education requirements and opportunities.

(5) Encourage providers to discuss advance care planning with their patients of all ages.

(6) Assist providers' understanding of the continuum of end-of-life care services and supports available to patients, including palliative care and hospice.

(7) Inform providers of best practices for discussing end-of-life care with dying patients and their loved ones.

SEC. 122. CONTINUING EDUCATION FOR PHYSICIANS AND NURSES.

(a) IN GENERAL.—Not later than January 1, 2012, the Secretary, acting through the Director of Health Resources and Services Administration, shall develop, in consultation with health care providers and State boards of medicine and nursing, a curriculum for continuing education that States may adopt for physicians and nurses on advance care planning and end-of-life care.

(b) CONTENT.—

(1) IN GENERAL.—The continuing education curriculum developed under subsection (a) for physicians and nurses shall, at a minimum, include—

(A) a description of the meaning and importance of advance care planning;

(B) a description of advance directives, including living wills and durable powers of attorney, and the use of such directives;

(C) palliative care principles and approaches to care; and

(D) the continuum of end-of-life services and supports, including palliative care and hospice.

(2) ADDITIONAL CONTENT FOR PHYSICIANS.—The continuing education curriculum for physicians developed under subsection (a) shall include instruction on how to conduct advance care planning with patients and their loved ones.

Subtitle B—Portability of Advance Directives; Health Information Technology

SEC. 131. PORTABILITY OF ADVANCE DIRECTIVES.

(a) MEDICARE.—Section 1866(f) of the Social Security Act (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (B), by inserting ''and if presented by the individual, to include the content of such advance directive in a prominent part of such record'' before the semicolon at the end;

(B) in subparagraph (D), by striking ''and'' after the semicolon at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(D) by inserting after subparagraph (E) the following new subparagraph:

''(F) to provide each individual with the opportunity to discuss issues relating to the information provided to that individual pursuant to subparagraph (A) with an appropriately trained professional.'';

(2) in paragraph (3), by striking ''a written'' and inserting ''an''; and

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

''(5)(A) An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider of services, a Medicare Advantage organization, or a prepaid or eligible organization shall be given the same effect by that provider or organization as an advance directive validly executed under the law of the State in which it is presented would be given effect.

''(B)(i) The definition of an advanced directive shall also include actual knowledge of instructions made while an individual was able to express the wishes of such individual with regard to health care.

''(ii) For purposes of clause (i), the term 'actual knowledge' means the possession of information of an individual's wishes communicated to the health care provider orally or in writing by the individual, the individual's medical power of attorney representative, the individual's health care surrogate, or other individuals resulting in the health care provider's personal cognizance of these wishes. Other forms of imputed knowledge are not actual knowledge.

''(C) The provisions of this paragraph shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this paragraph shall not preempt any State law that provides for greater portability, more deference to a patient's wishes, or more latitude in determining a patient's wishes.''.

(b) MEDICAID.—Section 1902(w) of the Social Security Act (42 U.S.C. 1396a(w)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (B)—

(i) by striking ''in the individual's medical record'' and inserting ''in a prominent part of the individual's current medical record''; and

(ii) by inserting ''and if presented by the individual, to include the content of such advance directive in a prominent part of such record'' before the semicolon at the end;

(B) in subparagraph (D), by striking ''and'' after the semicolon at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(D) by inserting after subparagraph (E) the following new subparagraph:

''(F) to provide each individual with the opportunity to discuss issues relating to the information provided to that individual pursuant to subparagraph (A) with an appropriately trained professional.'';

(2) in paragraph (4), by striking ''a written'' and inserting ''an''; and

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

''(6)(A) An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider or organization shall be given the same effect by that provider or organization as an advance directive validly executed under the law of the State in which it is presented would be given effect.

''(B)(i) The definition of an advance directive shall also include actual knowledge of instructions made while an individual was able to express the wishes of such individual with regard to health care.

''(ii) For purposes of clause (i), the term 'actual knowledge' means the possession of information of an individual's wishes communicated to the health care provider orally or in writing by the individual, the individual's medical power of attorney representative, the individual's health care surrogate, or other individuals resulting in the health care provider's personal cognizance of these wishes. Other forms of imputed knowledge are not actual knowledge.

''(C) The provisions of this paragraph shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this paragraph shall not preempt any State law that provides for greater portability, more deference to a patient's wishes, or more latitude in determining a patient's wishes.''.

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraphs (E) through (L) as subparagraphs (D) through (M), respectively; and

(2) by inserting after subparagraph (D) the following:

''(E) Section 1902(w) (relating to advance directives).''.

(d) STUDY AND REPORT REGARDING IMPLEMENTATION.—

(1) STUDY.—The Secretary shall conduct a study regarding the implementation of the amendments made by subsections (a) and (b).

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsections (a), (b), and (c) shall apply to provider agreements and contracts entered into, renewed, or extended under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and to State plans under title XIX of such Act (42 U.S.C. 1396 et seq.) and State child health plans under title XXI of such Act (42 U.S.C. 1397aa et seq.), on or after such date as the Secretary specifies, but in no case may such date be later than 1 year after the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsections (b) and (c), 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.

SEC. 132. STATE ADVANCE DIRECTIVE REGISTRIES; DRIVER'S LICENSE ADVANCE DIRECTIVE NOTATION.

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

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

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

(3) by adding at the end the following:

''SEC. 399U. STATE ADVANCE DIRECTIVE REGISTRIES.

''(a) STATE ADVANCE DIRECTIVE REGISTRY.—In this section, the term 'State advance directive registry' means a secure, electronic database that—

''(1) is available free of charge to residents of a State; and

''(2) stores advance directive documents and makes such documents accessible to medical service providers in accordance with Federal and State privacy laws.

''(b) GRANT PROGRAM.—Beginning on July 1, 2010, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants on a competitive basis to eligible entities to establish and operate, directly or indirectly (by competitive grant or competitive contract), State advance directive registries.

''(c) ELIGIBLE ENTITIES.—

''(1) IN GENERAL.—To be eligible to receive a grant under this section, an entity shall—

''(A) be a State department of health; and

''(B) submit to the Director an application at such time, in such manner, and containing—

''(i) a plan for the establishment and operation of a State advance directive registry; and

''(ii) such other information as the Director may require.

''(2) NO REQUIREMENT OF NOTATION MECHANISM.—The Secretary shall not require that an entity establish and operate a driver's license advance directive notation mechanism for State residents under section 399V to be eligible to receive a grant under this section.

''(d) ANNUAL REPORT.—For each year for which an entity receives an award under this section, such entity shall submit an annual report to the Director on the use of the funds received pursuant to such award, including the number of State residents served through the registry.

''(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal year 2010 and each fiscal year thereafter.

''SEC. 399V. DRIVER'S LICENSE ADVANCE DIRECTIVE NOTATION.

''(a) IN GENERAL.—Beginning July 1, 2010, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants on a competitive basis to States to establish and operate a mechanism for a State resident with a driver's license to include a notice of the existence of an advance directive for such resident on such license.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, a State shall—

''(1) establish and operate a State advance directive registry under section 399U; and

''(2) submit to the Director an application at such time, in such manner, and containing—

''(A) a plan that includes a description of how the State will—

''(i) disseminate information about advance directives at the time of driver's license application or renewal;

''(ii) enable each State resident with a driver's license to include a notice of the existence of an advance directive for such resident on such license in a manner consistent with the notice on such a license indicating a driver's intent to be an organ donor; and

''(iii) coordinate with the State department of health to ensure that, if a State resident has an advance directive notice on his or her driver's license, the existence of such advance directive is included in the State registry established under section 399U; and

''(B) any other information as the Director may require.

''(c) ANNUAL REPORT.—For each year for which a State receives an award under this section, such State shall submit an annual report to the Director on the use of the funds received pursuant to such award, including the number of State residents served through the mechanism.

''(d) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $50,000,000 for fiscal year 2010 and each fiscal year thereafter.''.

SEC. 133. GAO STUDY AND REPORT ON ESTABLISHMENT OF NATIONAL ADVANCE DIRECTIVE REGISTRY.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the feasibility of a national registry for advance directives, taking into consideration the constraints created by the privacy provisions enacted as a result of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Comptroller General of the United States determines to be appropriate.

Subtitle C—National Uniform Policy on Advance Care Planning

SEC. 141. STUDY AND REPORT BY THE SECRETARY REGARDING THE ESTABLISHMENT AND IMPLEMENTATION OF A NATIONAL UNIFORM POLICY ON ADVANCE DIRECTIVES.

(a) STUDY.—

(1) IN GENERAL.—The Secretary, acting through the Office of the Assistant Secretary for Planning and Evaluation, shall conduct a thorough study of all matters relating to the establishment and implementation of a national uniform policy on advance directives for individuals receiving items and services under titles XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.; 1397aa et seq.).

(2) MATTERS STUDIED.—The matters studied by the Secretary under paragraph (1) shall include issues concerning—

(A) family satisfaction that a patient's wishes, as stated in the patient's advance directive, were carried out;

(B) the portability of advance directives, including cases involving the transfer of an individual from 1 health care setting to another;

(C) immunity from civil liability and criminal responsibility for health care providers that follow the instructions in an individual's advance directive that was validly executed in, and consistent with the laws of, the State in which it was executed;

(D) conditions under which an advance directive is operative;

(E) revocation of an advance directive by an individual;

(F) the criteria used by States for determining that an individual has a terminal condition;

(G) surrogate decisionmaking regarding end-of-life care;

(H) the provision of adequate palliative care (as defined in paragraph (3)), including pain management;

(I) adequate and timely referrals to hospice care programs; and

(J) the end-of-life care needs of children and their families.

(3) PALLIATIVE CARE.—For purposes of paragraph (2)(H), the term ''palliative care'' means interdisciplinary care for individuals with a life-threatening illness or injury relating to pain and symptom management and psychological, social, and spiritual needs and that seeks to improve the quality of life for the individual and the individual's family.

(b) REPORT TO CONGRESS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(c) CONSULTATION.—In conducting the study and developing the report under this section, the Secretary shall consult with the Uniform Law Commissioners, and other interested parties.

TITLE II—COMPASSIONATE CARE

Subtitle A—Workforce Development

PART I—EDUCATION AND TRAINING

SEC. 201. NATIONAL GERIATRIC AND PALLIATIVE CARE SERVICES CORPS.

Section 331 of the Public Health Service Act (42 U.S.C. 254d) is amended—

(1) by redesignating subsection (j) as subsection (k); and

(2) by inserting after subsection (i), the following:

''(j) NATIONAL GERIATRIC AND PALLIATIVE CARE SERVICES CORPS.—

''(1) ESTABLISHMENT.—Not later than January 1, 2012, the Secretary shall establish within the National Health Service Corps a National Geriatric and Palliative Care Services Corps (referred to in this subsection as the 'Corps') which shall consist of—

''(A) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate;

''(B) such civilian employees of the United States as the Secretary may appoint; and

''(C) such other individuals who are not employees of the United States.

''(2) DUTIES.—The Corps shall be utilized by the Secretary to provide geriatric and palliative care services within health professional shortage areas.

''(3) APPLICATION OF PROVISIONS.—The loan-forgiveness, scholarship, and direct financial incentives programs provided for under this section shall apply to physicians, nurses, and other health professionals (as identified by the Secretary) with respect to the training necessary to enable such individuals to become geriatric or palliative care specialists and provide geriatric and palliative care services in health professional shortage areas.

''(4) REPORT.—Not later than 6 months prior to the date on which the Secretary establishes the Corps under paragraph (1), the Secretary shall submit to Congress a report concerning the organization of the Corps, the application process for membership in the Corps, and the funding necessary for the Corps (targeted by profession and by specialization).''.

SEC. 202. EXEMPTION OF PALLIATIVE MEDICINE FELLOWSHIP TRAINING FROM MEDICARE GRADUATE MEDICAL EDUCATION CAPS.

(a) DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(F)) is amended—

(1) in clause (i), by inserting ''clause (iii) and'' after ''subject to''; and

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

''(iii) INCREASE ALLOWED FOR PALLIATIVE MEDICINE FELLOWSHIP TRAINING.—For cost reporting periods beginning on or after January 1, 2011, in applying clause (i), there shall not be taken into account full-time equivalent residents in the field of allopathic or osteopathic medicine who are in palliative medicine fellowship training that is approved by the Accreditation Council for Graduate Medical Education.''.

(b) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

''(x) Clause (iii) of subsection (h)(4)(F) shall apply to clause (v) in the same manner and for the same period as such clause (iii) applies to clause (i) of such subsection.''.

SEC. 203. MEDICAL SCHOOL CURRICULA.

(a) IN GENERAL.—The Secretary, in consultation with the Association of American Medical Colleges, shall establish guidelines for the imposition by medical schools of a minimum amount of end-of-life training as a requirement for obtaining a Doctor of Medicine degree in the field of allopathic or osteopathic medicine.

(b) TRAINING.—Under the guidelines established under subsection (a), minimum training shall include—

(1) training in how to discuss and help patients and their loved ones with advance care planning;

(2) with respect to students and trainees who will work with children, specialized pediatric training;

(3) training in the continuum of end-of-life services and supports, including palliative care and hospice;

(4) training in how to discuss end-of-life care with dying patients and their loved ones; and

(5) medical and legal issues training.

(c) DISTRIBUTION.—Not later than January 1, 2011, the Secretary shall disseminate the guidelines established under subsection (a) to medical schools.

(d) COMPLIANCE.—Effective beginning not later than July 1, 2012, a medical school that is receiving Federal assistance shall be required to implement the guidelines established under subsection (a). A medical school that the Secretary determines is not implementing such guidelines shall not be eligible for Federal assistance.

Subtitle B—Coverage Under Medicare, Medicaid, and CHIP

PART I—COVERAGE OF ADVANCE CARE PLANNING

SEC. 211. MEDICARE, MEDICAID, AND CHIP COVERAGE.

(a) MEDICARE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)—

(i) by striking ''and'' at the end of subparagraph (DD);

(ii) by adding ''and'' at the end of subparagraph (EE); and

(iii) by adding at the end the following new subparagraph:

''(FF) advance care planning consultation (as defined in subsection (hhh)(1));''; and

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

''Advance Care Planning Consultation

''(hhh)(1) Subject to paragraphs (3) and (4), the term 'advance care planning consultation' means a consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to subparagraphs (A) and (B) of paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders regarding life sustaining treatment or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary may limit the requirement for explanations under clause (i) to consultations furnished in States, localities, or other geographic areas in which orders described in such clause have been widely adopted.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3)(A) An initial preventive physical examination under subsection (ww), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1).

''(B) An advance care planning consultation with respect to an individual shall be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5)(A) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual,

an actionable medical order relating to the treatment of that individual that—

''(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order) and is in a form that permits it to stay with the patient and be followed by health care professionals and providers across the continuum of care, including home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services;

''(ii) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

''(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary);

''(iv) is portable across care settings; and

''(v) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

''(B) The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

''(i) the intensity of medical intervention if the patient is pulseless, apneic, or has serious cardiac or pulmonary problems;

''(ii) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

''(iii) the use of antibiotics; and

''(iv) the use of artificially administered nutrition and hydration.''.

(2) PAYMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(FF),'' after ''(2)(EE),''.

(3) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (N), by striking ''and'' at the end;

(ii) in subparagraph (O) by striking the semicolon at the end and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(P) in the case of advance care planning consultations (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011.

(b) MEDICAID.—

(1) MANDATORY BENEFIT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended in the matter preceding clause (i) by striking ''and (21)'' and inserting '', (21), and (28)''.

(2) MEDICAL ASSISTANCE.—Section 1905 of such 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 new paragraph:

''(28) advance care planning consultations (as defined in subsection (y));''; and

(B) by adding at the end the following:

''(y)(1) For purposes of subsection (a)(28), the term 'advance care planning consultation' means a consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders for life sustaining treatments or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary may limit the requirement for explanations under clause (i) to consultations furnished in States, localities, or other geographic areas in which orders described in such clause have been widely adopted.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in section 1861(r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3) An advance care planning consultation with respect to an individual shall be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5) For purposes of this subsection, the term 'orders regarding life sustaining treatment' has the meaning given that term in section 1861(hhh)(5).''.

(c) CHIP.—

(1) CHILD HEALTH ASSISTANCE.—Section 2110(a) of the Social Security Act (42 U.S.C. 1397jj) is amended—

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

(B) by inserting after paragraph (27), the following:

''(28) Advance care planning consultations (as defined in section 1905(y)).''.

(2) MANDATORY COVERAGE.—

(A) IN GENERAL.—Section 2103 of such Act (42 U.S.C. 1397cc), is amended—

(i) in subsection (a), in the matter preceding paragraph (1), by striking ''and (7)'' and inserting ''(7), and (9)''; and

(ii) in subsection (c), by adding at the end the following:

''(9) END-OF-LIFE CARE.—The child health assistance provided to a targeted low-income child shall include coverage of advance care planning consultations (as defined in section 1905(y) and at the same payment rate as the rate that would apply to such a consultation under the State plan under title XIX).''.

(B) CONFORMING AMENDMENT.—Section 2102(a)(7)(B) of such Act (42 U.S.C. 1397bb(a)(7)(B)) is amended by striking ''section 2103(c)(5)'' and inserting ''paragraphs (5) and (9) of section 2103(c)''.

(d) DEFINITION OF ADVANCE DIRECTIVE UNDER MEDICARE, MEDICAID, AND CHIP.—

(1) MEDICARE.—Section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3)) is amended by striking ''means'' and all that follows through the period and inserting ''means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.''.

(2) MEDICAID AND CHIP.—Section 1902(w)(4) of such Act (42 U.S.C. 1396a(w)(4)) is amended by striking ''means'' and all that follows through the period and inserting ''means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.''.

(e) EFFECTIVE DATE.—The amendments made by this section take effect January 1, 2010.

PART II—HOSPICE

SEC. 221. ADOPTION OF MEDPAC HOSPICE PAYMENT METHODOLOGY RECOMMENDATIONS.

Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(6)(A) The Secretary shall conduct an evaluation of the recommendations of the Medicare Payment Commission for reforming the hospice care benefit under this title that are contained in chapter 6 of the Commission's report entitled 'Report to Congress: Medicare Payment Policy (March 2009)', including the impact that such recommendations if implemented would have on access to care and the quality of care. In conducting such evaluation, the Secretary shall take into account data collected in accordance with section 263(b) of the Advance Planning and Compassionate Care Act of 2009.

''(B) Based on the results of the examination conducted under subparagraph (A), the

Secretary shall make appropriate refinements to the recommendations described in subparagraph (A). Such refinements shall take into account—

''(i) the impact on patient populations with longer that average lengths of stay;

''(ii) the impact on populations with shorter that average lengths of stay; and

''(iii) the utilization patterns of hospice providers in underserved areas, including rural hospices.

''(C) Not later than January 1, 2013, the Secretary shall submit to Congress a report that contains a detailed description of—

''(i) the refinements determined appropriate by the Secretary under subparagraph (B);

''(ii) the revisions that the Secretary will implement through regulation under this title pursuant to subparagraph (D); and

''(iii) the revisions that the Secretary determines require additional legislative action by Congress.

''(D)(i) The Secretary shall implement the recommendations described in subparagraph (A), as refined under subparagraph (B).

''(ii) Subject to clause (iii), the implementation of such recommendations shall apply to hospice care furnished on or after January 1, 2014.

''(iii) The Secretary shall establish an appropriate transition to the implementation of such recommendations.

''(E) For purposes of carrying out the provisions of this paragraph, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817, of such sums as may be necessary to the Centers for Medicare & Medicaid Services Program Management Account.''.

SEC. 222. REMOVING HOSPICE INPATIENT DAYS IN SETTING PER DIEM RATES FOR CRITICAL ACCESS HOSPITALS.

Section 1814(l) of the Social Security Act (42 U.S.C. 1395f(l)), as amended by section 4102(b)(2) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new paragraph:

''(6) For cost reporting periods beginning on or after January 1, 2011, the Secretary shall remove Medicare-certified hospice inpatient days from the calculation of per diem rates for inpatient critical access hospital services.''.

SEC. 223. HOSPICE PAYMENTS FOR DUAL ELIGIBLE INDIVIDUALS RESIDING IN LONG-TERM CARE FACILITIES.

(a) IN GENERAL.—Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(f) PAYMENTS FOR DUAL ELIGIBLE INDIVIDUALS RESIDING IN LONG-TERM CARE FACILITIES.—For cost reporting periods beginning on or after January 1, 2011, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall establish procedures under which payments for room and board under the State Medicaid plan with respect to an applicable individual are made directly to the long-term care facility (as defined by the Secretary for purposes of title XIX) the individual is a resident of. For purposes of the preceding sentence, the term 'applicable individual' means an individual who is entitled to or enrolled for benefits under part A or enrolled for benefits under part B and is eligible for medical assistance for hospice care under a State plan under title XIX.''.

(b) STATE PLAN REQUIREMENT.—

(1) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (72), by striking ''and'' at the end;

(B) in paragraph (73), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (73) the following new paragraph:

''(74) provide that the State will make payments for room and board with respect to applicable individuals in accordance with section 1888(f).''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by paragraph (1) take effect on January 1, 2011.

(B) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), 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.

SEC. 224. DELINEATION OF RESPECTIVE CARE RESPONSIBILITIES OF HOSPICE PROGRAMS AND LONG-TERM CARE FACILITIES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy), as amended by section 223(a), is amended by adding at the end the following new subsection:

''(g) DELINEATION OF RESPECTIVE CARE RESPONSIBILITIES OF HOSPICE PROGRAMS AND LONG-TERM CARE FACILITIES.—Not later than July 1, 2011, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall delineate and enforce the respective care responsibilities of hospice programs and long-term care facilities (as defined by the Secretary for purposes of title XIX) with respect to individuals residing in such facilities who are furnished hospice care.''.

SEC. 225. ADOPTION OF MEDPAC HOSPICE PROGRAM ELIGIBILITY CERTIFICATION AND RECERTIFICATION RECOMMENDATIONS.

In accordance with the recommendations of the Medicare Payment Advisory Commission contained in the March 2009 report entitled ''Report to Congress: Medicare Payment Policy'', section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end; and

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

''(D) on or after January 1, 2011—

''(i) a hospice physician or advance practice nurse visits the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii) and attests that such visit took place (in accordance with procedures established by the Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services); and

''(ii) any certification or recertification under subparagraph (A) includes a brief narrative describing the clinical basis for the individual's prognosis (in accordance with procedures established by the Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services); and''.

SEC. 226. CONCURRENT CARE FOR CHILDREN.

(a) PERMITTING MEDICARE HOSPICE BENEFICIARIES 18 YEARS OF AGE OR YOUNGER TO RECEIVE CURATIVE CARE.—

(1) IN GENERAL.—Section 1812 of the Social Security Act (42 U.S.C. 1395d) is amended—

(A) in subsection (a)(4), by inserting ''(subject to the second sentence of subsection (d)(2)(A))'' after ''in lieu of certain other benefits''; and

(B) in subsection (d)—

(i) in paragraph (1), by inserting '' , subject to the second sentence of paragraph (2)(A),'' after ''instead''; and

(ii) in paragraph (2)(A), by adding at the end the following new sentence: ''Clause (ii)(I) shall not apply to an individual who is 18 years of age or younger.''

(2) CONFORMING AMENDMENT.—Section 1862(a)(1)(C) of the Social Security Act (42 U.S.C. 1395y(a)(1)(C)) is amended inserting ''subject to the second sentence of section 1812(d)(2)(A),'' after ''hospice care,''.

(b) APPLICATION TO MEDICAID AND CHIP.—

(1) MEDICAID.—Section 1905(o)(1)(A) of the Social Security Act (42 U.S.C. 1395d(o)(1)(A)) is amended by inserting ''(subject, in the case of an individual who is a child, to the second sentence of such section)'' after ''section 1812(d)(2)(A)''.

(2) CHIP.—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397jj(a)(23)) is amended by inserting ''(concurrent, in the case of an individual who is a child, with care related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made)'' after ''hospice care''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 227. MAKING HOSPICE A REQUIRED BENEFIT UNDER MEDICAID AND CHIP.

(a) MANDATORY BENEFIT.—

(1) MEDICAID.—

(A) IN GENERAL.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), as amended by section 211(b)(1), is amended in the matter preceding clause (i) by inserting ''(18),'' after ''(17),''.

(B) CONFORMING AMENDMENT.—Section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) is amended—

(i) in clause (iii)—

(I) in subclause (I), by inserting ''and hospice care'' after ''ambulatory services''; and

(II) in subclause (II), by inserting ''and hospice care'' after ''delivery services''; and

(ii) in clause (iv), by inserting ''and (18)'' after ''(17)''.

(2) CHIP.—Section 2103(c)(9) of such Act (42 U.S.C. 1397cc(c)(9))), as added by section 211(c)(2)(A), is amended by inserting ''and hospice care'' before the period.

(b) EFFECTIVE DATE.—The amendments made subsection (a) take effect on January 1, 2011.

SEC. 228. MEDICARE HOSPICE PAYMENT MODEL DEMONSTRATION PROJECTS.

(a) ESTABLISHMENT.—Not later than July 1, 2012, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Agency for Healthcare Research and Quality, shall conduct demonstration projects to examine ways to improve how the Medicare hospice care benefit predicts disease trajectory. Projects shall include the following models:

(1) Models that better and more appropriately care for, and transition as needed, patients in their last years of life who need palliative care, but do not qualify for hospice care under the Medicare hospice eligibility criteria.

(2) Models that better and more appropriately care for long-term patients who are not recertified in hospice but still need palliative care.

(3) Any other models determined appropriate by the Secretary.

(b) WAIVER AUTHORITY.—The Secretary may waive compliance of such requirements of titles XI and XVIII of the Social Security Act as the Secretary determines necessary to conduct the demonstration projects under this section.

(c) REPORTS.—The Secretary shall submit to Congress periodic reports on the demonstration projects conducted under this section.

SEC. 229. MEDPAC STUDIES AND REPORTS.

(a) STUDY AND REPORT REGARDING AN ALTERNATIVE PAYMENT METHODOLOGY FOR HOSPICE CARE UNDER THE MEDICARE PROGRAM.—

(1) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the ''Commission'') shall conduct a study on the establishment of a reimbursement system for hospice care furnished under the Medicare program that is based on diagnoses. In conducting such study, the Commission shall use data collected under new provider data requirements. Such study shall include an analysis of the following:

(A) Whether such a reimbursement system better meets patient needs and better corresponds with provider resource expenditures than the current system.

(B) Whether such a reimbursement system improves quality, including facilitating standardization of care toward best practices and diagnoses-specific clinical pathways in hospice.

(C) Whether such a reimbursement system could address concerns about the blanket 6-month terminal prognosis requirement in hospice.

(D) Whether such a reimbursement system is more cost effective than the current system.

(E) Any other areas determined appropriate by the Commission.

(2) REPORT.—Not later than June 15, 2013, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) STUDY AND REPORT REGARDING RURAL HOSPICE TRANSPORTATION COSTS UNDER THE MEDICARE PROGRAM.—

(1) STUDY.—The Commission shall conduct a study on rural Medicare hospice transportation mileage to determine potential Medicare reimbursement changes to account for potential higher costs.

(2) REPORT.—Not later than June 15, 2013, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(c) EVALUATION OF REIMBURSEMENT DISINCENTIVES TO ELECT MEDICARE HOSPICE WITHIN THE MEDICARE SKILLED NURSING FACILITY BENEFIT.—

(1) STUDY.—The Commission shall conduct a study to determine potential Medicare reimbursement changes to remove Medicare reimbursement disincentives for patients in a skilled nursing facility who want to elect hospice.

(2) REPORT.—Not later than June 15, 2013, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Commission determines appropriate.

SEC. 230. HHS EVALUATIONS.

(a) EVALUATION OF ACCESS TO HOSPICE AND HOSPITAL-BASED PALLIATIVE CARE.—

(1) EVALUATION.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall conduct an evaluation of geographic areas and populations underserved by hospice and hospital-based palliative care to identify potential barriers to access.

(2) REPORT.—Not later than December 31, 2012, the Secretary shall report to Congress, on the evaluation conducted under subsection (a) together with recommendations for such legislation and administrative action as the Secretary determines appropriate to address barriers to access to hospice and hospital-based palliative care.

(b) EVALUATION OF AWARENESS AND USE OF HOSPICE RESPITE CARE UNDER MEDICARE, MEDICAID, AND CHIP.—

(1) EVALUATION.—The Secretary, acting through the Director of the Centers for Medicare and Medicaid Services, shall evaluate the awareness and use of hospice respite care by informal caregivers of beneficiaries under Medicare, Medicaid, and CHIP.

(2) REPORT.—Not later than December 31, 2010, the Secretary shall report to Congress, on the evaluation conducted under subsection (a) together with recommendations for such legislation and administrative action as the Secretary determines appropriate to increase awareness or use of hospice respite care under Medicare, Medicaid, and CHIP.

Subtitle C—Quality Improvement

SEC. 241. PATIENT SATISFACTION SURVEYS.

Not later than January 1, 2012, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall establish a mechanism for—

(1) collecting information from patients (or their health care proxies or families members in the event patients are unable to speak for themselves) in relevant provider settings regarding their care at the end of life; and

(2) incorporating such information in a timely manner into mechanisms used by the Administrator to provide quality of care information to consumers, including the Hospital Compare and Nursing Home Compare websites maintained by the Administrator.

SEC. 242. DEVELOPMENT OF CORE END-OF-LIFE CARE QUALITY MEASURES ACROSS EACH RELEVANT PROVIDER SETTING.

(a) IN GENERAL.—The Secretary, acting through the Administrator of the Agency for Healthcare Research and Quality (in this section referred to as the ''Administrator'') and in consultation with the Director of the National Institutes of Health, shall require specific end-of-life quality measures for each relevant provider setting, as identified by the Administrator, in accordance with the requirements of subsection (b).

(b) REQUIREMENTS.—For purposes of subsection (a), the requirements specified in this subsection are the following:

(1) Selection of the specific measure or measures for an identified provider setting shall be—

(A) based on an assessment of what is likely to have the greatest positive impact on quality of end-of-life care in that setting; and

(B) made in consultation with affected providers and public and private organizations, that have developed such measures.

(2) The measures may be structure-oriented, process-oriented, or outcome-oriented, as determined appropriate by the Administrator.

(3) The Administrator shall ensure that reporting requirements related to such measures are imposed consistent with other applicable laws and regulations, and in a manner that takes into account existing measures, the needs of patient populations, and the specific services provided.

(4) Not later than—

(A) April 1, 2011, the Secretary shall disseminate the reporting requirements to all affected providers; and

(B) April 1, 2012, initial reporting relating to the measures shall begin.

SEC. 243. ACCREDITATION OF HOSPITAL-BASED PALLIATIVE CARE PROGRAMS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall designate a public or private agency, entity, or organization to develop requirements, standards, and procedures for accreditation of hospital-based palliative care programs.

(b) REPORTING.—Not later than January 1, 2012, the Secretary shall prepare and submit a report to Congress on the proposed accreditation process for hospital-based palliative care programs.

(c) ACCREDITATION.—Not later than July 1, 2012, the Secretary shall—

(1) establish and promulgate standards and procedures for accreditation of hospital-based palliative care programs; and

(2) designate an agency, entity, or organization that shall be responsible for certifying such programs in accordance with the standards established under paragraph (1).

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

(1) The term ''hospital-based palliative care program'' means a hospital-based program that is comprised of an interdisciplinary team that specializes in providing palliative care services and consultations in a variety of health care settings, including hospitals, nursing homes, and home and community-based services.

(2) The term ''interdisciplinary team'' means a group of health care professionals (consisting of, at a minimum, a doctor, a nurse, and a social worker) that have received specialized training in palliative care.

SEC. 244. SURVEY AND DATA REQUIREMENTS FOR ALL MEDICARE PARTICIPATING HOSPICE PROGRAMS.

(a) HOSPICE SURVEYS.—Section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)) is amended by adding at the end the following new paragraph:

''(6) In accordance with the recommendations of the Medicare Payment Advisory Commission contained in the March 2009 report entitled 'Report to Congress: Medicare Payment Policy', the Secretary shall establish, effective July 1, 2010, the following survey requirements for hospice programs:

''(A) Any hospice program seeking initial certification under this title on or after that date shall be subject to an initial survey by an appropriate State or local agency, or an approved accreditation agency, not later than 6 months after the program first seeks such certification.

''(B) All hospice programs certified for participation under this title shall be subject to a standard survey by an appropriate State or local agency, or an approved accreditation agency, at least every 3 years after initially being so certified.''.

(b) REQUIRED HOSPICE RESOURCE INPUTS DATA.—Section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)), as amended by subsection (a), is amended—

(1) in paragraph (3)—

(A) in subparagraph (F), by striking ''and'' at the end;

(B) by redesignating subparagraph (G) as subparagraph (H); and

(C) by inserting after subparagraph (F) the following new subparagraph:

''(G) to comply with the reporting requirements under paragraph (7); and''; and

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

''(7)(A) In accordance with the recommendations of the Medicare Payment Advisory Commission for additional data (as

contained in the March 2009 report entitled 'Report to Congress: Medicare Payment Policy'), beginning January 1, 2011, a hospice program shall report to the Secretary, in such form and manner, and at such intervals, as the Secretary shall require, the following data with respect to each patient visit:

''(i) Visit type (such as admission, routine, emergency, education for family, other).

''(ii) Visit length.

''(iii) Professional or paraprofessional disciplines involved in the visit, including nurse, social worker, home health aide, physician, nurse practitioner, chaplain or spiritual counselor, counselor, dietician, physical therapist, occupational therapist, speech language pathologist, music or art therapist, and including bereavement and support services provided to a family after a patient's death.

''(iv) Drugs and other therapeutic interventions provided.

''(v) Home medical equipment and other medical supplies provided.

''(B) In collecting the data required under subparagraph (A), the Secretary shall ensure that the data are reported in a manner that allows for summarized cross-tabulations of the data by patients' terminal diagnoses, lengths of stay, age, sex, and race.''.

Subtitle D—Additional Reports, Research, and Evaluations

SEC. 251. NATIONAL CENTER ON PALLIATIVE AND END-OF-LIFE CARE.

Part E of title IV of the Public Health Service Act (42 U.S.C. 287 et seq.) is amended by adding at the end the following:

''Subpart 7—National Center on Palliative and End-of-Life Care

''SEC. 485J. NATIONAL CENTER ON PALLIATIVE AND END-OF-LIFE CARE.

''(a) ESTABLISHMENT.—Not later than July 1, 2011, there shall be established within the National Institutes of Health, a National Center on Palliative and End-of-Life Care (referred to in this section as the 'Center').

''(b) PURPOSE.—The general purpose of the Center is to conduct and support research relating to palliative and end-of-life care interventions and approaches.

''(c) ACTIVITIES.—The Center shall—

''(1) develop and continuously update a research agenda with the goal of—

''(A) providing a better biomedical understanding of the end of life; and

''(B) improving the quality of care and life at the end of life; and

''(2) provide funding for peer-review-selected extra- and intra-mural research that includes the evaluation of existing, and the development of new, palliative and end-of-life care interventions and approaches.''.

SEC. 252. NATIONAL MORTALITY FOLLOWBACK SURVEY.

(a) IN GENERAL.—Not later than December 31, 2010, and annually thereafter, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall renew and conduct the National Mortality Followback Survey (referred to in this section as the ''Survey'') to collect data on end-of-life care.

(b) PURPOSE.—The purpose of the Survey shall be to gain a better understanding of current end-of-life care in the United States.

(c) QUESTIONS.—

(1) IN GENERAL.—In conducting the Survey, the Director of the Centers for Disease Control and Prevention shall, at a minimum, include the following questions with respect to the loved one of a respondent:

(A) Did he or she have an advance directive, and if so, when it was completed.

(B) Did he or she have an order for life-sustaining treatment, and if so, when was it completed.

(C) Did he or she have a durable power of attorney, and if so, when it was completed.

(D) Had he or she discussed his or her wishes with loved ones, and if so, when.

(E) Had he or she discussed his or her wishes with his or her physician, and if so, when.

(F) In the opinion of the respondent, was he or she satisfied with the care he or she received in the last year of life and in the last week of life.

(G) Was he or she cared for by hospice, and if so, when.

(H) Was he or she cared for by palliative care specialists, and if so, when.

(I) Did he or she receive effective pain management (if needed).

(J) What was the experience of the main caregiver (including if such caregiver was the respondent), and whether he or she received sufficient support in this role.

(2) ADDITIONAL QUESTIONS.—Additional questions to be asked during the Survey shall be determined by the Director of the Centers for Disease Control and Prevention on an ongoing basis with input from relevant research entities.

SEC. 253. DEMONSTRATION PROJECTS FOR USE OF TELEMEDICINE SERVICES IN ADVANCE CARE PLANNING.

(a) IN GENERAL.—Not later than July 1, 2013, the Secretary shall establish a demonstration program to reimburse eligible entities for costs associated with the use of telemedicine services (including equipment and connection costs) to provide advance care planning consultations with geographically distant physicians and their patients.

(b) DURATION.—The demonstration project under this section shall be conducted for at least a 3-year period.

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

(1) The term ''eligible entity'' means a physician or an advance practice nurse who provides services pursuant to a hospital-based palliative care program (as defined in section 262(d)(1)).

(2) The term ''geographically distant'' has the meaning given that term by the Secretary for purposes of conducting the demonstration program established under this section.

(3) The term ''telemedicine services'' means a service or consultation provided via telecommunication equipment that allows an eligible entity to exchange or discuss medical information with a patient or a health care professional at a separate location through real-time videoconferencing, or a similar format, for the purpose of providing health care diagnosis and treatment.

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

SEC. 254. INSPECTOR GENERAL INVESTIGATION OF FRAUD AND ABUSE.

In accordance with the recommendations of the Medicare Payment Advisory Commission for additional data (as contained in the March 2009 report entitled ''Report to Congress: Medicare Payment Policy''), the Secretary shall direct the Office of the Inspector General of the Department of Health and Human Services to investigate, not later than January 1, 2012, the following with respect to hospice benefit under Medicare, Medicaid, and CHIP:

(1) The prevalence of financial relationships between hospices and long-term care facilities, such as nursing facilities and assisted living facilities, that may represent a conflict of interest and influence admissions to hospice.

(2) Differences in patterns of nursing home referrals to hospice.

(3) The appropriateness of enrollment practices for hospices with unusual utilization patterns (such as high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices).

(4) The appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.

SEC. 255. GAO STUDY AND REPORT ON PROVIDER ADHERENCE TO ADVANCE DIRECTIVES.

Not later than January 1, 2012, the Comptroller General of the United States shall conduct a study of the extent to which providers comply with advance directives under the Medicare and Medicaid programs and shall submit a report to Congress on the results of such study, together with such recommendations for administrative or legislative changes as the Comptroller General determines appropriate.

By Mr. REID (for Mr. ROCKEFELLER (for himself and Ms. SNOWE)):

S. 1151. A bill to amend part A of title IV of the Social Security Act to require the Secretary of Health and Human Services to conduct research on indicators of child well-being; to the Committee on Finance.

Mr. ROCKEFELLER. Mr. President, today I am pleased to introduce with my distinguished colleague Senator OLYMPIA SNOWE, bipartisan legislation known as the State Child Well-Being Research Act of 2009. Companion legislation has already been introduced in the House by Congressmen FATTAH and CAMP. This bill is designed to enhance child well-being by requiring the Secretary of Health and Human Services to facilitate the collection of state-specific data based on a defined set of indicators. The well-being of children is important to both national and State governments. Therefore, data collection is a priority that cannot be ignored if we hope to make informed decisions on public policy.

In 1996, Congress passed bold legislation, which I supported to dramatically change our welfare system. The driving force behind this reform was to promote the work and self-sufficiency of families and to provide the flexibility to States necessary to achieve these goals. States, which is where most child and family legislation takes place, have used this flexibility to design different programs that work better for the families who rely on them. The design and benefits available under other programs that serve children, ranging from the Children Health Insurance Program, CHIP, to child welfare services, can vary widely among States.

It is obvious that in order for policy makers to evaluate child well-being, we need state-specific data on child well-being to measure the results. Current surveys provide minimal data on some important indicators of child well-being, but insufficient data is available on low-income families, geographic variation, and young children. Additionally, the information is not provided in a timely manner, which impedes legislators' ability to effectively measure child well-being and design effective programs to support our children.

The State Child Well-Being Research Act of 2009 is intended to fill this information gap by collecting up-to-date, State-specific data that can be used by policymakers, researchers, and child advocates to assess the well-being of children. As we strive to promote quality programs, we need basic benchmarks to measure outcomes. Our bill would require that a survey examine the physical and emotional health of children, adequately represent the experiences of families in individual states, be consistent across states, be collected annually, articulate results in easy to understand terms, and focus on low-income children and families. This legislation also establishes an advisory committee, consisting of a panel of experts who specialize in survey methodology and indicators of child well-being, and the application of this data to ensure that the purpose is being achieved.

Further, this bill avoids some of the problems in the current system by making data files easier to use and more readily available to the public. As a result, the information will be more useful for policy-makers managing welfare reform and programs for children and families. Finally, this legislation also offers the potential for the Health and Human Service Department to partner with private charitable foundations, like the Annie E. Casey Foundations, which has already expressed an interest in forming a partnership to provide outreach, support and a guarantee that the data collected would be broadly disseminated. This type of public-private partnership helps to leverage additional resources for children and families and increases the study's impact. Given the tight budget we face, partnerships make sense to meet this essential need.

I hope my colleagues review this legislation carefully and choose to support it so that Federal and state policy makers and advocates have the information necessary to make good decisions for children.

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. 1151

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 ''State Child Well-Being Research Act of 2009''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The well-being of children is a paramount concern for our Nation and for every State, and most programs for children and families are managed at the State or local level.

(2) Child well-being varies over time and across social, economic, and geographic groups, and can be affected by changes in the circumstances of families, by the economy, by the social and cultural environment, and by public policies and programs at the Federal, State, and local level.

(3) States, including small States, need information about child well-being that is specific to their State and that is up-to-date, cost-effective, and consistent across States and over time.

(4) Regular collection of child well-being information at the State level is essential so that Federal and State officials can track child well-being over time.

(5) Information on child well-being is necessary for all States, particularly small States that do not have State-level data in other federally supported databases. Information is needed on the well-being of all children, not just children participating in Federal programs.

(6) Telephone surveys of parents represent a relatively cost-effective strategy for obtaining information on child well-being at the State level for all States, including small States, and can be conducted alone or in mixed mode strategy with other survey techniques.

(7) Data from telephone surveys of the population are currently used to monitor progress toward many important national goals, including immunization of preschool children with the National Immunization Survey, and the identification of health care issues of children with special needs with the National Survey of Children with Special Health Care Needs.

(8) A State-level telephone survey, alone or in combination with other techniques, can provide information on a range of topics, including children's social and emotional development, education, health, safety, family income, family employment, and child care. Information addressing marriage and family structure can also be obtained for families with children. Information obtained from such a survey would not be available solely for children or families participating in programs but would be representative of the entire State population and consequently, would inform welfare policymaking on a range of important issues, such as income support, child care, child abuse and neglect, child health, family formation, and education.

SEC. 3. RESEARCH ON INDICATORS OF CHILD WELL-BEING.

Section 413 of the Social Security Act (42 U.S.C. 613) is amended by adding at the end the following:

''(k) INDICATORS OF CHILD WELL-BEING.—

''(1) RENAMING OF SURVEY.—On and after the date of the enactment of this subsection, the National Survey of Children's Health conducted by the Director of the Maternal and Child Health Bureau of the Health Resources and Services Administration shall be known as the 'Survey of Children's Health and Well-Being'.

''(2) MODIFICATION OF SURVEY TO INCLUDE MATTERS RELATING TO CHILD WELL-BEING.—The Secretary shall modify the survey so that it may be used to better assess child well-being, as follows:

''(A) NEW INDICATORS INCLUDED.—The indicators with respect to which the survey collects information shall include measures of child-well-being related to the following:

''(i) Education.

''(ii) Social and emotional development.

''(iii) Physical and mental health and safety.

''(iv) Family well-being, such as family structure, income, employment, child care arrangements, and family relationships.

''(B) COLLECTION REQUIREMENTS.—The data collected with respect to the indicators developed under subparagraph (A) shall be—

''(i) statistically representative at the State and national level;

''(ii) consistent across States, except that data shall be collected in States other than the 50 States and the District of Columbia only if technically feasible;

''(iii) collected on an annual or ongoing basis;

''(iv) measured with reliability;

''(v) current;

''(vi) over-sampled (if feasible), with respect to low-income children and families, so that subgroup estimates can be produced by a variety of income categories (such as for 50, 100, and 200 percent of the poverty level, and for children of varied ages, such as 0–5, 6–11, 12–17, and (if feasible) 18–21 years of age); and

''(vii) made publicly available.

''(C) OTHER REQUIREMENTS.—

''(i) PUBLICATION.—The data collected with respect to the indicators developed under subparagraph (A) shall be published as absolute numbers and expressed in terms of rates or percentages.

''(ii) AVAILABILITY OF DATA.—A data file shall be made available to the public, subject to confidentiality requirements, that includes the indicators, demographic information, and ratios of income to poverty.

''(iii) SAMPLE SIZES.—Sample sizes used for the collected data shall be adequate for microdata on the categories included in subparagraph (B)(vi) to be made publicly available, subject to confidentiality requirements.

''(D) CONSULTATION.—

''(i) IN GENERAL.—In developing the indicators under subparagraph (A) and the means to collect the data required with respect to the indicators, the Secretary shall consult and collaborate with a subcommittee of the Federal Interagency Forum on Child and Family Statistics, which shall include representatives with expertise on all the domains of child well-being described in subparagraph (A). The subcommittee shall have appropriate staff assigned to work with the Maternal and Child Health Bureau during the design phase of the survey.

''(ii) DUTIES.—The Secretary shall consult with the subcommittee referred to in clause (i) with respect to the design, content, and methodology for the development of the indicators under subparagraph (A) and the collection of data regarding the indicators, and the availability or lack thereof of similar data through other Federal data collection efforts.

''(iii) COSTS.—Costs incurred by the subcommittee with respect to the development of the indicators and the collection of data related to the indicators shall be treated as costs of the survey.

''(3) ADVISORY PANEL.—

''(A) ESTABLISHMENT.—The Secretary, in consultation with the Federal Interagency Forum on Child and Family Statistics, shall establish an advisory panel of experts to make recommendations regarding—

''(i) the additional matters to be addressed by the survey by reason of this subsection; and

''(ii) the methods, dissemination strategies, and statistical tools necessary to conduct the survey as a whole.

''(B) MEMBERSHIP.—

''(i) IN GENERAL.—The advisory panel established under subparagraph (A) of this paragraph shall include experts on each of the domains of child well-being described in paragraph (2)(A), experts on child indicators, experts from State agencies and from nonprofit organizations that use child indicator data at the State level, and experts on survey methodology.

''(ii) DEADLINE.—The members of the advisory panel shall be appointed not later than 2 months after the date of the enactment of this subsection.

''(C) MEETINGS.—The advisory panel established under subparagraph (A) shall meet—

''(i) at least 3 times during the first year after the date of enactment of this subsection; and

''(ii) annually thereafter for the 4 succeeding years.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 2010 through 2014, $20,000,000 for the purpose of carrying out this subsection.''.

SEC. 4. GAO REPORT ON COLLECTION AND REPORTING OF DATA ON DEATHS OF CHILDREN IN FOSTER CARE.

(a) IN GENERAL.—Within 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall conduct a study to determine, and submit to the Congress a written report on the adequacy of, the methods of collecting and reporting data on deaths of children in the child welfare system.

(b) MATTERS TO BE CONSIDERED.—In the study, the Comptroller General shall, for each year for which data are available, determine—

(1) the number of children eligible for services or benefits under part B or E of title IV of the Social Security Act who States reported as having died due to abuse or neglect;

(2) the number of children so eligible who died due to abuse or neglect but were not accounted for in State reports; and

(3) the number of children in State child welfare systems who died due to abuse or neglect and whose deaths are not included in the data described in paragraph (1) or (2).

(c) RECOMMENDATIONS.—In the report, the Comptroller General shall include recommendations on how surveys of children by the Federal Government and by State governments can be improved to better capture all data on the death of children in the child welfare system, so that the Congress can work with the States to develop better policies to improve the well-being of children and reduce child deaths.

By Mr. REID (for Mr. KENNEDY (for himself, Mr. DODD, Mr. HARKIN, Ms. MIKULSKI, Mrs. MURRAY, Mr. SANDERS, Mr. BROWN, Mr. CASEY, Mr. INOUYE, Mr. LEVIN, Mr. KERRY, Mr. AKAKA, MRS. BOXER!, MR. FEINGOLD, Mr. DURBIN, Mr. JOHNSON, Mr. SCHUMER, Mr. LAUTENBERG, Mr. MENENDEZ, Mr. BURR, and Mrs. GILLIBRAND)):

S. 1152. A bill to allow Americans to earn paid sick time so that they can address their own health needs and the health needs and the health needs of their families; to the Committee on Health, Education, Labor, and Pensions.

Mr. KENNEDY. Mr. President, in this turbulent economy, working families are facing enormous challenges. Too many families are living paycheck to paycheck, just one layoff or health crisis away from disaster. Now more than ever, workers are struggling to balance the demands of their jobs and their families. When a sickness or health problem arises, these challenges can easily become insurmountable.

Unfortunately, almost half of all private sector workers—including 79 percent of low-wage workers—have no paid sick days they can use to care for themselves or a sick family member. For these workers, taking a day off to care for their own health or a sick child means losing a much-needed paycheck, or even putting their jobs in danger. In a recent survey, 1 in 6 workers reported that they or a family member have been fired, punished or threatened with termination for taking time off because of their own illness or to care for a sick relative.

Workers can't afford to take that kind of risk now. Losing even one paycheck can mean falling behind on bills, foregoing needed medicines, or skipping meals. As a result, many employees continue to go to work when they are ill, and send their children to school or day care sick, because it's the only way to make ends meet.

The lack of paid sick day is not just a crisis for individual families—it is a public health crisis as well. The current flu outbreak provides a compelling illustration. To prevent the spread of the virus, the World Health Organization, the Center for Disease Control, and numerous state and local public health officials urged people to stay home from work or school if they flu-like symptoms. Strong scientific evidence proves that this is one of the best ways to prevent the spread of disease and protect the public health.

But without paid sick days, following this sound advice is often impossible—millions of employees want to do the right thing and stay home, but our current laws just do not protect them. The Family and Medical Leave Act enables workers to take time off for serious health conditions, but only about half of today's workers are covered by the act, and millions more can not take advantage of it because this leave is unpaid.

Hardworking Americans should not have to make these impossible choices. That's why Senator DODD, Representative ROSA DELAURO and I are introducing the Healthy Families Act, which will enable workers to take up to 56 hours, or about 7 days, of paid sick leave each year. Employees can use this time to stay home and get well when they are ill, to care for a sick family member, to obtain preventive or diagnostic treatment, or to seek help if they are victims of domestic violence.

This important legislation will provide needed security for working families struggling to balance the jobs they need and the families they love. It will improve public health and reduce health costs by preventing the spread of disease and giving employees the access they need to obtain preventive care. It will also help victims of domestic violence to protect their families and their futures.

In addition, the legislation will benefit businesses by decreasing employee turnover, and improving productivity. ''Presenteeism''—sick workers coming to work and infecting their colleagues instead of staying at home—costs our economy $180 billion annually in lost productivity. For employers, the cost averages $255 per employee per year, and exceeds the cost of absenteeism and medical and disability benefits. The lack of paid sick days also leads to higher employee turnover, especially for low-wage workers. When the benefits of the Healthy Families Act are weighed against its costs, providing paid sick days will actually save American businesses up to $9 billion a year by eliminating these productivity losses and reducing turnover.

Above all, enabling workers to earn paid sick time to care for themselves and their families is a matter of fundamental fairness. Every worker has had to miss days of work because of illness. Every child gets sick and needs a parent at home to take care of them. And all hardworking Americans deserve the chance to take care of their families without putting their jobs or their health on the line.

It is long past time for our laws to deal with these difficult choices that working men and women face every day. As President Obama has said, ''Nobody in America should have to choose between keeping their jobs and caring for a sick child.'' I urge all of my colleagues to join in supporting the Healthy Families Act.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 155—EXPRESSING THE SENSE OF THE SENATE THAT THE GOVERNMENT OF THE PEOPLE'S REPUBLIC OF CHINA SHOULD IMMEDIATELY CEASE ENGAGING IN ACTS OF CULTURAL, LINGUISTIC, AND RELIGIOUS SUPPRESSION DIRECTED AGAINST THE UYGHUR PEOPLE

Mr. BROWN (for himself and Mr. INHOFE) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 155

Whereas protecting the human rights of minority groups is consistent with the actions of a responsible member of the international community;

Whereas recent actions taken against the Uyghur minority by authorities in the People's Republic of China and, specifically, by local officials in the Xinjiang Uyghur Autonomous Region, have included major violations of human rights and acts of cultural suppression;

Whereas the authorities of the People's Republic of China have manipulated the strategic objectives of the international war on terrorism to increase their cultural and religious oppression of the Muslim population residing in the Xinjiang Uyghur Autonomous Region;

Whereas an official campaign to encourage the migration of Han Chinese people into the Xinjiang Uyghur Autonomous Region has resulted in the Uyghur population becoming a minority in the Uyghur traditional homeland and has placed immense pressure on people and organizations that are seeking to preserve the linguistic, cultural, and religious traditions of the Uyghur people;

Whereas, pursuant to a new policy of the Government of the People's Republic of China, young Uyghur women are recruited and forcibly relocated to work in factories in