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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable TOM UDALL, a Senator from the State of New Mexico.

PRAYER

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

Let us pray.

Eternal God, thank You for the gift of this day. Help us to use it for Your glory. Guide our lawmakers to labor with diligence for the good of our Nation. Deliver them from bitterness, frustration, and futility as they lift their eyes to You, their ever-present help for life's difficulties. Lord, save them from the futile repetition of old errors and the restoration of old evils. May they live such exemplary lives that people who see their good works will glorify You. Use the Members of this body to increase opportunities for more abundant life to people everywhere. Help our lawmakers to be aware of Your nearness and to recognize Your voice as You lead them to Your desired destination. We pray in Your sacred Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable TOM UDALL led the Pledge of Allegiance, as follows:

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

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

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

The assistant legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 2, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable TOM UDALL, a Senator from the State of New Mexico, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

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

RECOGNITION OF THE MAJORITY LEADER

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

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the health care reform legislation. It will be for debate only until 11:30 a.m., with alternating blocks of time. The first 30 minutes will be under the control of the Republicans; the majority will control the next 30 minutes.

The Senate will recess from 11:30 a.m. until 12:30 p.m. today. Following the recess, the Senate will resume consideration of the health care legislation. I am hopeful we can have some votes this afternoon. We have been unable to work that out with the minority and so we will see what the afternoon brings.

HEALTH CARE REFORM

Mr. REID. Mr. President, this historic health care reform bill before us is strong, and it is a strong head start in the right direction toward urgently needed change. But similar to nearly every bill to come before the Senate, it stands to benefit from the constructive input of all Senators. This good bill will be even better when this body debates it, refines it, and improves it.

I am pleased we have begun the amendment process. I hope we will soon be able to begin voting on those amendments—the ones drafted and sponsored by both Republicans and Democrats. But as we delve into the details and give the individual parts of this bill the considerable thought and attention they deserve, let's not forget the big picture.

So as we begin the third day of debate on this bill, let's remember what it does: First, we are making it more affordable for every American to live a healthy life. Second, we are doing it in a way that is fiscally responsible and in a way that will help our economy recover.

This bill does not add a dime to the deficit—quite the opposite. In fact, we will cut it by $130 billion in the first 10 years and as much as $¾ trillion in the next 10 years. We do this by keeping costs down. This critical piece of legislation will cost less than $85 billion a year over the next decade—well under President Obama's goal. It will make sure every American can afford quality health care. We will make sure that more than 30 million Americans who don't have health care today will soon have it. It will not only protect Medicare, but it will make it stronger. In short, this legislation saves lives, saves money, and saves Medicare.

The Congressional Budget Office and respected economists outside Washington have studied it, and they agree. The bill will do what we set out to do at the beginning of this Congress: It will lower costs and increase value so all Americans can afford quality health care, not just a few.

The experts have crunched the numbers, and they have come back with positive reviews. It will help parents afford to take care of their children and help bosses provide coverage for their workers. It creates more choices and more competition in the health care market. It will protect everyone against insurance company abuses, and for all the changes, in areas where our health care system does work, it keeps it the way it is.

I am very happy with the way Democratic Senators have stood for these

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

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principles and those who have defended them against hollow attacks from the other side. One after another, Republicans have come to the floor with disingenuous claims.

For example, they have talked about health care premiums, overlooking the fact that those costs will go down for the vast majority of Americans—in fact, 93 percent. They have talked about the deficit, ignoring the fact that health care reform will do more to lower the deficit than any other measure has in years—remember, over 20 years, almost $¾ trillion. They have tried to scare seniors, saying you are going to die soon, as an example, closing their eyes to the fact that we strengthen Medicare and cut waste, fraud, and abuse from the program. They have tried to scare women, closing their ears to the fact that we will make it easier than ever for women to get the preventive screenings they need, and that is a gross understatement. They claim to speak for the American people but neglect to mention that, for the last year, a majority of the Americans have consistently said it is more important than ever to nurse our health care system back to health.

What is the most consistent Republican attack on this bill? They carefully count the number of pages in this legislation but completely discount the number of people it helps. Can anyone think of a more superficial way to measure the worth of a bill than how many pages it is printed on? As far as I can tell, the only threat that poses is more paper cuts, perhaps.

Those who want to keep the broken system the way it is throw everything they can at the wall, but nothing has stuck. Incredibly, my distinguished counterpart, the Republican leader, last week, called the health care crisis manufactured, in spite of the fact that 750,000 people filed for bankruptcy last year—70 percent of them because of health care costs. In one sense, my Republican counterpart is right—it was manufactured. This health care crisis has been manufactured by the greedy insurance companies that raise families' rates on a whim and deny health care to the sick.

Remember, the health care industry is exempt from the antitrust laws. They can conspire to fix prices with no civil or criminal penalties. No other business is like that, except baseball. This crisis was manufactured by leaders who enabled them, who empowered them, and who sat idly by while the problem grew worse and worse, until it finally collapsed into a crisis.

My Republican friends have been so busy coming up with distortions that they have forgotten to come up with solutions. They seem more concerned with scaring the American people than helping them. This barrage of baseless accusations underscores how desperate some are to distract the American people from the real debate and from the fact they have no vision for fixing our health care system, which is broken.

Yes, correcting the record has taken a long time. That is OK. We will continue to do so as long as necessary. Democrats are more than willing to defend this good bill. After all, it is not hard to do. As Mark Twain, a great Nevadan, said: ''If you tell the truth, you don't have to remember anything.''

I wish to note that I especially appreciate the assistant leader, my friend of decades, Senator DURBIN, for his brilliant statements on the floor during the last several weeks on this health care issue. I so admire his spunk, his intelligence, and his ability to deliver a message.

RESERVATION OF LEADER TIME

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

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Mikulski amendment No. 2791 (to amendment No. 2786), to clarify provisions relating to first-dollar coverage for preventive services for women.

McCain motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, the time until 11:30 will be equally divided with alternating blocks of time, with Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes.

The Senator from Wyoming is recognized.

Mr. ENZI. Mr. President, I suggest the absence of a quorum.

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

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. KYL. Mr. President, to continue our debate on the McCain amendment to ensure Medicare benefits for our seniors are not cut, as would happen under this legislation, I wanted to talk a little bit about the commitments we have made to our seniors and what exactly would happen under the legislation that is before us.

As we all know, seniors have paid into the Medicare Program, and that is with the expectation that they will get the benefits that have been promised to them. The question is, Why would we, at this point, reduce the benefits that have been promised to them, especially if the purpose is not to enhance the financial viability of Medicare, which everyone knows is going broke but, rather, to use that money to establish a new entitlement program?

Let me break down the list of cuts seniors would face under this legislation: $137.5 billion would be cut from hospitals that treat seniors, $120 billion from the Medicare Advantage plan. By the way, that Medicare Advantage plan serves almost 40 percent of the Arizona seniors on Medicare. It cuts $14.6 billion from nursing homes, $42.1 billion from home health care, and $7.7 billion from hospice care. These are deep cuts, and you cannot avoid jeopardizing the health care seniors now have under Medicare by making these deep cuts. That is why the Chief Actuary at the Centers for Medicare and Medicaid Services—we use the initials CMS—believes these cuts would cause some providers to end their participation in Medicare, which, of course, would further threaten seniors' access to care. There would not be as many providers to whom they could go for their services.

Our friends on the other side of the aisle say part of this is an intention to eliminate waste, fraud, and abuse. Of course, we have known for many years that there is waste, fraud, and abuse in Medicare, but actually doing something about the problem and recognizing it are two different things. If it were easy to wring hundreds of billions of dollars of savings from Medicare by just pointing to waste, fraud, and abuse, we would have done it a long time ago. Certainly the President would, during his first year in office, want to do that, given the fact we are spending a lot of money and he is trying to find sources of revenue for the various spending programs he has proposed. If it were that easy to do, it would have been done before now.

Moreover, Medicare faces a $38 trillion, 75-year unfunded liability. That is almost incomprehensible. Most of us believe that whatever savings we could achieve in Medicare, to the extent you could eliminate waste, fraud, and abuse, for example, you should do that to help make Medicare solvent.

Next I want to talk about what seniors are telling us. They believe, according to public opinion surveys—and I have talked to enough of them to know this is true—that these Medicare cuts are going to jeopardize their health care. They are troubled in particular by this $120 billion proposed cut to Medicare Advantage. It has been called the crown jewel of Medicare. It is the private insurance addition to Medicare in which many are able to participate in programs they would never have been able to afford otherwise. It gives them this choice to supplement Medicare to provide all kinds

of benefits such as dental, vision, hearing, physical fitness programs, and other things, as I said, that they could not get otherwise. One in four of the beneficiaries in Arizona, as I said, signs up for this program—more than 329,000 seniors. They like the low deductibles and copayments in Medicare Advantage.

But the Congressional Budget Office has bad news for the seniors who like this program and who like the extra benefits they have under Medicare Advantage because, as the Congressional Budget Office notes, it would cut benefits on average by 64 percent over the next 10 years, from an actuarial value of $135 to $49 a month. Think about that. The actuarial value of the benefits the average Medicare Advantage participant has is worth $135 a month today. It would be cut in this bill to $49 a month. That is a 64-percent cut, according to the Congressional Budget Office. When we say we are not cutting benefits seniors currently receive, that is not true. This legislation would do that.

I have been sharing letters from constituents who have expressed concerns to me. Let me share three more letters today.

One recently arrived from Joseph and Mary-Lou Dopak of Sun City West, in Arizona, of course. They wrote as follows:

> The plan to reduce our coverage and take $120 billion from Medicare Advantage is a slap in the face to all seniors. The Medicare Advantage plan works because Medicare funds are given to a private insurance company to administer the plan.
>
> We do not want our Medicare Advantage plan robbed to fund a government-operated comprehensive health insurance plan. Commonsense tells us that will not work.
>
> The President should be fixing what ails the current health care system, instead of putting everyone into a government-operated health care plan.
>
> For our President to pick on Medicare Advantage is totally unfair to those of us upon whose shoulders this country has been built.

A constituent from Tucson, AZ, wrote a rather short and direct letter, and so it is easy to quote here.

> I am a senior citizen age 83. If I lose my Medicare Advantage coverage, I'll also lose my primary care physician of 18 years because he does not accept Medicare Direct. Senator KYL, do not let them take away my Medicare Advantage.

I get these letters every day. I have not yet had a constituent come up to me and say: Please, would you take away the Medicare Advantage Program, it is not right. Everybody has said, of course: Please preserve this important program.

Finally, a constituent from Phoenix, AZ, who suffers from multiple sclerosis, describes what it means to her.

> I am a 57-year-old woman with multiple sclerosis, currently on Social Security Disability. I make under $14,000 a year and have been on the Secure Horizons Medicare Advantage plan for a long time now. . . .
>
> I realize it is hard for Congress to understand, but we need to keep our Medicare Advantage plans in order to have [quality] health care at a price we can afford.
>
> We need you to help protect Medicare Advantage plans for the seniors in your State. We are the ones you need to fight for and we should not have to choose between going to a doctor and getting our medication and having food on the table and a place to live. Please do your part to protect our Medicare Advantage plans and keep prices within our reach.

As I said, these are the kinds of letters we get all the time. It is hard for these folks to understand, first of all, why, having paid into the plan and having taken advantage of what is a good supplement to the basic Medicare, that would be taken away from them. I think it is even harder for them to fathom that the reason it is being done is to pay for a new program rather than to keep Medicare itself solvent.

I tell folks like this that I will continue to fight for her and I will continue to try to protect this program because we believe it is essential. It is why I support the McCain amendment to commit the bill back to committee. It only has to be there a day. We are not talking about a further delay here. But it addresses both of the key issues of cuts and savings. If the McCain amendment passes, it would send the bill back to the Finance Committee with instructions to remove the Medicare cuts from the bill. That is all it does. But, second, those savings would be applied to Medicare rather than to fund a new government program. Those savings could therefore address the waste, fraud, and abuse problem that has been identified by everyone. It can be used to strengthen the Medicare trust fund rather than to fund a new health care entitlement program.

We believe the first thing we should do to see whether we can actually fix this bill—I have been quoted as saying that I don't think we can fix this bill. By that, I mean, with all due respect to my colleagues on the other side of the aisle, I don't think they want to make the changes I think would be necessary for the American people to begin to support this kind of legislation. Seniors are overwhelmingly opposed to the Medicare cuts. That is a fact. If my colleagues on the other side of the aisle are not willing to support the McCain amendment or something like it, I don't know how we could then say we can fix this bill. So I hope my colleagues will use this process we have to actually make amendments to the bill and not simply have a political discussion.

Republicans have pointed out that there are better ways to reform the health care problems we have today than to do it on the backs of seniors. We put forth a bounty of ideas. Let me just recoup some of them.

We think we could start and we could save a great deal of money by medical malpractice reform. That would bring down costs. We could allow Americans to buy lower cost insurance policies across State lines. That alone would unleash a wave of competition for patients' business. We could allow small businesses to band together to get the same purchasing power big businesses have. These ideas have essentially been ignored by the majority. Instead, we have this big government takeover of health care at a huge cost and significant reduction in quality and benefits to the American people. We don't think this is the way to go.

Certainly, on behalf of my senior citizen constituents and others who are on Medicare Programs, I am going to continue to fight for them, as my colleague John McCain is, and therefore urge my colleagues to support his amendment to eliminate the Medicare cuts under this bill.

The ACTING PRESIDENT pro tempore. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I rise to speak in favor of the McCain motion, and I do it from the perspective of a representative of the State of Kansas.

We have a number of senior citizens and hospitals that are Medicare-dependent. We have a number of providers for whom a majority of their practice is Medicare reimbursement. They are scared to death of these cuts, and the cuts are well documented—$500 billion in Medicare cuts, and for the 43 million senior citizens on a program that is already projected to go insolvent by 2017, specific cuts of $135 billion from hospitals, $120 billion from 11 million seniors in Medicare Advantage, nearly $15 billion from nursing homes, nearly $40 billion from home health agencies, and then—a cruel gesture, it seems to me—nearly $8 billion from hospice, where people are getting their final care for cancer and diseases that are killing them—$8 billion cut from hospice.

What that does in a State such as mine and in many rural hospitals, it cuts the legs out from under them. They are not going to have the money they need to operate. They are going to do everything they can to continue to operate—and they will, probably. What they will try to do is tax their local citizenry, raise property taxes, in all probability, to make up for the Medicare cuts because they are going to have a hospital there and they are going to do everything they can to keep a hospital there.

But what a terrible gesture on our part here, to take money that has been going into Medicare—and people have been paying into Medicare—and then steal it for a new program that is not going to get everybody covered on top of that and from a program that is already set to go insolvent by 2017. It is like writing a big fat check on an overdrawn bank account to start something new, to buy a new motorcycle. That doesn't make sense to people. Then it seems cruel and unusual to the senior citizens that you are taking $500 billion and really gutting a lot of their care programs on a program that doesn't work.

I met earlier, within the last several days, with the Kansas Association of

Anesthesiologists. They are looking at these things and saying: This is really going to hurt us and our ability to provide services and care. I talked with other individuals who look at this, and they say: Wait a minute, you are going to change everything to try to get a few more people covered and you are going to gut a Medicare program that is not paying the bills now, that a number of private insurance plans are helping to subsidize Medicare and Medicaid, and you are going to cut the reimbursements that are not making things work yet? It makes no sense to individuals that this would take place.

I get called by a number of individuals across the State of Kansas saying they are very scared of this bill and what it is going to do to their health care. I do telephone townhall meetings, as a number of individuals across this body do, and the individuals there whom you get on a random phone calling basis are scared and mad about this bill and the prospects of what it does to their health care. I get it from individuals. I get it from mail.

I was in a meeting in Kansas the week of Thanksgiving, and I polled the audience—it was an audience that was mostly over the age of 65—how many were in favor of the overall bill? There were about 200-some people there, and 10 were in favor. How many opposed? Everybody else, with a few saying they don't have an opinion. But it was 90 percent, 95 percent opposed to this bill, and it is because they look at it and they see what it is going to do to them, and they don't see it providing the care that is being promised—and adding, on top of that, to the deficit.

One of two things is going to happen on these Medicare cuts, because we have seen, in the past, efforts to control the spending in Medicare passed by this body and then each year those cuts to try to restrain the spending on Medicare being restored.

One of two things is going to happen. Either these cuts in Medicare are going to take place, and it is going to cripple the program and particularly hurt it in a number of rural areas across the country and in my State, or these cuts will never take place in Medicare and it is going to add to a ballooning deficit and debt that is taking place right now. Either choice is an irresponsible choice for this body to do. It is irresponsible for us to do for this country. Most people look at it and say: I want to get more people covered, and I want to bend down the cost curve. But let's do that on an incremental basis.

Senator KYL spoke about incremental changes that can take place, whether it is tort reform, allowing bigger pooling on health insurance, whether it is starting more community-based clinics, one that I look at as something that has worked in my State to get more people covered at an earlier phase in their health care needs. All of those are incremental, low cost, and, in some cases, ones that actually do bend down the cost curve and that can help, not a gargantuan $2.5 trillion program that takes $500 billion out of Medicare that is already headed toward insolvency in less than a decade. The bill doesn't make sense to individuals.

Then to do it on top of a time period when the President, 10 days ago, comes back from China, meeting with our bankers, as most people look at it, and the bankers lecturing us on why are we spending more money which we don't have, going further and further into debt, which we should not do at this point in time, being lectured by the Chinese when we ought to be talking to them about what they are doing about human rights and currency. We are being lectured about fiscal irresponsibility, and it is because of bills such as this. If we just stop and slow down and listen to seniors and others across this country, there is a commonsense middle ground that we can go to, that doesn't cost anything along the nature of this, doesn't change health care for most people but addresses the narrow problem of getting the cost curve down, of getting more people covered. This bill with these cuts in Medicare cripples many of my providers in the State of Kansas and will make them raise property taxes to keep the hospitals open, to try to provide doctors in the community—a lot of the hospitals are going to close and a lot of providers will stop providing Medicare—or, in all probability, these cuts will never happen, and it will be added to the debt and deficit, completely irresponsible toward our kids.

I urge my colleagues to vote for the McCain motion that makes sense, that is what the citizenry wants to do: send these cuts in Medicare back to communities and pull out of this bill.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. CORKER. Mr. President, how much time remains on our side?

The ACTING PRESIDENT pro tempore. There is 7 minutes 6 seconds.

Mr. CORKER. I thank the Chair.

Mr. President, I am glad to be on the floor of the Senate with the distinguished Senators from Kansas and Connecticut and Montana. We have obviously before us one of the most important issues we will deal with in this body.

I have had over 40 townhall-like meetings since the beginning of August. I can say without hesitation that I have never used those meetings to try to focus on some of the hot-button issues that divide us. On not one occasion have I tried to do that. I have tried to focus on the fundamentals of this health care bill. Way back when, when I began meeting with the distinguished chairman of the Finance Committee—I greatly appreciated his desire to meet with me—and realized that Medicare may be a place where money will be taken to leverage a new entitlement, I began expressing my concerns about that.

Later, I sent a letter to Majority Leader REID, signed by 36 Senators, talking about the fact that if Medicare moneys were used to leverage a new entitlement, we could not support that effort.

The reason I say this is, this is the same exact thing I have been saying about this bill from day one, before it was ever constructed. I am very dismayed that we find ourselves here in December debating a bill that does exactly that.

When I first came to this body, there was a lot of concern about the solvency of Medicare. Everyone here knows the trustees have stated that in 2017 Medicare will be absolutely insolvent. Two Senators from opposite sides of the aisle have tried to create legislation that would put in place a commission, eight Republicans and eight Democrats, to actually solve that issue. We realize we do not have the resources in Medicare to actually deal with the liabilities we have with seniors.

The fact that we are taking $464 billion in savings out of Medicare to leverage a new entitlement, to me, is totally irresponsible. It is the same thing I have been saying from day one. I am dismayed that we would consider kicking the can down the road, making sure that people of the generation of the many people who are helping us on the floor today will be saddled with huge amounts of cost that they will not be able to deal with in a responsible manner. I am discouraged.

The fact is, the other piece of this that is extremely troubling is that we all know we have the issue of SDR, the doc fix, which is a colloquial term to describe the fact that in any year after this bill passes, physicians across the country will be receiving a 23-percent cut for serving Medicare recipients. Medicare recipients understand what that means. It means they will have less physicians to deal with the needs they will have at that time. This bill, instead of dealing with that issue, deals with it for one year. What that means is there is about $250 billion worth of expenses that are not being dealt with with this Medicare savings.

Let me go walk it one more time. We have a program that is insolvent. We have a program that cannot meet the needs of those people who have paid into it for years and many of us continue to pay into. This program is insolvent, and we are going to take moneys out of this program, $464 billion—something that most Americans cannot do, something that does not pass the commonsense test in Tennessee, and my guess is doesn't pass the commonsense test in most States—we are going to take $464 billion out of this program, this entitlement which is underfunded and insolvent, and we will leverage it to create a new entitlement for Americans. Yet we are not going to deal with the issue of the doc fix, which is a $250 billion issue. We are going to kick the can down the road. We are going to cause physicians around the

country next year to, if this bill passes—if not, certainly they will be dealing with that this year—but we are going to cause physicians around the country another year to be concerned about these huge cuts, not deal with it in this bill, and possibly end up with a $250 billion obligation that could have been dealt with during this health care reform that now is not met, that is going to create additional fiscal burdens to this country and certainly great distress to seniors and physicians who care for them.

I tried to stick with the basic fundamental building blocks of this bill. I don't think anybody in this body has ever heard me focus on some of the more emotional issues. The fact that we would use Medicare moneys to create a new entitlement, the fact that we would have an unfunded mandate to States through Medicaid of $25 billion, to me, is problematic; the fact that premiums are going to increase, whether it is the CBO number of 10 to 13 percent or the Oliver Wyman number in my State which says 60 percent, the fact that private premiums are going to go up and the fact that we are using 6 years' worth of costs and 10 years' worth of revenues—I don't know how we have gotten caught up in this debate in such a manner that we are ignoring basic fundamentals that I don't think any of us on our own accord would consider supporting.

The fact is, I am afraid this, again, has become nothing but a political victory for the President.

What I hope we will do is step back and do some things in a bipartisan way that will stand the test of time. I ran on health care reform. I would like to see us do responsible health care reform. The basic fundamentals of this bill do not meet that test.

I see my time has expired. I thank the Chair and the Senators on the other side of the aisle who have worked hard to put this bill together. I hope they will step back away from these flawed fundamentals, and I hope in some form or fashion we will put together a bill that will stand the test of time.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, how much time do we have?

The ACTING PRESIDENT pro tempore. The Senator has 30 minutes.

Mr. DODD. Mr. President, let me first talk about the Medicare issue, because this has been the subject of sort of round-and-round debate, back and forth over the last couple of days. It is important to share, again, as emphatically as I know how what is being done with regard to Medicare. The whole idea is to strengthen Medicare, to put it on a sounder footing, to extend its solvency from 8 years by an additional 5 years, which we do under this bill, making it a stronger, more reliable source of health care for older Americans.

In fact, the finest and largest organization representing older Americans, which doesn't lightly endorse proposals without examining them thoroughly—hardly a partisan group given the fact of where they have been on these issues—has put out, once again, in the last 24 hours, a statement laying out the facts of what is included in the bill drafted by the Finance Committee principally in this area of Medicare.

Let me recite, if I may, the facts as they identify them. Fact No. 1, none of the health care reform proposals being considered by Congress would cut Medicare benefits or increase out-of-pocket costs for Medicare services. That is not from the Democratic National Committee. It is not from the HELP Committee or the Finance Committee. This is from AARP saying: None of the proposals in this bill cut Medicare benefits or cut Medicare services.

Fact No. 2, the health care reform bill drafted by the Finance Committee will lower prescription drug costs for people in the Medicare Part D coverage gap, or the so-called doughnut hole with which many seniors are familiar.

We are going to cut the cost of prescription drugs. Again, this is not from some partisan group announcing what is in the bill. This is from an objective, nonpartisan analysis of the bill that is before us.

Fact No. 3, health care reform will protect seniors' access to their doctors and reduce the cost of preventive services so patients stay healthier. Again, that is critical.

I presume others understand this; it is so axiomatic you wonder why you have to explain it. It is better to catch a problem before it becomes a major problem. Through mammograms, colonoscopies, obviously examinations and screenings, you can discover that an individual has a problem and, if caught early enough, can address it. As many of my colleagues know because it became rather public, I went through cancer surgery in August. It was discovered that I had an elevated PSA test, indicating I had prostate cancer. That screening let me know that I had a growing problem that I had to deal with. So I went through a variety of discussions on what best to do, what was the best way to handle all of this and decided that surgery made the most sense.

The cost of that surgery is expensive. It is not cheap—$5,000, $6,000, $7,000, $8,000 to do it. If I had not discovered I had prostate cancer and it had grown, I could have become 1 of the 30,000 men a year in this country who die from it, or if I had waited longer for it to be full-blown cancer, I am told it could have easily cost $250,000. So by catching this early and getting the needed treatment, I was not only able to stay alive and stay healthier, with two young daughters aged 4 and 8—and looking forward to the day I may dance at their weddings—but also there were the savings because it did not grow into a problem that would require massive expenditures to deal with it.

Our bill deals with that. We provide for the first time ever that seniors and other Americans have access to prevention and screening tests that would allow them to discover problems they have early on. That is according to AARP. That is what we drafted in this legislation. It is a major benefit.

I listened to our colleague from North Carolina yesterday, Senator HAGAN, talk about nurses in a hospital in her State of North Carolina who were not getting mammograms early, not because they did not want them but because, of course, the out-of-pocket expenses for them are so high they could not afford to do it and pay rent and put food on the table and take care of their families.

That hospital in North Carolina decided they were no longer going to require their nurses to pay those high out-of-pocket expenses and they eliminated that. As a result, every nurse—or almost every nurse—in that hospital got those mammograms early on and, of course, could identify problems before they became larger issues for them to grapple with.

That is what this bill of ours does. That is a major achievement—a major achievement. So the suggestion is, we ought to roll back and commit this bill. But that would eliminate the kind of investments we make in reducing the cost of prescription drugs or providing the kinds of benefits so people can get screenings and treat problems while they are still small.

As a Senator, I have a health care plan that allows me to do that. I am 1 of 8 million people in this country who are Federal employees. We all get to do that. Why should a Senator's battle with cancer be more important than someone else's in this country? Why shouldn't every American male over the age of 50 be able to be screened to determine whether they might have prostate cancer?

That is what we are talking about. That is what we are achieving in this bill. The idea that the status quo is OK is wrong. It is not OK. To say we ought to throw the bill back into committee, again—we all know what the meaning of that is, of course. It will mean an end to this legislation. Those are the facts.

Fact No. 4, if you will: Rather than weaken Medicare, the health care reform will strengthen the financial status of the Medicare Program. That is from AARP. That is not some partisan conclusion.

I say, respectfully, to our colleagues, and having been through this at great length over the summer, filling in for our friend whom we have now lost, Senator Kennedy, we went through long debates and discussions early on, a lot of bipartisan discussions. As I pointed out earlier, as to the bill that came out of the Health, Education, Labor, and Pensions Committee in the Senate, we conducted the longest

markup in the history of that committee, going back decades, in order to listen to each other and to try to provide a bipartisan bill.

In many ways, that bill is a bipartisan bill. It did not get bipartisan votes, unfortunately, coming out of committee. But the substance of the legislation includes the ideas and thoughts of our colleagues across the political spectrum, and it is important the public know that during the debate.

This is not a bill that was rushed through, jammed through. My colleague from Montana, Senator BAUCUS, spent weeks and weeks—months—with Democrats and Republicans gathered around the table late into the evenings talking about how we can shape this bill on a bipartisan basis. I attended many of those meetings in his office. No one can accuse the Senator from Montana of not reaching out to the other side to be a part of this solution. He went beyond the extra mile to achieve that, and he was flatly turned down, regretfully, in that effort. But that should not be a reason why we do not try to move forward.

I am still hoping we can get bipartisan support for the bill before it is concluded, but we will only get there if we work at it, and this is where we are working at it: on the floor of the Senate, and this debate is an opportunity to come forward and make constructive suggestions—not sending the bill back to committee, in effect, killing the legislation. That is the effect of what would happen if the McCain amendment were adopted.

Rather than engage in this kind of debate back and forth, where the Republicans say Medicare gets cut and the Democrats say, no, it does not, I wished to share with my colleagues this morning what nonpartisan, outside groups say about this bill. Listen to those who have made an analysis of this bill who do not wear a partisan hat, who do not have a political label attached to their names but are viewing every syllable, every punctuation mark in the bill to determine what it does for people. The most important, significant organization that represents the interests of the elderly in this country has analyzed this bill and has said to America: This is a good bill. This bill strengthens Medicare, provides benefits, and reduces costs.

That is what we have tried to achieve over these many months. So let's move on. If you want to cut this bill, if you want to change all this, then offer an amendment and let's vote on it, up or down, and move forward. I urge my colleagues to support this legislation and reject the McCain amendment because I think his proposal would do great damage to the effort we have achieved so far.

With that, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I noted that the other side, in the last couple, 3 days, has tried to make the case that seniors' Medicare benefits are in jeopardy because ''this legislation cuts Medicare.'' I have heard that statement over and over and over and over again. In fact, the last speaker on the other side made that same point.

I am confounded, I am very surprised, when I hear those statements. Why am I very surprised? Because it is totally, patently false. It is false. It is untrue. There are no benefits cut here, none. One could say that with the private plans, the Medicare Advantage plans, which are vastly overpaid—the nonpartisan MedPAC organization states they are vastly overpaid by about 14 percent—one could say those private plans—it is not Medicare; those private plans, Medicare Advantage; those are not Medicare plans, those are private plans, private insurance plans—they may be overprescribing some nonguaranteed benefits for beneficiaries, things such as eyeglasses or something like that, which might be cut back. That is true. But none of the guaranteed benefits—the basic benefits under Medicare that every senior knows about when he or she goes to the doctor; and it is care under Medicare—is reduced. None. Nothing is cut.

In fact, this legislation adds benefits to seniors. For example, it virtually fills up this thing we call the doughnut hole. That is the portion of prescription drug payments that seniors otherwise would have to pay. But we say $500 of that is going to be paid for, and the rest of it is going to be paid for at least for 1 more year. So that is an additional benefit. Then all the screening provisions that are in this bill, that is an additional benefit. There are many other benefits that are added onto the ordinary benefits seniors have.

So it is not true—it is not true—that the basic guaranteed benefits under Medicare are cut. None of the guaranteed benefits under Medicare are cut—none. So it is totally untrue. It is false when people make the claim that ''Medicare is being cut.''

They are being very clever, the people who are making those claims. What they are saying when they say Medicare will be cut—they want you to think they mean benefits will be cut—but deep in their mind, what they are holding back in their mind—well, when pressed, they will agree, well, it is the Medicare providers, it is the hospitals, it is the medical equipment manufacturers, it is the pharmaceutical industry. That is being cut. That is ''Medicare'' that is being cut and, therefore, that will hurt seniors. That is kind of the way they get around it.

Well, the fact is, the way you preserve the solvency of the trust fund is to make sure there are not so many payments, frankly, by Uncle Sam going to pay for all the doctors and hospitals and so forth so the solvency of the trust fund is extended. Right now this legislation extends the solvency of the Medicare trust fund. If this legislation were not to pass, the Medicare trust fund would probably go insolvent in about the year 2017. But this legislation extends the solvency of the trust fund for at least 5 more years to 2022.

So I wish to make it very clear that this legislation we are considering does not cut Medicare benefits. In fact, the hospitals and docs, I would say, are going to find at least a 5-percent increase in growth over the next 10 years in payments to them under the Medicare Program—growth. I have a chart which I showed yesterday on the floor. It showed, for each of the various years, it is a 5-percent increase in growth for all those industries. They are being cut 1.5 percent, but that is from a 6.5-percent growth, to net down to a 5-percent growth for each of the years.

You ask analysts on Wall Street how hospitals are doing. They are doing great under this legislation. You ask analysts on Wall Street how the pharmaceutical industry is doing. They are doing great under this legislation. You ask any analyst about other industries—home health care, hospice care, you name it—they are all doing OK. Wall Street analysts say they are doing fine.

Why are they doing fine? Why, objectively, are they doing fine? Why do the CEOs of these organizations not grumble too much? Because they know what they may lose in a little bit of a reduction in their payments—they will still get big, hefty payments—they will make up in volume because so many more people will have health insurance. They know that. They are going to make a lot of money. So they are OK.

So it is not true that Medicare is going to go broke under this legislation. First of all, there is no reduction in benefits. That is very clear. Senator DODD read a letter from AARP making that very clear. Also, the reductions are not reductions in provider payments; they are reductions in the rate of growth of provider payments, and they are going to do fine. Providers do not care that much because they are making it on volume because everybody is going to have health insurance. They have quite a bit—a 5-percent growth rate anyway. So it is not true—it is not true—that Medicare is in jeopardy because of this legislation. It is not true that benefits are going to be cut. In fact, just the opposite is true. This legislation strengthens benefits, increases benefits, extends the length of the Medicare trust fund to a future date further down the road, so it stays solvent for many years than otherwise is the case.

This legislation helps seniors. It helps seniors, contrary to what you are hearing on the other side that it hurts seniors. If you just look at the facts, not the rhetoric—not the rhetoric but just look at the facts, look at the facts and look at who the supporters of this legislation are and objective groups and what they say about this legislation—you cannot help but be compelled

to the conclusion that this legislation is not only good for seniors, it is very good for seniors.

RECOGNITION OF THE MINORITY LEADER

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

Mr. MCCONNELL. Mr. President, with the apologies to my good friends from Montana and Connecticut, I was unavoidably detained at the opening and would like to now, on my leader time, give my opening remarks.

The ACTING PRESIDENT pro tempore. The Senator has the floor.

AFGHANISTAN

Mr. MCCONNELL. Mr. President, the challenges of the ongoing war in Afghanistan are immense, but Americans believe in the mission. They trust the advice of our commanders in the field to see that mission through.

So I support the President's decision to follow the advice of General Petraeus and General McChrystal in ordering the same kind of surge in Afghanistan that helped turn the tide in Iraq.

These additional forces will support a counterinsurgency strategy that will enable us to begin the difficult work of reversing the momentum of the Taliban and keeping it from power.

The President is right to follow the advice of the generals in increasing troops, and he is also right to focus on increasing the ability of the Afghan security forces so they can protect the people.

By doing both, he has made it possible for our forces to create the right conditions for Afghanistan—the right conditions for them to defend themselves, create a responsible government, and remain an ally in the war on terror.

Although our forces are in Afghanistan to defend our security interests, the people of Afghanistan must assume a greater burden in the future. The President's plan recognizes that.

Once we achieve our objectives—an Afghanistan that can defend itself, govern itself, control its borders, and remain an ally in the war on terror—then we can reasonably discuss withdrawal, a withdrawal based on conditions, not arbitrary timelines.

But, for now, we owe it to the American people, to those who died on 9/11, and to the many brave Americans who have already died on distant battlefields in this long and difficult struggle, to make sure Afghanistan never again serves as a sanctuary for al-Qaida. We owe it to the men and women who are now deployed or who will soon be deployed to provide every resource they need to prevail.

HEALTH CARE REFORM

With every passing day, the American people become more and more perplexed about the Democratic plan for health care, and they like it less and less.

Americans thought reform meant lowering costs. This bill actually raises costs. Americans thought reform meant helping the economy. This bill actually makes it worse. Americans thought reform meant strengthening Medicare. This bill raids it to create a new government program that will have the same problems that Medicare does. Americans wanted reform. What they are getting is the opposite—more spending, more debt, more burdens on families and businesses already struggling to get by.

One of the biggest sources of money to pay for this experiment is Medicare. This bill cuts Medicare Advantage by $120 billion. It cuts hospitals by $135 billion. It cuts home health care by $42 billion. It cuts nursing homes by $15 billion. It cuts hospice by $8 billion.

Reform shouldn't come at the expense of seniors. The McCain amendment guarantees it wouldn't. The McCain amendment would send this bill back to the Finance Committee with instructions to remove the language that cuts Medicare. The McCain amendment also says any funds generated from rooting out waste, fraud, and abuse should be used to strengthen Medicare, not to create an entirely new government program.

A vote in favor of the McCain amendment is a vote to protect Medicare. Let me say that again. A vote in favor of the McCain amendment is a vote to protect Medicare. A vote against the McCain amendment is a vote to raid this vital program in order to create another one for an entirely new group of Americans. So a vote against the McCain amendment is a vote to take money out of Medicare to create a program for an entirely different set of Americans. A vote against the McCain amendment is a vote against our seniors, and it is a vote against real health care reform.

Mr. President, I yield the floor.

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

The ACTING PRESIDENT pro tempore. There is 13½ minutes.

Mr. DODD. I yield myself 5 minutes, if I may. I want to go back, if I can. I wish to put up these charts. Again, I say this respectfully, because I genuinely believe that people across the spectrum want to see some reform of the health care system. The question is whether the proposal that has been laid before us by the Finance Committee and the HELP Committee achieves reform and whether the ideas we bring to the table are actually going to achieve lower costs, provide greater access, and improve the quality of health care. We believe very firmly and strongly that it does.

There are outside observers of this process who have no political agenda whatsoever other than to make determinations as to whether the goals we have sought in this legislation achieve the desired results. It is the conclusion of the major organizations that make these determinations that, in fact, we have done exactly what we said we had set out to do.

But I wish to point out, because I think it is important when I hear the arguments from our friends on the other side about their deep concerns about Medicare, it is very important they understand that over the last number of years, we have seen quite the opposite reaction when it comes to the Medicare Program in our Nation. Going back to 1995, when our friends took control of both this body and the other body, the then-Speaker of the House Newt Gingrich announced to the world that basically he was prepared to let Medicare ''wither on the vine.'' That is not ancient history. That is not 1965 when the Medicare Program was adopted; that is merely 14 years ago when the other party, for the first time in 40 years, became the dominant party here in Congress. One of the first statements from the leadership of that party was to let this program ''wither on the vine.'' Again, that is one person, the Speaker, the leader of the revolution that produced the results electorally in 1994. But I think it is important as a backdrop. When we hear the debate about Medicare, it is important to have some history about where the parties have been on this issue, generally speaking. So in 1995 we begin with that as a backdrop.

In 1997, 2 years later, it happened again. In 1997, proposed Medicare cuts in the Republican Balanced Budget Act of that year were twice as much as the savings we are talking about in this bill. They proposed a 12.4-percent reduction in Medicare benefits in 1997. Of course, the last budget submitted by President Bush last year—again, reflective of where things stand, and this is a year ago, not 14 years ago, and not 1997, but 2009—the Bush administration in its submission of this budget proposed a $481 billion reduction in Medicare benefits. That was not in the context of a health reform bill; that was in the context of a budget proposal.

Here we are talking about savings by reducing costs for hospitals and other providers as a way of strengthening Medicare, providing more benefits to the beneficiaries themselves through things such as prescription drugs as well as screenings and early prevention efforts which are included in our bill. Those things have been identified, of course, by AARP and the National Committee to Preserve Social Security and Medicare. They have analyzed our proposals and have suggested we do just that. We strengthen Medicare and we preserve those benefits. Our bill saves $380 billion in order to strengthen the Medicare proposal. It improves the quality of health care for seniors as part of our comprehensive reform. In fact, Senator COBURN's Patient Choice Act actually imposes $40 billion more in cuts to Medicare Advantage than our bill does.

I find it somewhat intriguing that those who are arguing for the Coburn proposal as an alternative and simultaneously suggesting we ought not to do anything to Medicare Advantage have

not read the Coburn bill, because he cuts $40 billion more out of Medicare Advantage than we did in our legislation as proposed.

In conclusion, let me quote from the National Committee to Preserve Social Security and Medicare—again, not a partisan organization. Their sole mission is to see to it that Social Security and Medicare will be there for the people it was intended to support. Let me quote exactly from a letter sent to every Senator yesterday from the committee:

> Not a single penny of the savings in the Senate bill—
>
> the bill now before us—
>
> will come out of the pockets of beneficiaries in the traditional Medicare program. The Medicare savings included in H.R. 3590, the Patient Protection and Affordable Care Act, will positively impact millions of Medicare beneficiaries by slowing the rate of increase in out-of-pocket costs and improving benefits, and it will extend the solvency of the Medicare trust fund by 5 years. To us, this is a win-win for seniors and the Medicare program.

So we can hear all of the partisan debate back and forth as to what this bill does, but if you are interested in what those organizations say, whose sole mission is to analyze whether beneficiaries are going to be advantaged or disadvantaged by what is being proposed here, they categorically, unequivocally, suggest that the McCain amendment does just the opposite of what our bill does. It would roll the clock back, damage seniors terribly by reducing or eliminating the provisions we have included in our bill, and they strongly support what the Finance Committee wrote in its bill that is now presented to all of us here as a way to strengthen and preserve the Medicare Program.

I say to my colleagues and to others, you can listen to this partisan debate back and forth as to whether you want to believe the Democrats or believe the Republicans, but I would suggest if you are not clear who to believe in this, listen to the organizations whose job it is to protect this program, with whom we have worked very closely to determine that we would not in any way reduce those guaranteed benefits that Senator BAUCUS addressed in his remarks. That is what we do. That is why this bill is a good bill and deserving of our support. I urge our colleagues to reject the McCain amendment.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, the Republican leader a few moments ago said this bill raises costs. With all due respect to my good friend from Kentucky, that statement is false.

Just this week, the nonpartisan Congressional Budget Office, the organization that analyzes legislation—and both sides, both bodies depend on it; it is a very professional outfit, I might add—said our bill would reduce premiums, not increase but reduce premiums for 93 percent of Americans. And for all Americans, it would make sure that better quality insurance is available.

Let me state that a little bit differently. The Congressional Budget Office said that for 93 percent of Americans, premiums would be reduced. It is true that for 7 percent that is not the case. Those are Americans whose incomes are too high to qualify for subsidies; that is, the tax credits, buying insurance in exchange. But those 7 percent would get a lot better insurance, a lot higher quality insurance than they get today because of the insurance market reforms that are in this legislation. The provisions prevent insurance companies from denying coverage based on preexisting conditions, health status, the committee market rating provisions, no rescissions, et cetera. So for all Americans, it is true that this legislation will provide better quality insurance comparing apples with apples. There is a reduction for 93 percent of Americans. The other 7 percent would be in the individual market and they would have a lot higher quality insurance. So if the quality is much higher, it would exceed the increase in premiums. They would be getting a better deal than they would otherwise be getting.

CBO looked at this for the year 2016. They didn't look at it for other years, but at least that is the case for 2016: a reduction, not an increase but a reduction. In fact, for many in the nongroup market, those who individually buy insurance, they would find their premiums would be reduced about 40 or 50 percent. About 60 percent of those in the nongroup market are finding their insurance premiums would be reduced. I don't have the exact figure in front of me, but it is in the neighborhood of a 40- or 50-percent reduction in premiums. That is due to tax credits. Again, CBO says those tax credits would cover nearly two-thirds of premiums. So I guess I was a little conservative. It is a little more than 40 or 50 percent. It would cover two-thirds of premiums.

CBO said those getting these tax credits would pay for roughly 56 percent to 59 percent lower premiums than they would without our bill. Those are real savings. That is with respect to the premiums.

What about out-of-pocket costs? This legislation has absolute limits on out-of-pocket costs. Today insurance companies can sell you a policy, you pay certain premiums, but there is no limit on the out-of-pocket costs you might have to pay. Your deductible is so high, for example. This legislation puts an absolute limit so no policy can be sold that allows you to have out-of-pocket costs above a certain amount. I think it is $6,000 for an individual, and it might be double that for a family. But there is a limit. So this bill does not, as stated by the minority leader, raise costs. In fact, it reduces costs.

In addition, there are many people who say, Oh, gosh, this is a $1 trillion bill. Some people even say it is a $2.5 trillion bill. Senators on the other side of the aisle make those statements and they say this to try to scare us.

I will be honest with you. I don't know if they believe it. They like saying it because it is a nice, good scare tactic. I say I am not sure they believe it. I wonder if they believe it, because when you read the legislation, it is deficit neutral. It does not add to the deficit.

We have a budget resolution. Under that budget resolution, health care legislation for the next 10 years has to be deficit neutral. It cannot add one thin dime to the deficit. So I am a little curious when people talk about a $1 trillion bill. In fact, it reduces the deficit by $130 billion over a 10-year period. That is what the Congressional Budget Office says, the professional nonpartisan budget office.

In the second 10 years, the CBO says our bill reduces the deficit by a one-quarter of 1 percent of the gross domestic product. That is roughly $½ trillion. In the second 10 years, this legislation reduces the deficit by $½ trillion. That is a reduction in the deficit.

I don't know why these people are saying on the other side that this is a trillion-dollar bill. One said—and I will not mention his name—the other day that this is a $2.5 trillion bill. That is not true. It is just not true because it is paid for. It would only be fair for them to say it is paid for. I think it is fair to get both sides of the story, not just one side. It does cost $1 trillion over 10 years, but it is more than paid for over 10 years. Those who say $2.5 trillion—they start at 2014 up to 2020, and say that is why it costs so much. It is paid for during those years, too.

Let me make it very clear this bill doesn't raise costs. In fact, it lowers costs, and the CBO says so. It doesn't add to the Federal deficit. In fact, it reduces the Federal deficit. I urge everyone to look at the facts closely whenever we hear statements made by anybody, including me. I urge people to listen to the words and read between the lines and see what is really going on. Like my father used to say: Don't believe everything you read and only half of what you hear. Take everything with a few grains of salt.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Tennessee is recognized.

Mr. ALEXANDER. Mr. President, I agree with the Senator. That is why we have 22 minutes on the Republican side to clear up some misconceptions.

The Democratic health care bill does cost $2.5 trillion over 10 years when it is fully implemented. If I may say so, it is arrogant to think the American people couldn't figure out the difference between the first 10 years, when the bill wasn't implemented in 4 of those years, and they would like to know that it costs $2.5 trillion.

Mr. BAUCUS. Will the Senator yield for a question?

Mr. ALEXANDER. If it is on your time.

Mr. BAUCUS. Is it paid for?

Mr. ALEXANDER. The Senator is right. It is paid for by cutting grandma's Medicare. It is paid for by cutting grandma's Medicare by $465 billion over a 10-year period of time, and about $500 billion in taxes——

Mr. BAUCUS. That is a second question I would love to debate with the Senator. But on the first question only, the Senator admits it is paid for?

Mr. ALEXANDER. No. I admit it costs $2.5 trillion, and the attempt to pay for it is through Medicare cuts, tax increases, and increases to the deficit by not including the physician reimbursement in the health care bill.

Mr. BAUCUS. One more question. I think we all know the House has taken action on physician reimbursement, and the Senate will also do so before we adjourn. That is the so-called doc fix. That is a separate issue. That will be paid for. Putting the doctor issue aside, health care reform—and I say that because we take up the doc fix virtually every year. We don't take up health care reform every year. That is an entirely separate proposition, separate legislative endeavor.

If the Senator will bear with me and take the doc fix off the table for a second—we can address that later—health care reform—to use a 10-year number, or when you start in 2010 or in 2014, wherever you are starting—either there is $1 trillion or $2.5 trillion, depending where you start, not getting into how it is paid for. Is it paid for and therefore it is not deficit; am I not correct?

Mr. ALEXANDER. I will concede to the Senator from Montana that the attempt of the Democrats to pay for this $2.5 trillion bill consists of Medicare cuts, tax increases, and additions to the deficit by not including the physician reimbursement, which is an essential part of any 10-year health care plan. There may be other problems, but those are the three things I know about.

Mr. BAUCUS. One more question on my time. Is it true there are no cuts in guaranteed beneficiary payments—none whatsoever—in this legislation—in guaranteed benefits?

Mr. ALEXANDER. I would say no to that, Mr. President, because the Director of the Congressional Budget Office made it clear there would be specific cuts in benefits for those who have Medicare Advantage, which is about one out of four seniors.

Mr. BAUCUS. Is it true those provisions are not guaranteed provisions? I am talking about guaranteed benefits that seniors expect to get when they go to the doctor, fee for service, expected benefits, under ordinary Medicare, not benefits that a private plan may pay in addition.

Mr. ALEXANDER. Mr. President, it is clear there are $465 billion in cuts in Medicare. The Chair and the Senator from Montana and the Senator from Connecticut have all agreed that is a big part of how the bill is supposedly paid for. It is specific enough to say that $135 billion comes from hospitals; $120 billion from Medicare Advantage, which 11 million seniors have; nearly $15 billion from nursing homes; $40 billion from home health agencies; $8 billion from hospices.

The Director of the CBO testified that provisions like that would result in specific cuts to benefits for Medicare Advantage. He said that fully half of the benefits currently provided to seniors under Medicare Advantage would disappear. The changes would reduce the extra benefits, such as dental, vision, and hearing coverage, that currently are made available to beneficiaries.

Mr. BAUCUS. One more question. Does the Senator agree this legislation will extend the solvency of the Medicare trust fund for 5 years, and failure to pass this would mean the solvency of the Medicare trust fund would not be extended for 5 years?

Mr. ALEXANDER. I wholeheartedly disagree with that. The Medicare trustees have said that between 2015 and 2017 Medicare will be approaching insolvency. They have asked that we take urgent action. The urgent action recommended by the Democratic majority is that we take $465 billion out of the Medicare Program over 10 years and spend it on a new entitlement.

It is hard for me to understand how that can make Medicare more solvent, when you take money out of grandma's Medicare and spend it on someone else.

Mr. MCCAIN. Will the Senator yield?

Mr. ALEXANDER. Yes.

Mr. MCCAIN. Isn't it, shall we say, Enron accounting when you have a proposal that, as soon as the bill becomes law, you begin to raise taxes and cut benefits, and then you wait 4 years before any of the benefits are then extended to the beneficiaries? That, on its face, is a remarkable piece of legislation. My experience, which has only been 20-some years, is that we haven't passed legislation that says we are going to collect taxes on it for 4 years, and then we are going to give you whatever benefits that may accrue from this legislation. Again, there has been no time in history where we have taken money from an already failing system to create a new entitlement program.

Mr. BAUCUS. Which colleague is the Senator asking that?

Mr. MCCAIN. I believe the Senator from Tennessee has the floor.

Mr. BAUCUS. He does.

Mr. MCCAIN. I was addressing the person who has the floor, which I am sure the Senator from Montana should understand by now.

Mr. ALEXANDER. I say to the Senator from Arizona that he is exactly right. Another way to describe it, the Senator from Kansas said it was like writing a big check on an overdrawn bank account and buying a big new car. Maybe another way, if I may respond to the Senator from Arizona—I ask unanimous consent that Republican Senators, on our time, be allowed to engage in a colloquy.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BAUCUS. May I ask the Senator another question?

Mr. ALEXANDER. I would like to finish responding to Senator MCCAIN, if I might.

Mr. BAUCUS. Then I have a question on the same subject.

Mr. ALEXANDER. I hope the Parliamentarian is keeping track of the Republican time. I am enjoying the questioning, and I thank the Senator for his question. One of the things—in fact, a great compliment has been paid to the Senator from Arizona. It is rare that a Senator can have something he said actually begin to break through the fog.

Dana Milbank, a columnist for the Washington Post, wrote a column about it being all about grandma and wondering why we never mention grandpa. Maybe Mr. Milbank hasn't seen the movie ''My Big Fat Greek Wedding,'' where the man said, ''I'm the head of the house,'' and the woman said, ''I'm the neck, because I can turn the head any way I want.''

We are talking about grandma because she can help persuade grandpa. If we take $465 billion out of Medicare over 10 years, grandma and grandpa and those who are younger and looking forward to Medicare will be affected.

If I may say to the Senator from Arizona—and I see the Senator from Oklahoma and the Senator from Nebraska—it wasn't long ago, in response to the question—in fact, in 2005, when we sought to restrain the growth of Medicare by $10 billion over 5 years, and this is what they said—remember, they are ''restraining'' the growth of Medicare by $465 billion and spending it on a new program, and Republicans were, at that time, trying to save $10 billion over 5 years.

''An immoral document,'' said Senator REID and Senator DODD. The Senator from Connecticut said that funding for Medicare would be cut. Senator ROCKEFELLER: ''A moral disaster of monumental proportion.'' Senator BOXER, in the same way, compared it to Katrina. Senator KERRY said we are ''passing the costs on to seniors.'' Senator LEVIN said people are ''going to be hurt by this bill.'' ''Irresponsible and cruel,'' said Senator KOHL. Senator REED and Senator Hillary Clinton also made similar comments.

That was for $10 billion of restraining the growth of Medicare to spend it on the existing program. Yet this proposal by the Democrats would take $465 billion and spend it on a new program.

Mr. MCCAIN. Isn't it true—and the Senator from Montana is on the Senate floor and wants to enter into this. Maybe he can respond to his comments of 14 years ago. We weren't trying to create a new entitlement program, which is the object of the Senator's bill. We were just trying to enact some savings in the Medicare system.

What did Senator BAUCUS say? He said:

And above all, we must not use Medicare as a piggy bank.

What are we using the $483 billion in cuts in Medicare for?

Then he said:

That is disgraceful. Perhaps some changes lie ahead. But if they do, they should be made for the single purpose of keeping Medicare services for senior citizens and people with disabilities.

Isn't it true that now that we are taking $483 billion out of a failing system the Medicare trustees say is going to go bankrupt, and the Senator from Montana, 14 years ago, said:

Seniors could easily be forced to give up their doctor, as doctors begin to refuse Medicare patients and hospitals—especially rural hospitals—close.

Isn't that the effect of taking $483 billion in cuts in Medicare? Then the Senator from Montana went on to say:

Equivalent to blowing up the house and erecting a pup tent where it used to be.

Instead of blowing up a pup tent, I would say what they are doing is like a hydrogen bomb. Finally, Senator BAUCUS said:

Staggering. The leadership now proposes something like $250 billion in Medicare cuts. It is staggering. It is a reduction of nearly a quarter in Medicare services by the year 2002.

All of us here learn about the issues. Apparently, the Senator from Montana didn't learn much, because he was deeply concerned 14 years ago about a very small savings in Medicare. Now he wants to spend $2.5 trillion and taking $483 billion out of Medicare to create a new entitlement system.

Mr. BAUCUS. Might I respond to the Senator?

Mr. ALEXANDER. Mr. President, I am happy to see a debate actually break out on the Senate floor on this issue.

Mr. BAUCUS. Here is your opportunity; here is your chance.

Mr. ALEXANDER. As long as it is on Democratic time.

Mr. BAUCUS. It is on both sides. We have even time.

Mr. ALEXANDER. I mean whatever time the Senator uses should be on Democratic time.

Mr. BAUCUS. Yes. The basic question, obviously, is how to protect Medicare benefits. I think most of us would say how do we protect Medicare benefits and extend the solvency of the Medicare trust fund. I think we would all agree that excessive payments to providers would cause insolvency of the trust funds to come earlier rather than later. We all agree with that proposition.

The next question is, What would excessive payments to providers be? Do providers get paid excessively? I think that is an honest question we should ask ourselves in a way to help extend the solvency of the Medicare trust fund. In fact, in 1995, many Senators, especially on the other side of the aisle, did say just that, that we have to cut Medicare in order to save benefits. That was made by many Senators. I have them right in front of me, if anybody wants to hear them. I am not going to go through all of that, but it is the truth. That is exactly what we are doing in this bill. We are trying to help extend the solvency of the Medicare trust fund by cutting down on excessive provider payments from the Medicare trust fund.

How do we decide whether payments are excessive? That is the basic question here. All we can do is just give it our best shot, make our best judgment. I think it makes sense to look at the recommendations by outside independent groups, what they think. One is MedPAC, the Medicare Payment Advisory Commission. That is an outside group, as we all know, that advises Congress on Medicare payments. As Members of Congress, we are not totally competent to know exactly what dollars should go to which industry group. We have too many other obligations to think about. As Senators, we must be responsible to do the best we can. MedPAC has said these groups have been overpaid. And Wall Street analysts tend to agree. In fact, MedPAC said, with respect to Medicare Advantage, that they have been overpaid—I forget the exact amount but much less than the $118 billion reduction in this bill.

In fact, I totaled up and looked at the projected growth rate of providers—hospitals, nursing homes, home health, hospice, PhRMA, you name it—and on average their growth rate over the next decade is going to be 6½ percent. That is the growth rate of providers. We decided to trim that a little bit by 1.5 percent. So it is 5 percent. It is a 5-percent growth rate in an attempt to try to find the right levels of reimbursement to providers, which will also help extend the solvency of the Medicare trust fund.

When we talk to providers, they basically agree with those cuts. They basically agree. Why do they basically agree? They basically agree because they know that with much more coverage, with many more people having health insurance, they could spread out their business. They may lose a little on margin, but they can pick it up on volume. That is exactly what their business plan is under this bill.

Wall Street analysts say—I quote them—these industries are doing great, they are doing well under this bill. They are not getting hurt. So we do achieve a win-win—I don't like that phrase, by the way, but I will use it here—where the solvency of the trust fund is being extended and where reimbursement rates to providers are fair—not being hurt; it is fair. And that is why they want this bill, by and large.

Most groups tend to want this bill enacted because they know it is good for the country, it is good for the seniors, and it is good for them too.

Mr. MCCAIN. Mr. President, may I just mention again, $70 billion in fraud, abuse, and waste, and Senator COBURN, the doctor, can tell you, that is nowhere in this bill. The fact is, maybe some of the providers have been bought off, jawboned, or had their arms twisted or given a good deal, like PhRMA has. Recipients have not. Medicare recipients know you cannot cut $483 billion without ultimately affecting their benefits, and that is a fact.

Again, conspicuous by its absence, I say to the Senator from Montana, totally conspicuous by its absence is any meaningful malpractice reform, which has been proven in the State of Texas and other States to reduce costs and to increase the supply of physicians and caregivers. There is nothing in this bill that is meaningful about medical malpractice reform.

I had a townhall meeting with doctors in my State, and everyone stood up and said: I practice defensive medicine because I fear being sued.

If you are really serious, I say to the Senator from Montana, if you are really serious about this, medical malpractice should be a key and integral part of it. Even the CBO costed it out at about $54 billion a year. When you count in all the defensive medicine, it could be as much as $200 billion over 10 years. That is conspicuous by its absence. I think it brings into question the dedication of really reducing health care costs across America.

Mr. ALEXANDER. Mr. President, we have enjoyed our discussion with the distinguished chairman of the Finance Committee and thank him for his questions.

Senator COBURN, who is a physician—the Senator from Montana talked about doctors being overpaid. He talked about——

Mr. BAUCUS. No, no, no, I did not. With all due respect, I did not say that.

Mr. ALEXANDER. Didn't I hear the words ''providers overpaid''?

Mr. BAUCUS. I talked about hospitals. I did not talk about doctors overpaid. If I may say to my friend from Tennessee, this legislation pays more to primary care doctors, a 10-percent increase in Medicare reimbursement for each of the next 5 years. I did not say ''doctors.''

Mr. ALEXANDER. I must have misunderstood. Normally when we talk about providers, we talk about hospitals and physicians.

We have a physician on the Senate floor, the Senator from Oklahoma. I wonder if he, having heard this debate, might want to comment. I might say, isn't it true that the McCain motion, which we have on the floor, would send this back to the Finance Committee and say: If there are savings, let's spend it on Medicare to actually strengthen it?

Mr. COBURN. Mr. President, I thank the Senator. The first comment I have is about relying on what Wall Street analysts say today. They have about this much credibility in this country today. Look at the economic situation we find ourselves in because of what

Wall Street analysts have said. That is the first point I would make.

The second point is that the majority whip yesterday said we should cut Medicare Advantage because of the 14 percent. Senator DODD just recently went after the Patients' Choice Act because we actually make it be competitively bid without any reduction in benefits. Your bill, for every Medicare Advantage, cuts 50 percent of the benefits out. It cuts the benefits.

The difference is—and I agree with the majority whip—we do need to have the savings in Medicare Advantage, but the way you get that is through competitively bidding it while at the same time maintaining the requirements for the benefits that are offered. There is a big difference in those two. Ours ends up being pure savings to save Medicare. The savings in this bill are to create a new entitlement.

The other point I wish to make is, if you are a senior out there listening and if you are going to be subject to the new increase in Medicare tax, for the first time in history, we are going to take the Medicare tax and not use it for Medicare, we are going to use it for something else under this bill. This one-half of 1 percent is now going to be consumed in something outside of Medicare. So no longer do we have a Medicare tax for the Medicare trust fund. We have a Medicare tax that funds the Medicare trust fund plus other programs.

I say to my colleagues, I think we want a lot of the same things. How we go about it—the Senator from Montana recognized the fact that we are going to increase payments to primary care physicians. Ask yourself the question why only 1 in 50 doctors last year who graduated from medical school is going into primary care. Why do you think that is? Could it be that the government that is setting the payment rates created a maldistribution in remuneration to primary care physicians; therefore, they choose to go where they can make 200 percent more over their lifetime by spending 1 additional year in residency rather than doing primary care?

What this bill does, and what the Senator from Arizona is trying to do by sending this bill back, is to refocus it on the fact that Medicare money ought to be used for Medicare. If, in fact, we are going to slow the growth of Medicare, can we do that without cutting benefits? To slow the growth in this bill for 11 million Americans who now have Medicare Advantage will diminish their benefits. That is out of the $120 billion that is going to come.

You cannot tell a senior who is in a rural area today, who is on the economic lower rungs of the ladder, who uses Medicare Advantage to equalize their care with somebody who can afford a Medicare supplemental policy, you cannot tell them this is not going to decrease their benefits and their care, because it is. And in the bill, it actually states that it is going to decrease their benefits.

Mr. MCCAIN. Will the Senator yield? Very briefly, the Senator from Montana talked about the support the bill gets. AARP makes more money from Medigap plans they sell to seniors. AARP should be opposing the bill, but other groups such as 60 Plus are educating seniors.

The AMA endorsement of the bill—shocking. The bill puts the government in charge, but AMA cut a deal to get their Medicare payments addressed by increasing the deficit by $250 billion.

Mr. COBURN. Mr. President, will the Senator yield for a minute?

Mr. MCCAIN. PhRMA—my God, if there ever was an obscene alliance made that will harm seniors because it has the administration against drug reimportation from Canada and competition for treatment of Medicare patients.

So now we understand a little bit better why these special interest groups, 500-some of them, have visited the White House in recent months, according to White House logs.

Mr. COBURN. The Senator would probably be interested to know—and, I know, my colleagues on the other side—that the American Medical Association now represents less than 10 percent of the actively practicing physicians in this country. The physicians as a whole in this country are adamantly opposed to this bill. The reason they are opposed to this bill is because you are inserting the government between them and their patient. That is why they are opposed to this bill.

So you have the endorsement of the AMA which represents less than 10 percent of the practicing doctors—actively practicing doctors—in this country because not only will it increase payments, but CPT code revenue is protected. That is the revenue AMA gathers from the payment system that continues to be fostered in this bill, which is their main source of revenue.

Mr. MCCAIN. May I ask my colleague's indulgence for just a moment because, as you know, the majority leader seems to appear more and more frantic as he, perhaps, is reading the same polls we are that more and more Americans, when they figure out this legislation, are becoming more and more opposed to it.

Yesterday, the majority leader came out and directly addressed me, saying:

> This man talks about earmarks, but his amendment is one big earmark to the insurance industry. And in addition to that, the sponsor of the amendment—

Talking about me—

> during his Presidential campaign talked about cutting these moneys.

Mr. President, I hate, I say to my colleagues, to take a trip back down memory lane, but at the time—of course, this was echoed by a DNC spokesperson, who then echoed it throughout the blogosphere and left-wing liberal blogs. The fact is, on October 20, FactCheck.org says:

> He accuses McCain of proposing to cut benefits. Not true.

This is from FactCheck.

> In a TV ad and in speeches, Obama is making bogus claims that McCain plans to cut $880 billion from Medicare spending and to reduce benefits.
>
> A TV spot says—

A very well-funded campaign, I might add—

> McCain's plan requires ''cuts in benefits, eligibility, or both.''
>
> Obama said in a speech that McCain plans ''cuts'' that would force seniors to ''pay more for your drugs, receive fewer services, and get lower quality care.''
>
> A second ad claims that McCain's plan would bring about a 22 percent cut in benefits.

FactCheck.org says:

> These claims are false, and based on a single newspaper report that says no such thing. McCain's policy director states unequivocally that no benefit cuts are envisioned.

Mr. President, I ask unanimous consent to have printed in the RECORD the entire FactCheck.org article.

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

OBAMA'S FALSE MEDICARE CLAIM

SUMMARY

In a TV ad and in speeches, Obama is making bogus claims that McCain plans to cut $880 billion from Medicare spending and to reduce benefits.

A TV spot says McCain's plan requires ''cuts in benefits, eligibility or both.''

Obama said in a speech that McCain plans ''cuts'' that would force seniors to ''pay more for your drugs, receive fewer services, and get lower quality care.''

Update, Oct. 21: A second Obama ad claims that McCain's plan would bring about a 22 percent cut in benefits, ''higher premiums and co-pays,'' and more expensive prescription drugs.

These claims are false, and based on a single newspaper report that says no such thing. McCain's policy director states unequivocally that no benefit cuts are envisioned. McCain does propose substantial ''savings'' through such means as cutting fraud, increased use of information technology in medicine and better handling of expensive chronic diseases. Obama himself proposes some of the same cost-saving measures. We're skeptical that either candidate can deliver the savings they promise, but that's no basis for Obama to accuse McCain of planning huge benefit cuts and more expensive prescription drugs, and claims that both nursing home care and a patient's choice of doctor could be affected.

ANALYSIS

As the narrator says that McCain's plan ''means a 22 percent cut in benefits,'' the ad displays a footnote citing an Oct. 6 Wall Street Journal story as its authority.

But, in fact, the Journal story makes no mention of any 22 percent reduction, or any reduction at all. To the contrary, the story's only mention of what might happen to benefits is a quote from McCain adviser Douglas Holtz-Eakin promising to maintain ''the benefit package that has been promised.'' The story quotes him as saying ''savings'' would come from eliminating Medicare fraud and by reforming payment policies to lower the overall cost of care.

The fact is that McCain has never proposed to cut Medicare benefits, or Medicaid benefits either. Obama's claim is based on a false reading of a single Wall Street Journal story, amplified by a one-sided, partisan

analysis that piles speculation atop misinterpretation. The Journal story in turn was based on an interview with McCain adviser Holtz-Eakin. He said flatly in a conference call with reporters after the ad was released, ''No service is being reduced. Every beneficiary will in the future receive exactly the benefits that they have been promised from the beginning.''

TWISTING FACTS TO SCARE SENIORS

Here's how Democrats cooked up their bogus $882 billion claim.

On Oct. 6, the Journal ran a story saying that McCain planned to pay for his health care plan ''in part'' through reduced Medicare and Medicaid spending, quoting Holtz-Eakin as its authority. The Journal characterizes these reductions as both ''cuts'' and ''savings.'' Importantly, Holtz-Eakin did not say that any benefits would be cut, and the one direct quote from him in the article makes clear that he's talking about economies:

Wall Street Journal, Oct. 6: Mr. Holtz-Eakin said the Medicare and Medicaid changes would improve the programs and eliminate fraud, but he didn't detail where the cuts would come from. ''It's about giving them the benefit package that has been promised to them by law at lower cost,'' he said.

Holtz-Eakin complains that the Journal story was ''a terrible characterization'' of McCain's intentions, but even so it clearly quoted him as saying McCain planned on ''giving [Medicare and Medicaid beneficiaries] the benefit package that has been promised.''

Nevertheless, a Democratic-leaning group quickly twisted his quotes into a report with a headline stating that the McCain plan ''requires deep benefit and eligibility cuts in Medicare and Medicaid''—the opposite of what the Journal quoted Holtz-Eakin as saying. The report was issued by the Center for American Progress Action Fund, headed by John D. Podesta, former chief of staff to Democratic President Bill Clinton. The report's authors are a former Clinton administration official, a former aid to Democratic Sen. Bob Kerrey and a former aid to Democratic Sen. Barbara Mikulski.

The first sentence said—quite incorrectly—that McCain ''disclosed this week that he would cut $1.3 trillion from Medicare and Medicaid to pay for his health care plan.'' McCain said no such thing, and neither did Holtz-Eakin. The Journal reporter cited a $1.3 trillion estimate of the amount McCain would need to produce, over 10 years, to make his health care plan ''budget neutral,'' as he promises to do. The estimate comes not from McCain, but from the Urban-Brookings Tax Policy Center. McCain and Holtz-Eakin haven't disputed that figure, but they haven't endorsed it either.

Nevertheless, the report assumes McCain would divide $1.3 trillion in ''cuts'' proportionately between the two programs, and comes up with this: ''The McCain plan will cut $882 billion from the Medicare program, roughly 13 percent of Medicare's projected spending over a 10-year period.'' And with such a cut, the report concludes, Medicare spending ''will not keep pace with inflation and enrollment growth—thereby requiring cuts in benefits, eligibility, or both.''

The Obama campaign began the Medicare assault with a 30-second TV ad released Oct. 17, which it said would run ''across the country in key states.''

ANNOUNCER. John McCain's health care plan . . . first we learned he's going to tax health care benefits to pay for part of it.

Now the Wall Street Journal reports John McCain would pay for the rest of his health care plan ''with major reductions to Medicare and Medicaid.''

Eight hundred and eighty-two billion from Medicare alone. ''Requiring cuts in benefits, eligibility, or both.''

John McCain . . . Taxing Health Benefits . . . Cutting Medicare. We Can't Afford John McCain.

OBAMA. I'm Barack Obama and I approved this message.

The ad quotes the Wall Street Journal as saying McCain would pay for his health care plan with ''major reductions to Medicare and Medicaid,'' which the ad says would total $882 billion from Medicare alone, ''requiring cuts in benefits, eligibility, or both.''

Obama elaborated on the theme Oct. 18 in a stump speech in St. Louis, Mo., claiming flatly that seniors would face major medical hardships under McCain:

Obama, Oct. 18: But it turns out, Senator McCain would pay for part of his plan by making drastic cuts in Medicare—$882 billion worth. Under his plan, if you count on Medicare, you would have fewer places to get care, and less freedom to choose your doctors. You'll pay more for your drugs, receive fewer services, and get lower quality care.

Update, Oct. 21: A second and even more misleading Obama ad begins: ''How will your golden years turn out?'' It states flatly that McCain's plan would mean a 22 percent cut in benefits, higher premiums, higher co-pays, . . .

Mr. McCAIN. Mr. President, I hope the Senator from Nevada will stop making false claims—repeating the false claims that were in attack ads on me throughout the campaign, funded by tens of millions of dollars, about my positions on health care in America which the fact checkers found to be totally false.

As the narrator says that McCain's plan ''means a 22 percent cut in benefits,'' the ad displays a footnote citing an Oct. 6 Wall Street Journal story as its authority.

FactCheck:

But, in fact, the Journal story makes no mention of any 22 percent reduction, or any reduction at all.

I hope, among other things, in his, may I describe, frustration, that the Senate majority leader would at least not repeat false accusations about what I wanted to do in the Presidential campaign. It is unfortunate.

And I hope that maybe, instead of attacking David Broder, instead of attacking me, instead of attacking others who are in support of this amendment, maybe we could have a more meaningful discussion about the facts surrounding this legislation.

Mr. DODD. Mr. President, may I inquire how much time remains on both sides?

The PRESIDING OFFICER. Thirty seconds remains for the minority.

Mr. DODD. The minority has 30 seconds.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. JOHANNS. Mr. President, I will speak very quickly, since we have 30 seconds.

Reality does set in. We have looked at the impact of these cuts on our nursing home beds in Nebraska. We have about 14,000 beds dedicated to Medicare. This will be a loss of $663 per bed. That affects real people.

I thank the Chair.

The PRESIDING OFFICER. The minority's time has expired.

Mr. DODD. Mr. President, I yield 2 minutes of our time to the Senator from Nebraska.

Mr. JOHANNS. I thank the Senator. That is very kind of you, and I appreciate that.

Maybe it comes from my time as Governor, maybe it comes from my time as mayor, but somehow, some way, you have to live with the legislation that is passed, whether it is by the Federal Government, whether it is at the State level or whatever. You can bounce this back and forth all day, but the reality is these are real cuts and they involve real programs that involve real people in our States. You can describe them any way you want, you can call them excessive payments, you can do this, that, or the next thing. You can say: Well, we are giving this our best shot, but the difficulty is this is a high-risk venture. We will be impacting in my State, for example—and every Senator could stand up and give this same speech—but this will impact the most vulnerable population in our Nation—people who are in a nursing home and who are the Medicare beneficiaries.

As I said in my short statement, there are 14,061 nursing home beds across our State that are dedicated to Medicare patients. We are working overtime to try to understand what this legislation does to real people. The number we have come up with, working with our nursing home industry, is that if this legislation is passed, each bed is impacted by a loss of $663.

I will sum up my comments by reading something that was sent to me by someone who works in the nursing home industry. Here is what this person says:

For the first time in my career, I am honestly questioning how much longer I can continue. To constantly be up against regulation and funding, when all you want to do is make a difference in someone's life, is exhausting.

This is a high-risk venture. This shouldn't be about taking our best shot, this should be about getting this legislation right.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, let me, if I can, address a couple of points. First of all, I made this point yesterday, but it deserves being made again because the suggestion somehow that this bill doesn't provide any benefits to anyone until the year 2014 is untrue. I could spend the next 40 minutes describing the various things our bill does immediately. Upon the enactment of this legislation, there are tax breaks immediately for small businesses to be able to reduce the cost of health care in a market where small businesses pay, on average, 18 percent more for health care premiums than other businesses do. As pointed out by the CBO, under our bill you are actually seeing premium cost reductions in the small

business market, as well as the individual market and the large-group market.

Right away our legislation closes a good part of that doughnut hole, which is an immediate benefit to the cost of prescription drugs for the elderly. That doesn't happen 4 or 5 years from now, but immediately.

We provide immediate screening and prevention services for Americans. As I mentioned earlier, that is not only the humane thing to do, it is also a great cost saver. If you can detect an early problem and deal with it, the cost savings are monumental, and we all know that.

Under our health care plans as Senators—where we get 23 different options every year to choose from—we have that benefit. I am a beneficiary of that benefit, having identified a health care problem early through screening. That was not only beneficial to me personally, because I am going to be alive for a longer period of time than otherwise, but it saved thousands of dollars in long-term medical costs that would have occurred if I had not identified the problem. Those are simple things that are included in our bill that happen immediately.

You can't be dropped by your health care carrier, as you are today. Today, you can be dropped for no cause—for no reason whatsoever. That is stopped immediately on the adoption of this legislation.

So when I heard my good friend from Arizona saying there are no benefits in this bill for 4 or 5 years, that is not true. And again, a simple reading of the legislation would identify any number—I have here a long list—of benefits that will happen immediately.

The issue Senator BAUCUS has raised over and over again is the issue of guaranteed benefits under Medicare. Guaranteed benefits. Let me challenge my colleagues to identify a single guaranteed benefit under Medicare that is cut by the bill before us. There is not a single benefit under the guaranteed program that is in any way disadvantaged or reduced as a result of this legislation. What is cut are private health care plans under the Medicare Advantage Program. The reason why we are doing this is Medicare Advantage overpayments cost every senior more money. A typical elderly couple pays $90 more per year in Part B premiums to pay for the Medicare Advantage overpayments, even if they are not enrolled in these plans. That is $90, on average, for every couple, and they get none of the benefits from it. Fully 78 percent of beneficiaries are forced to pay higher premiums for non-Medicare extra benefits they will never see.

Again, I understand some people would like to have these additional benefits. I understand that. They are not guaranteed Medicare benefits. These are benefits that are provided for under Medicare Advantage. But 78 percent of our elderly are paying higher premiums so a smaller percentage of people can get those benefits. Why should 78 percent of the elderly in this country pay a higher premium for a smaller percentage of people under private health care plans?

What Senator BAUCUS and the Finance Committee tried to do is to reduce those costs. Those are not guaranteed Medicare benefits. There is no guaranteed Medicare benefit that is cut under this bill, and I defy any Member of this body to find one guaranteed benefit that is reduced under this plan.

Mr. BURR. Will the Senator yield for a question?

Mr. DODD. I will be happy to yield to my friend.

Mr. BURR. I would ask the distinguished Senator from Connecticut if we empower the independent Medicare advisory board to come up with $23.4 billion in cuts under Medicare? Can the Senator from Connecticut assure me that the independent Medicare advisory board would not find a benefit that they would suggest cutting?

Mr. DODD. Absolutely. That is not allowed under this. You cannot cut guaranteed benefits. Going back and looking at providers—

Mr. BURR. If the Senator will yield for an additional question: Is this board empowered to find $23.4 billion worth of cuts?

Mr. DODD. Not under guaranteed benefits. That is very clear.

Mr. BURR. Will the Senator show me that language?

Mr. DODD. The board is prohibited, forbidden, from proposing changes that would take benefits away from seniors or increase their costs. The board cannot ration care, raise taxes on Part B premiums, or change Medicare benefits eligibility or cost-sharing standards.

It couldn't be more clear. They are absolutely prohibited from doing that. And that is the point we have been trying to make here. Frankly, as we know, there are hospitals that will tell you themselves, in many cases, as a provider, there are cost savings there. I am told—and again my colleagues know more about these details than I do—that it is not uncommon for an elderly person to leave a hospital and, on average, be given four prescription drugs to take. I am told as well that within a month or so that elderly person is not following their prescriptions very well—either they live alone, or for one reason or another they do not follow their prescriptions—and they end up being readmitted. There is a very high readmission rate in hospitals, thus raising the cost for hospitalization.

Our bill makes significant efforts to try to reduce the problem of hospital readmissions, which, again, raises costs tremendously. That is where the savings are coming from here, by taking steps to try and reduce the readmission rate to the hospitals. That is a cost savings that is not denying a benefit to the elderly. It is trying to save money and save lives. That is what we are trying to achieve here.

But, again, I challenge any Member to come up and identify a single guaranteed benefit under Medicare that is cut in this bill. There are none. And 78 percent of our elderly should not be required to pay additional premiums to take care of a handful of other people out there. I understand why they want some of these benefits, and they shouldn't be denied them, if they want to pay for them, but don't charge the other Medicare beneficiaries for the benefit they never get.

Mr. DURBIN. Will the Senator yield for a question?

Mr. DODD. I would be happy to yield to my colleague.

Mr. DURBIN. It is interesting to me that under the McCain amendment, the first line in the amendment—the motion to commit—relates to Medicare Advantage. I used to work for an old fellow in Illinois politics named Cecil Partee, and Cecil said: For every issue in politics, there is a good reason and a real reason. We hear a lot of good reasons on the floor for this McCain amendment and the future of Medicare. The real reason is on the first line of Senator MCCAIN's motion to commit. He says: Send this back to committee and don't touch Medicare Advantage.

I want to ask the Senator from Connecticut about Medicare Advantage, because some of the things I have read around the country about Medicare Advantage tell me this plan, run by private health insurance companies, costs more than basic Medicare. These companies promised us, when they got involved, they would show us how to run a health insurance plan. They would show us how to provide Medicare benefits and they would save us money. Some have. But by and large, if I am not mistaken, isn't the verdict in—a 14-percent increase in cost for Medicare benefits under this Medicare Advantage?

Mr. DODD. My colleague from Illinois is absolutely correct, it is 14 percent. In some States it is 50 percent more.

Mr. DURBIN. When we talk about saving over $100 billion in the Medicare Program over the 10 years, part of it is by saying to those private health insurance companies that are overcharging Medicare recipients, the party is over. The subsidy is over. We are going to make sure that every American who qualifies for Medicare gets the basic benefits, but we will not allow these private health insurance companies to get a subsidy from the Federal Government at the expense of Medicare and its recipients.

Mr. DODD. And then charging the other 78 percent of Medicare recipients to raise their premiums. That is the outrage of all this.

Mr. DURBIN. So the motive behind the McCain amendment is less about saving Medicare and more about saving a private health insurance program called Medicare Advantage.

Mr. DODD. And talk about misbranding, calling something Medicare

Advantage. It is neither Medicare nor an advantage. Quite the opposite, in fact.

You are accurate in your numbers, by the way, because I want people to know, as much as we respect the Senator from Illinois and his math, the numbers he identifies of $100 billion this program is costing us, comes from the Congressional Budget Office. We didn't make up these numbers. That is the cost savings by modifying Medicare Advantage that has cost us so much and deprived the overwhelming majority of our elderly the benefits they end up paying for. So I appreciate very much the Senator's question.

Mr. BAUCUS. If the Senator will yield for another question, might I ask my friend if it isn't also true that in the June MedPAC report it states that Medicare Advantage overpayments cost taxpayers an extra $12 billion?

Mr. DODD. That is correct. And again, that is MedPAC.

Mr. BAUCUS. Well, that is right, that is MedPAC. I think the point the Senator from Illinois is making needs to be underlined two or three or four times here—and the Senator from Connecticut has made it too—and that is there is a huge distinction between Medicare and these private insurance plans.

Mr. DODD. I think too many of our fellow citizens hear the word Medicare Advantage and assume that is the Medicare Program, and it is not.

Mr. BAUCUS. It is not. It is a private plan.

What Medicare Advantage is overpaid—that is what these insurance companies are overpaid, and a lot of that goes back to the Part D drug bill and so forth—do those overpayments necessarily mean better benefits for persons who signed up for those plans?

Mr. DODD. No. In fact, there is no evidence that overpayments to plans leads to better health care. That is again according to MedPAC.

Mr. BAUCUS. If that is true, why might that be the case, just so people understand?

Mr. DODD. Because insurers, not seniors or the Medicare Program, determine how these overpayments are used. And too often they are used to line the pockets of insurers, to increase their profits and not to provide benefits.

Mr. BAUCUS. Does Medicare decide what the benefits will be for those folks?

Mr. DODD. No, it is the private carriers that decide that.

Mr. BAUCUS. The private insurance carriers.

Mr. DODD. Yes, they are the ones that set the rates and determine where the profits go. That is why it is such a misnomer to call this Medicare Advantage, because it is neither Medicare nor an advantage.

The PRESIDING OFFICER. The time has expired.

Mr. DODD. Mr. President, I ask unanimous consent for 2 additional minutes.

The PRESIDING OFFICER. Is there objection?

Mr. COBURN. Reserving the right to object, I will ask for 2 additional minutes for my side.

Mr. DODD. Well, I gave 2 minutes to my friends earlier.

Mr. COBURN. How about 1?

Mr. DODD. OK, 1. Well, make that 2. If he wants 2 additional minutes, I have no problem giving my colleague 2 additional minutes.

Mr. BAUCUS. You already said it, but I think it is worth repeating——

The PRESIDING OFFICER. Without objection, the request is agreed to.

Mr. BAUCUS. Most seniors, as they pay Part B premiums under fee for service, don't get any benefit whatsoever?

Mr. DODD. That is correct. None whatsoever. In fact, all they do get is higher premiums.

Mr. BAUCUS. That is right. Higher premiums.

Mr. DODD. Higher premiums. And 78 percent, almost 80 percent are paying more for a program from which they never get any benefit.

Mr. BAUCUS. The figure I saw—I guess it is $90 a year they pay extra and get no benefit from it.

Mr. DODD. So vote for the McCain amendment and you do exactly what Senator DURBIN is suggesting: Preserve Medicare Advantage, and under Medicare Advantage 78 percent of our elderly pay more premiums, never get any benefits, and the private carriers get to pocket the difference. That is a great vote around here. That is great health care reform.

Mr. DURBIN. I say to the Senator from Connecticut, could we characterize this as an earmark in the Medicare Advantage Program?

Mr. DODD. It is two ears, not even one ear. I give it two ears.

Mr. BROWN. I say to Senator DODD, we remember 10 years ago when the insurance companies came to the government and said we can do something that later became Medicare Advantage, and we can do it less expensively. They said we can do it for 5 percent less than the cost of Medicare and the government unfortunately made the agreement with them to sign up to do that. Then what happened in the last 10 years is, the insurance lobbyists came here and lobbied the Bush administration and lobbied the Congress and got bigger payments. It is a subsidy for the insurance companies, but you and Senator BAUCUS and Senator DURBIN said it is not Medicare, it is private insurance, privatized form of Medicare that serves the insurance companies very well, is that correct, but doesn't serve the seniors in this country?

Mr. DODD. I will sit here all day waiting for someone to identify a single benefit guaranteed under the Medicare Program that is cut in our bill. They are all talking about Medicare Advantage, not Medicare. There are no guaranteed benefits cut under this bill nor can those benefits be cut. Our legislation bans and prohibits any cuts in guaranteed benefits.

The PRESIDING OFFICER (Mr. CASEY). The Senator from Oklahoma is recognized.

Mr. COBURN. One of the questions and one of the promises was: If you have what you have now and you like it, you can keep it. What is happening under this bill for 11 million seniors on Medicare Advantage, that is not going to happen. If they like it, they are not going to be able to keep what they have. You can't deny that. That is the truth.

Medicare Advantage needs to be reformed. There is no question about it. I agree. As the Senator alluded to, in the Patients Choice Act we actually save $160 billion in the Patients' Choice Act, but we don't diminish any of the benefits, and we do that because CMS failed to competitively bid it, because when it was written—and I understand who wrote it—when it was written we didn't make them competitively bid it. You could get the same savings, actually get more savings and not reduce benefits in any amount, if you competitively bid that product. But we have decided we are not going to do that.

The second point I make with my colleagues is the vast majority of people on Medicare Advantage are on the lower bottom economically. They can't afford an AARP supplemental bill. They can't afford to pay an extra $150 or $200 a month. So what happens most of the time with Medicare Advantage is we bring people up to what everybody else in Medicare gets because most people can afford—84 percent of the people in this country can afford to buy a Medicare supplemental policy because Medicare doesn't cover everything.

Your idea to try to save money, I agree with. But cutting the benefits I do not agree with. You are right, Senator DODD, the basic guaranteed benefits have to be supplied to Medicare Advantage and then the things above that which you get from the supplemental policy, what you can afford to buy, is what these people get. And what you are taking away from poorest of our elderly is the ability to have the same care that people get who can afford to buy a supplemental policy. That is the difference.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. COBURN. I appreciate my chairman for his courtesy in yielding the time.

RECESS

The PRESIDING OFFICER. Under the previous order, the Senate stands in recess until 12:30 p.m.

Thereupon, the Senate, at 11:35 a.m., recessed until 12:30 p.m. and reassembled when called to order by the Presiding Officer (Mrs. HAGAN).

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—Continued

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, on Monday the Congressional Budget Office sent a letter to the Senator from Indiana, Mr. BAYH, that provides a very comprehensive analysis of what health insurance premiums will look like as a result of this 2,074-page bill before us, introduced by Senator REID. Listening to that discussion, I am starting to wonder if anyone actually read the letter. I hear a lot of people saying this letter proves that premiums will go down under the Reid bill, even though that is not what the letter says. I am here to tell my colleagues what the letter really says.

The letter makes it very clear that premiums will increase on average by 10 to 13 percent for people buying coverage in the individual market. Since it seems to fly by everybody what this letter actually said about increasing premiums, I brought down a chart to show everyone in case they missed it.

The letter from the CBO says very clearly that for the individual market, premiums are going to go up 10 to 13 percent. My colleagues keep saying premiums are going to go down, conveniently forgetting, then, to mention this 10- to 13-percent increase. They prefer to talk about the 57 percent of Americans in the individual market who are getting subsidies. It is true that government is spending $500 billion in hard-earned taxpayer money to cover up the fact that this bill drives up premiums faster than current law. So we might as well repeat it: Premiums will go up faster under this bill.

Supporters of this bill are covering this increase in cost how? By handing out subsidies. If you are one of the 14 million who doesn't happen to get a subsidy, you are out of luck. You are stuck with a plan that is 10 to 13 percent more expensive and also, simultaneous with it, an unprecedented new Federal law that mandates that you purchase insurance. If you don't purchase insurance, you are going to pay a penalty to the IRS every time you file your income tax. Some may say this is just the individual market. It only accounts for a small portion of the total market. If you are comfortable with 14 million people paying more under this bill than they would under current law, let's look at the employer-based market.

The Congressional Budget Office analysis says this bill maintains the status quo in the small group and large group insurance market. Is that something to be celebrating? Are expectations so low at this point that my friends on the other side of the aisle are celebrating that this bill will increase premiums for some and maintain the status quo for everyone else? I am being generous in using the phrase ''status quo'' because this bill actually makes things worse for millions of people. This bill is so bad that my friends on the other side of the aisle are trying to convince the American people that this is just more of the same, when that doesn't happen to be the case.

Whatever happened to bending the growth curve? If that is too Washingtonese for people, the goal around here of a bill at one time was to make sure the inflation in insurance didn't continue to go up so much that it would go the other way.

Then what about the President's promise that everyone would save $2,500? According to the Congressional Budget Office, almost every small business will pay between 1 percent more to 2 percent less for health insurance. That means, of course, that compared to what businesses would have paid under current law, this bill will either raise premiums 1 percent or decrease them a whopping 2 percent. It doesn't sound like this bill is providing any real relief or, for sure, not providing $2,500 savings for every American, as President Obama repeatedly pledged during the campaign. Larger businesses will pay the same or up to 3 percent less for health insurance. Once again, that doesn't sound like relief; it sounds like more of the same.

In fact, the Congressional Budget Office has confirmed that between now and 2016, premiums will continue to grow at twice the rate of inflation. I thought Congress was considering health reform to put an end to unsustainable premium increases.

So this bill cuts Medicare by $500 billion, raises taxes by $500 billion, restructures 17 percent of our economy, and spends $2.5 trillion. Yet some of my colleagues on the other side of the aisle are celebrating that they have achieved the status quo when, in fact, the situation will be worse. I always thought the status quo was unacceptable. I thought businesses could not afford the status quo. I thought the status quo was killing American businesses, killing jobs, and making this country less competitive. But Member after Member keeps coming down to the floor to celebrate spending $2.5 trillion on the status quo. We could have done that for free. Am I missing something? Did people really read the same letter I did from the CBO?

When President Obama visited Minneapolis in September, he didn't sound as though he was celebrating maintaining the status quo. On the contrary, I have a chart with one of his quotes:

> I will not accept the status quo. Not this time. Not now. . . .

Some Members seem to disagree. Some Members are celebrating that they are making things worse for millions of Americans and maintaining the status quo for everyone else.

Here is what Vice President BIDEN said:

> The status quo is simply unacceptable. Let me say that again—the status quo is simply unacceptable. Rising costs are crushing us.

That doesn't sound like a call for more of the same. Once again, Members on the other side of the aisle seem quite comfortable investing $2.5 trillion in more of the same. That is taxpayer dollars we are talking about.

If I asked most Iowans how they would feel about government spending $2.5 trillion and premiums would still increase as fast or faster, they would say that was a pretty bad investment. Well, I will not argue with what our constituents would say on that point. I agree with them.

This Congressional Budget Office letter tells me that we are debating a pretty bad investment. Our constituents want lower costs. That is their main concern. But this bill fails to address that concern because it raises premiums. Despite offering new ideas throughout the committee process and on the floor of the Senate, Republicans are being accused of supporting the status quo. CBO has spoken, and it is pretty clear that my colleagues are not only OK with the status quo, they are OK with making things worse: higher taxes, higher premiums, increased deficit, less Medicare. They are celebrating that they spent $2.5 trillion to raise premiums for 14 million people, not bending the growth curve of inflation in health care, and not cutting costs. Don't take my word for it. Read the letter. Read the letter from the Congressional Budget Office. I have copies I will pass out if anybody wants them. I have this chart that demonstrates that point.

I also wish to take a few minutes at this time to correct some inaccurate comments made earlier by some of my colleagues. When we are talking about 17 percent of the economy and something that touches the lives of every single American, I want to make sure we have an honest and accurate debate. This morning I heard at least three Members on the other side of the aisle say that Medicare Advantage is not part of Medicare. This is totally false.

But don't take my word for it. I would like to have Members turn to page 50 of the handbook,''Medicare and You.'' Presumably it has the date of 2010 on it. It is sent out every year. In fact, I think I have two copies of this in my household. If anybody wants to save paper and not waste taxpayer money, they can get on the Internet and tell them only to send one to their house next year. I have done that.

This book says, for those who say Medicare Advantage is not part of Medicare:

> A Medicare Advantage plan is another health coverage choice that you may have as part of Medicare.

I repeat, despite what Members were saying earlier, the ''Medicare and You'' handbook says very clearly: Medicare Advantage Plans are part of Medicare. So if you are cutting Medicare Advantage benefits, you are, in fact, cutting Medicare benefits.

Next, I hear a lot of Members talking about guaranteed benefits versus statutory benefits. I can't speak for my other 99 colleagues, but the seniors in Iowa who have come to rely upon the free flu shots, eyeglasses, and dental care that Medicare Advantage provides don't care if they are guaranteed or if they are statutory. Seniors in Iowa just want to know they will still have

these benefits after health reform is passed.

The Senator from Connecticut challenged any Member to come down to the Senate floor and point out where this bill will cut benefits. He even read a section from page 1,004 of this 2,074-page bill that talks about how the Medicare Commission cannot cut benefits or ration care. I have read page 1,004. What Senator DODD failed to mention is that this section only refers to Parts A and B of Medicare. It fails to provide any protection to Medicare Part D, the prescription drug benefit, or the Medicare Advantage Program that covers 11 million seniors.

Are we now going to start hearing that Medicare Part D is not part of Medicare either? In fact, on page 1,005, it specifically says the Medicare Commission can ''[i]nclude recommendations to reduce Medicare payments under parts C and D.''

I have asked CBO, and they have confirmed this authority could result in higher premiums and less benefits to seniors. In fact, this is what Congressional Budget Office Director Elmendorf said, and we have that on a chart for you to see the quote I am going to read: ''A reduction in subsidies to [Part D] would raise the cost to beneficiaries.''

Lastly, I wish to raise an issue about access to care. I keep hearing my friends on the other side of the aisle talk about how these cuts will not affect seniors. They say they are just overpayments to providers. Well, in my opinion, if you cannot find a doctor or if you cannot find a home health provider or a hospice provider to deliver care, then that tends to be a very big problem. I would even consider that a cut in benefits or hurting access to care.

But, once again, do not take my word for it. In talking about similar cuts to Medicare in the House bill, the Office of the Actuary at the Centers for Medicare & Medicaid Services said providers that rely on Medicare might end their participation, ''[p]ossibly jeopardizing access to care for beneficiaries.''

So let's be accurate and let's be honest. Medicare Advantage is part of Medicare, and this bill cuts benefits seniors have come to rely upon. The Medicare Commission absolutely has authority to cut benefits and to raise premiums, and this bill will jeopardize that access to care.

Those are all facts. They are not my facts but facts taken directly from the language of this 2,074-page bill and from reports of the Congressional Budget Office and the Office of the Actuary at the Centers for Medicare & Medicaid Services.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Madam President, it seems I am following the Senator from Iowa every day. I, first, wish to acknowledge my friendship and respect for him. But the Medicare Advantage Program, which the Republican side is trying to protect, is a program which is private health insurance.

The largest political opponent to health care reform in America is the private health insurance industry. We estimate they have spent $23 million so far lobbying to defeat this bill because they are doing very well under the current system. They are very profitable companies, and they realize, if they face competition, limitations on the way they do business, it will cut into their bottom line and their profits, and, naturally, are fighting the bill.

The amendment before us, the motion to commit by Senator MCCAIN—the first thing it does is to protect the Medicare Advantage Program. That is a private health insurance program that was created with the promise that it would be cheaper than traditional government-run Medicare. In some cases, they have offered a cheaper policy. But, overall, these private health insurance companies are charging the Medicare Program 14 percent more than the actual cost of the government-run system.

The promise that the private sector could do it more cheaply and better turned out not to be true. So we are paying a subsidy in profits—extra profits—to private health insurance companies. The McCain amendment, which has been supported by Senator GRASSLEY and others who have come to the floor, is an effort to stop us from eliminating this subsidy.

What is this subsidy worth? This subsidy to private health insurance companies will cost the Medicare Program $170 billion over the next 10 years—no small amount. We believe that money is better spent on extending benefits to Medicare beneficiaries, not in providing additional profits to already profitable private health insurance companies.

Yes, Medicare Advantage policies are offering Medicare benefits, but they are charging more for it than the government. So it did not turn out to be a bargain. It turned out to be a loss to the Medicare Program. They did not do what they promised to do. We want to hold them accountable. The McCain amendment wants to let them off the hook and basically say: Private health insurance companies, keep drawing that money out of Medicare. We are not going to hold you accountable.

That earmark of the Medicare Advantage Program, that decision by Congress to give them a special privilege in selling this health insurance, is too darn expensive for senior citizens and people who rely on Medicare. That is why we are opposing the McCain amendment.

I might add, this is the third day of the debate on health care reform in America. We have yet to vote on a single amendment because the Republicans refuse to allow us to bring an amendment to the floor for a vote. How can you have an honest debate about a bill of this seriousness and magnitude if you cannot bring a measure to a vote on the floor?

Those who follow the Senate know it is a peculiar institution and its rules protect minorities, and individual Senators can object to a vote. The Republican Senators have objected to a vote, even on the McCain amendment, which I believe was filed on Monday, and here we are on Wednesday. We have talked about it. We know what is in it. We should vote on it. But the Republicans do not want to vote on it. They want to drag this out in the hopes that our desire to go home for Christmas means we will walk away from health care reform.

Well, if a few of the Republican Senators could have just left the Democratic caucus, they would know better. We are determined to bring this bill to a vote. We are determined to bring real health care reform to this country. We know what is at stake.

The current health care system in America is not affordable for most Americans. Health insurance premiums have gone up dramatically in cost. Individuals cannot afford to buy a policy. Businesses are dropping coverage of their employees. We know the costs are unsustainable.

Unless we start bringing those costs down, this great health care system is going to collapse. We need to preserve the things that are good in this system and fix those that are broken. Affordability is the first thing we need to address. The second thing we need to address, quite obviously, is to make sure every American has the right, as a consumer, to get coverage when they need it.

How many times have you heard the story of people who pay their health insurance premiums their whole lives, then somebody gets sick in their house—a new baby, a child, your wife, your husband—a big medical bill is coming, you go to the health insurance company, and you are in for a battle. They will not pay it. They say: Oh, we took a look at your application you filed a few years ago. You failed to disclose that you had acne when you were an adolescent. Am I making that up? No. That is an actual case. Because you did not disclose that you had acne as an adolescent, you failed to disclose a preexisting condition, so we have no obligation to pay for anything. If this sounds farfetched, believe me, it is an actual case—and there are many others like it.

Private insurance companies have spent a fortune hiring an army of people, sitting in front of computer screens, talking to the people who are paying the premiums, and above their computers is a sign that says: ''Just Say No.'' They say no consistently because every time they say no, their profits go up. But it leaves individuals and families in a terrible situation—denied coverage because of a preexisting condition; denied coverage because they could not carry their health insurance policy with them after they

lost their job; denied coverage because of a cap in the amount of money the policy would pay; rescinded, where they walk away from an insurance policy because of some objection they have, legal objection; or how about one of your kids who turned age 24, no longer covered by your family health plan, now out on their own, maybe fresh from college, and has no job and no health insurance.

This bill addresses those issues. This bill eliminates the concern people will have over a preexisting condition. It takes away the power of the health insurance companies to say no. It finally creates a situation, which we have waited for for a long time. America is the only civilized, industrialized country in the world where a person can die for lack of health insurance. It does not happen anywhere else—only in America. Madam President, 45,000 people a year die for lack of health insurance.

Who are these people? Let me give you an example, one person whom I met. Her name is Judie, and she works in a motel in southern Illinois. She is 60 years old, a delightful, happy woman. She is the one who takes the dishes at the end of this little breakfast they offer at the motel. She could not be happier and nicer. She is 60 years old, with diabetes. She never had health insurance in her life—never. She goes to work every day, works 30 hours a week, and makes about $12,000 a year. She does not have health insurance, but she does have diabetes. She said to me: If I had health insurance, I would go to the doctor. I have had some lumps that have concerned me for a little while here, but I can't afford it, Senator.

That is an example of a person who does not have the benefit of health insurance. This bill we are talking about—this bill we are going to produce for everyone to read on the Internet; it is already there; it has been there for 10 days already; it will continue to be there—this bill makes sure that 94 percent of the people in America have health insurance coverage. That is an alltime high for the United States of America.

I might also say, despite the criticisms—and they are entitled to be critical on the Republican side of the aisle—they have yet to answer the most basic criticism I have offered. Where is your bill? Where is the Republican health care reform bill? They cannot answer that question because it does not exist. They have had a year to explore their ideas and develop them, but they have failed. They cannot produce a bill. They are for the current system, as it exists, that is unsustainable, unaffordable, leaving too many Americans vulnerable to health insurance companies that say no and too many Americans without health insurance.

I wish to address one particular issue that seems to come up all the time, and it is the issue of medical malpractice. I know my Republican colleagues are going to bring up that issue. Senator MCCAIN has, many others have as well. President Obama recently recognized this as an issue of concern. Our bill will as well. We are going to explore, encourage, and fund State efforts to find ways to reduce medical malpractice premiums and to reduce, even more importantly, the incidence of medical errors.

Medical malpractice reform proposals are based in States. The Federal Government does not have a medical malpractice law, not in general terms. It does for specific programs such as Indian health care, for example, or federally qualified clinics. But when it comes to the general practice of medicine, that is governed by State laws, and the States decide when you can sue, what you can sue for, and the procedures you have to follow.

In almost every State there has been a system that has developed over the years to handle these cases. States regularly change and update their laws. The States try to strike a balance to protect patients, preserve their hospitals and doctors and other medical providers, ensure that those who are injured have a chance for compensation, and manage the cost of their system.

At least twenty-eight States, as of last year, have decided to impose caps on noneconomic damages in medical malpractice cases. A long time ago, before I came to Congress, I used to be a practicing lawyer in Springfield, IL, and I handled medical malpractice cases. So I do not profess to be an expert, nor even have current knowledge of medical malpractice, but I did in a previous life have some experience. I defended doctors, when they were sued, for a number of years on behalf of insurance companies, and I represented plaintiffs who were victims of medical negligence. So I have been on both sides of the table. I have been in the courtroom. I have gone through the process.

Here is what it comes down to. If you are a victim of medical malpractice, medical negligence, the jury can give you an award, which usually includes a number of possibilities: pay your medical bills, pay for any lost wages, pay for any additional expenses that may be associated with the court case, and pay for pain and suffering. Those are the basic elements that are involved in a medical malpractice lawsuit.

The pain and suffering part of it—it is pain, suffering, loss of a spouse or child, loss of fertility, scars, and disfigurement—is an area where many States have said: We want to limit the amount you can recover for pain and suffering, what they call noneconomic losses. It is not medical bills. It is not lost wages. So my State, for example, has a limitation of $500,000 on noneconomic damages in a medical malpractice case, recently enacted by our general assembly. In the State of Texas, it is $250,000. Those are so-called caps, limitations on the amount of money a jury can award for pain and suffering, when they find, in fact, you were a victim of medical negligence.

Some States have decided to establish caps on pain and suffering, how much you can recover; others have not. The reason many imposed caps was because they wanted to bring down the cost of medical malpractice insurance for doctors and hospitals. Well, a number of States have done that. At least twenty-eight States have done that, and we have been able to step back and take a look: How did it work? If you put a cap, a limitation, on recovery for pain and suffering, noneconomic loss, does that mean there will be lower malpractice premiums for doctors? In some cases, yes; in some cases, no.

Minnesota is an interesting example. Minnesota does not have caps on damages. Yet it has some of the lowest malpractice premiums in America. Twenty-five States, including Minnesota, use a certificate of merit system which means before you can file a lawsuit you need a medical professional to sign an affidavit that you have a legitimate claim before you even get into the court. That is in Minnesota, it is in Illinois, and a number of other States to stop so-called frivolous lawsuits.

Some States such as Vermont have low malpractice premiums and don't have any malpractice reforms. It is hard to track cause and effect here between tort reform, malpractice changes, and the actual premiums charged physicians.

There are ways Congress can help States build on what already works for each State. Senator BAUCUS, who is here on the floor and who is chairman of the Senate Finance Committee, has worked with Senator ENZI to create incentives for State programs to look for innovative ways to reduce malpractice premiums and the incidence of medical negligence. I think that is a good idea and I hope it will ultimately be included in this bill.

One of the major considerations when it comes to malpractice reform is making sure we focus on real facts. One myth we hear over and over again is about frivolous lawsuits flooding the courts. I have heard many colleagues come to the floor and call it ''jackpot justice,'' frivolous lawsuits, fly-by-night lawyers filing medical malpractice lawsuits. I am sure there is anecdotal evidence for each and every statement, but when you look at the record, you find that malpractice claims and lawsuit payouts are actually decreasing in America.

In 2008, according to the Kaiser Family Foundation, there were 11,025 paid medical malpractice claims against physicians nationwide. One year in America, the total number of medical malpractice claims paid, according to the Kaiser Family Foundation, was 11,025. There are 990,000 doctors in America, so roughly 1 percent of doctors is being charged with malpractice

and paying each year. This is a decrease from 2007 where the number was 11,478. So the number of malpractice claims has gone down. The number of paid claims for every 1,000 physicians has decreased from 25.2 in 1991 to 11.1 in 2008. That is a little over 1 percent of doctors actually paying malpractice claims.

Not only is the number of claims decreasing, but the amount they are paying to victims is decreasing as well. The National Association of Insurance Commissioners—not a group that is biased one way or the other when it comes to plaintiffs or defendants—said in 2003, malpractice claim payouts peaked at $8.46 billion. In 2008 that number had been cut in half. In 5 years it went down from $8.4 billion to $4 billion. So rather than a flood of frivolous lawsuits, fewer lawsuits are being filed and dramatically less money is being paid out.

Incidentally, the New York Times in a summary of research in September of this year found that only 2 to 3 percent of medical negligence incidents actually lead to malpractice claims. So it is not credible to argue that we have this flood of malpractice cases—they are going down—or this flood of payouts for malpractice in America. It has been cut in half in 5 years.

A third key consideration in this debate is cost. One of the main goals of pursuing health care reform is to try to reduce the cost to the system and we want to try to do that in a way that won't compromise the quality of care. There has been a lot of talk about the Congressional Budget Office report that was ordered up by Senator HATCH on October 9. The Congressional Budget Office for years said they could not put a pricetag on medical malpractice reform in terms of savings to the system, but on October 9 they reported to Senator HATCH that they could. Senator HATCH asked them what would be the impact on our health care system if we had a Texas-style cap, which is $250,000 for pain and suffering—I see the Senator from Texas on the floor and I hope I am quoting the Texas law correctly. He was a former Texas supreme court justice. Am I close?

Mr. CORNYN. Close.

Mr. DURBIN. Close. That is all I will get from the Senator from Texas, close. But the fact is that Senator HATCH said to the CBO, what if we had the Texas-style cap on every State in the Union, what would be the net result? They came back and said there would be a savings of over $50 billion over the next 10 years. They said 40 percent of the savings would come from lower medical liability premiums, 60 percent through reduced utilization of health care services.

I don't question the Congressional Budget Office reaching that conclusion. They worked hard to come up with their figures. But there are other ways to reach results they want to achieve of lowering medical liability premiums and saving overall health care expenditures rather than adopting Federal damage caps. Keep in mind, these caps on what you can recover are for people who have been judged by a jury of their peers to have been victims. These are not people who have said I think I was hurt. We are talking about people who have a right to recovery in a lawsuit who are being told even though you were hurt, and somebody did something wrong, we are going to limit how much you can be paid when it comes to these noneconomic losses.

The CBO analysis that Senator HATCH received went on to say:

> Because medical malpractice laws exist to allow patients to sue for damages that result from negligent health care, imposing limits on that right might be expected to have a negative impact on health outcomes.

They cited one study which found that a 10-percent reduction in costs related to medical malpractice liability would increase the Nation's overall death rate by .2 percent. By calculation that means that if the Hatch proposal were applied nationwide, according to the CBO—and this is a cited study—4,853 more Americans would be killed each year by medical malpractice—or more than 48,000 Americans over a 10-year period of time that the CBO examines. So if you accept their projection on the savings for medical malpractice reform asked for by Senator HATCH, you cannot escape the fact that they say yes, you will save money, but more Americans will die because there will be more malpractice.

Let's look at the savings that can be achieved through reduced malpractice insurance premiums. The CBO said a $250,000 Federal damage cap would reduce overall malpractice premiums by about 10 percent and would reduce overall health care spending by .2 percent. Do we need a federally mandated cap to achieve that? Malpractice insurance premiums are already going down. According to the Medical Liability Monitor's comprehensive survey of premiums in the areas of internal medicine, general surgery and OB/GYN: ''The most recent three years have shown a leveling and now a reduction in the overall average rate change'' for medical malpractice premiums. There was a time in the early 2000s where malpractice premiums were going up 20 percent a year, in 2003, 2004, and 9 percent in 2005. Since then they have gone down each year by less than 1 percent in 2006, by .4 percent—I am sorry, .4 percent increase in 2007, but a 4.3 percent decrease in 2008. That is without any Federal cap on damages.

Let's also consider the issue of defensive medicine. Many people claim that doctors do things such as order tests to cover themselves because they are afraid of being sued. I agree that there are undoubtedly some doctors who think that way. There was a famous article printed in the New Yorker where a surgeon from Boston, Dr. Gawande, who went to McAllen, TX—you probably saw this, Senator CORNYN—and he wanted to know in this article why in McAllen, TX, they were paying more for Medicare patients than any other place in the United States. So he visited with doctors and surgeons and hospital administrators to ask them why. What is peculiar about that city and its elderly people? He sat down with the doctors, and the first doctor said, Well, it is defensive medicine. We are doing all of these extra tests and extra costs to Medicare to cover ourselves, to protect ourselves. The doctor sitting next to him said, Oh, come on. With the Texas law, nobody is filing malpractice lawsuits around here. We are doing these extra procedures because it is a fee-for-service system. You are paid more when you do more. So at least in this case there was a dispute as to whether this was truly defensive medicine or overbilling.

Dr. Carolyn Clancy, the director for the Agency of Healthcare Research and Quality in the Department of HHS, has called medical errors a national problem of epidemic proportions. According to that agency, the rate of adverse events has risen about 1 percent in each of the past 6 years. The Institute of Medicine estimated in 1999 that up to 98,000 people died in America due to preventable medical errors. These medical errors cost a lot. A 2003 study published in the Journal of the American Medical Association found the medical errors in U.S. hospitals in the year 2000—just 1 year—led to approximately 32,600 deaths, 2.4 million extra days of patient hospitalization, and an additional cost of $9.3 billion.

I wish to also say a word about the medical malpractice insurers. Remember, insurance companies and organized baseball are the only two businesses in America exempt from the antitrust laws. What it means is that insurance companies can literally legally sit down and collude and conspire when it comes to the prices they charge, and they do. They have official organizations—one used to be known as the Insurance Services Offices—that would sit down to make sure every insurance company knew what the other insurance company was charging, and they could literally work out the premiums, how much they charge.

The same thing was true in market allocation. Insurance companies, unlike any other business in America, can pick and choose where they will do business: Company X, you take St. Louis; company Y, you take Chicago; company Z, you get Columbus, OH. They can do it legally.

So the obvious question is: If this is not on the square in terms of real competition from health insurance companies, are these companies, in fact, paying out the kind of money they should?

Let me see if I can find a chart here. My staff was kind enough to bring these out. Well, I can't. They are great charts, but I can't find the one I am looking for at this moment.

According to the information of the National Association of Insurance Commissioners, in 2008, medical malpractice insurers charged $11.4 billion

in premiums, but only paid out $4.1 billion in losses. In other words, they took in $7 billion more than they paid out in losses. That is a loss ratio of 36 percent, which means they are basically collecting $3 for every $1 they pay out—pretty close. How does that compare to the rest of the insurance industry? Well, it turns out that private automobile liability insurance had a loss ratio of 66 percent, a payout of $2 out of every $3; homeowners, 72 percent, workers comp insurance, 65 percent. These medical malpractice insurance companies are holding back premiums and not paying them out. It reached a point in my State where our insurance commissioner ordered that they declare a dividend and pay back some of the premiums they had collected from doctors and hospitals when it came to malpractice insurance.

But rather than get lost in statistics, as important as they are, I think it is important that we also talk about the real life stories that are involved in medical malpractice. I hear these terms such as ''frivolous lawsuits'' and ''jackpot justice'' and people taking advantage of the system, but let's not forget the real life stories that lie behind medical malpractice. Let me show my colleagues a picture here of a couple. This is Molly Akers of New Lenox, IL, a lovely young lady, with her husband. Molly Akers had a swelling in her breast and went to her doctor who performed a biopsy that showed she had breast cancer. Molly had several mammograms which found no evidence of a tumor, but the doctors decided that despite the mammograms, she must have a rare form of breast cancer. They recommended a mastectomy, removing Molly Akers' right breast. After the operation, the doctor called her into the office and said that on further review, she never actually had breast cancer. The radiologist had made a mistake. He reviewed her slides and accidentally switched Molly's slides with someone else. Molly was permanently disfigured by an unnecessary surgery. She said afterwards:

> I never thought something like this could happen to me, but I know now that medical malpractice can ruin your life.

By the way, that other woman whose slides were switched with Molly's was told she was cancer free. What a horrific medical error that turned out to be.

This next picture is of Glenn Steinberg of Chicago. He went into surgery for the removal of a tumor in his abdomen. Ten days after the surgery, while still in the hospital, Glenn was having severe gastrointestinal problems. The doctors x-rayed his abdomen where the original surgery took place, and they found a 4-inch metal retractor from the surgery lodged against his intestine. A second surgery was performed to remove the metal piece, during which Glenn's lungs aspirated, and he died later that night.

Glenn's wife, Mary Steinberg, lost her husband. She said:

> Not a day goes by that I don't miss Glenn's companionship and the joy he brought to our household. Because of gross negligence, he was not here to support me when my son went off to serve our country in Iraq.

In this photo is a group of kids, including Martin Hartnett of Chicago. When Martin's mom Donna arrived at the hospital to deliver, her labor wasn't progressing. Her doctor broke her water and found out that it was abnormal.

Rather than considering a C-section, Donna's doctor started to administer a drug to induce contractions. Six hours later, she still hadn't delivered, but her son's fetal monitoring system began indicating that he was in severe respiratory distress. The doctor finally decided it was time to perform an emergency C-section, but it was another hour before Donna was taken into the operating room.

During that time, the doctor failed to administer oxygen or take immediate steps to help Martin breathe. After he was born, Martin was in the intensive care unit for 3 weeks. Later, Donna learned that Martin had substantial brain damage and cerebral palsy—a direct result of the doctor's failure to respond to indications of serious oxygen deprivation and delivery in a timely manner.

Donna's doctor told her not to have any more children because there was a serious problem with her DNA, which could result in similar disabilities in any of her future kids. Since then, Donna has given birth to three perfectly healthy sons.

Donna sued the doctor responsible for Martin's delivery and received a settlement. She is thankful she has money from the settlement to help cover the costs associated with Martin's care that aren't covered by health insurance, such as the wheelchair-accessible van that she bought for $50,000 and the $100,000 she spent making changes to her home so her son can get around the house in a wheelchair.

What would Donna have done without the money from that settlement? It is a scary thought because Martin is going to require a lifetime of care. When we put caps on recoveries and say there is an absolute limit to how much someone who has created a problem has to pay out, we have to think about it in terms of real-life stories, such as Martin's. Martin will live for a long time, and he is going to need help. Somebody needs to be responsible for that. The person who caused this should be responsible for it. That is pretty basic justice in America.

When you establish an artificial cap on noneconomic losses for pain and suffering, then you are saying there is a limit to how much can be paid. I recall the case of a woman in Chicago who went into a prominent hospital—one that I have a great deal of respect for—to have a mole removed from her face—a very simple mole removal. They gave her a general anesthesia. In the course of that anesthesia, they gave her oxygen. The oxygen tank—in the administration of it—caught fire, literally burning off her face. She went through repeated reconstructive surgeries. I have met her. There was scarring and, as you can imagine, a lot of pain. Was $250,000 too much money for that, for what she went through? Her life will never be the same. That is the kind of disfigurement covered by noneconomic losses that would be limited by medical malpractice caps.

There are better ways to do this. We can, in fact, reduce the cost of medical malpractice insurance. We can, in fact, reduce medical errors. We should not do it at the expense of innocent victims—people who went in, with all the trust in the world, to doctors and hospitals and had unfortunate and tragic results.

Every time I get up to speak on this subject I always make a point of saying—and I will today—how much I respect the medical profession in America. There isn't one of us in this Chamber, or anyone watching this, who can't point to men and women in the practice of medicine who are true heroes in their everyday lives, who sacrifice greatly to become doctors, and who work night and day to get the best results for their patients. They richly deserve not only our praise but our respect.

But there are those who make mistakes—serious mistakes. There are innocent victims who end up with their lives changed or lost because of it. We cannot forget them in the course of this debate. This is about more than dollars and cents. It is about justice in this country. I urge my colleagues, when the issue of medical malpractice comes before us, to remember the doctors but not to forget the victims and their families.

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mr. CORNYN. Madam President, while our colleague from Illinois is still on the Senate floor, I always enjoy listening to him. He is one of the most effective advocates, and he is an outstanding lawyer. He and I frequently disagree, but I always enjoy listening to his arguments. That isn't what I came to talk about, but I am glad I happened to be here when he talked about the successful effort we have had in Texas, through medical liability reform laws, to make medical liability insurance more affordable for physicians and, as a consequence, increase the number of doctors who have moved to our State, including rural areas, which has increased the public's access to good, quality health care. We have seen, in 100 counties, where they didn't even have an OB–GYN, or obstetrician—a doctor who delivers babies—after medical liability reform, that has changed dramatically, along with a number of other high-risk specialties that have moved to these counties where they were previously afraid to go for risk of litigation and what that might mean to their future and career.

This is an important topic. We will talk about it more. I appreciate the Senator raising the issue. We have a different view about it. If we can save $54 billion and still allow each of these people who were harmed by medical negligence to recover—which, in fact, they would be under the Texas cap on noneconomic damages—each of these individuals would be able to recover their lost wages, their medical bills, and they would be able to receive large amounts of money for pain and suffering—I am sure not enough to compensate them for what they have been through. But no one should understand that these individuals would somehow be precluded or that the courthouse doors would be shut to people who are victims of medical negligence.

There needs to be some reasonable limitations that will help, in the end, make health care more accessible, which is what we are talking about.

I want to focus briefly on the cuts to Medicare in this new, huge piece of legislation we are considering. Of course, we are told by the CBO that as a result of Medicare cuts and the huge number of tax increases this bill is ''paid for.'' In other words, assuming the assumptions that the CBO took into account, which span for a 10-year budget window and are almost never true in the end—but if you take it on faith that we are going to raise taxes by $½ trillion and cut Medicare by $½ trillion, they say this is a budget-neutral bill—notwithstanding the fact that it spends $2.5 trillion over 10 years—basically, what we are saying to America's seniors, those already vested in the Medicare Program, is that we are going to take $464 billion that would go into the Medicare Program and we are going to use it to create a new government entitlement program.

Our record of fiscal responsibility, when it comes to entitlement programs, is lousy, to say the least. We know Medicare, Social Security, which is another entitlement program, and Medicaid have run up tens of trillions of dollars in unfunded liabilities. Most of them are riddled with fraud, waste, and abuse.

The question I have, and I think many have, is why in the world would you take money out of the Medicare Program that is scheduled to go insolvent in 2017, that has tens of millions of dollars in unfunded liabilities—why would you take $½ trillion out of Medicare to create yet another entitlement program that, no doubt, will have many of the problems we see now under our current entitlement programs? It just doesn't make sense, if you are guided by the facts.

Of course, our colleagues on the floor have said: We can cut $465 billion out of Medicare and, you know what, Medicare beneficiaries would not feel a thing.

Well, I don't think that is possible when you cut $135 billion in hospital payments, when you cut $120 billion out of Medicare Advantage on which 11 million seniors depend, on which they depend for their health care, or when you cut $15 billion from payments to nursing homes, another $40 billion in home health care. I think one of the most effective ways of delivering low-cost health care is in people's homes. You cut $40 billion from that, and you cut $8 billion from hospice, which is where people go during their final days in their terminal illness.

Some of my colleagues claim these cuts would not hurt patients, but many people, including me, disagree. As a matter of fact, to quote President Obama's own Medicare actuary, he said providers might end their participation in the program. In other words, as in Medicare now, in my State, 58 percent of doctors will see a new Medicare patient because reimbursements—payments to providers—are so low, which means that 42 percent will not see a new Medicare patient.

In Travis County, Austin, TX, the last figures showed that only 17 percent of physicians in Travis County will see a new Medicare patient because reimbursement rates are so low. Yet we are going to take money from Medicare to create a new entitlement program. There is no question in my mind that providers—in the words of the Medicare actuary—might be hedging their bets. I think he is hedging his bets. He also said many will end their participation in the program and thus jeopardize access to care for beneficiaries.

We have heard some of the debate earlier about when our side of the aisle made proposals to fix some of the problems with the Medicare Program—not to create a new entitlement program—by taking this amount of money, $464 billion, from it. When we tried to fix it earlier, some colleagues, including the majority leader, called those cuts immoral and cruel. To quote President Obama on the campaign trail, he was one of those who criticized Senator MCCAIN for some of the proposals he made to try to fix the broken Medicare Program.

As we have heard from a Texas Hospital Association, the Medicare cuts to hospitals simply will not work because—and this is another sort of accounting trick that in Washington, DC, and in Congress people think we can get away with and fool the American people about what is actually happening. People are a lot smarter than I think Members of Congress sometimes give them credit for. Under the Senate bill, the expanded coverage doesn't start until 2014. But the hospital cuts begin immediately.

I have talked about the broken Medicare Program and, frankly, I think a lot of people would rather see us fix Medicare and Medicaid before we create yet another huge entitlement program that is riddled with fraud, that is on a fiscally unsustainable path, and one that, frankly, promises coverage but ultimately denies access to care because of unrealistically low payments to providers. We are going to make that worse if this bill passes, not better.

Well, this bill also includes something else that I think the public needs to be very aware of. It uses not only budget gimmicks so that our friends who support this bill can say that it extends the life of the Medicare trust fund for a few years, the problem is it doesn't solve the fundamental imminent bankruptcy of Medicare. That is one of the reasons the bill sponsored by the distinguished majority leader creates a new, unaccountable, unelectable board of bureaucrats to make further cuts to Medicare Programs.

After the Reid bill pillages Medicare for $½ trillion, as I said, to pay for a new entitlement, it creates a board of unelected, unaccountable bureaucrats, the so-called Medicare advisory board, which sounds pretty innocuous, but they have been given tremendous power—to meet budget targets—another $23 billion in the first years alone.

If Congress doesn't substitute those cuts with other cuts to providers or benefits, the board's Medicare cuts would go into effect automatically. That would mean Medicare patients, physicians, hospitals, and everyone else who depends on Medicare would have no say in what happens to personal medical decisions because they would just be cut and shut down by this unelected, appointed board.

The government-charted boards of experts we have in existence today are not always right. We may remember the Medicare Payment Advisory Commission, so-called MedPAC, which was created by Congress in 1997, has recommended more than $200 billion in cost cuts in the last year alone that Congress has not seen fit to order. In other words, this MedPAC board makes recommendations, and Congress is then left with the option in its wisdom to act to make those cuts. Congress has said no to the tune of $200 billion in the last year alone.

Then there is another relatively notorious board of experts—unaccountable, faceless, nameless bureaucrats—that we have learned a little bit about in the last few days: the U.S. Preventive Services Task Force. They are supposed to recommend preventive services but just recently said that women under the age of 50 do not need a mammogram to screen for breast cancer. Respected organizations, such as the American Cancer Society and the Komen Advocacy Alliance, disagree based on their own rigorous review of the latest medical evidence.

As the father of two daughters, I can tell you, I do not want my wife or my daughters restricted in their access to diagnostic tests that may save their lives if their doctor recommends, in his or her best medical judgment, that they get those tests. Yet what we will have in the future, if the medical advisory board is passed, is an unelected, unaccountable board of bureaucrats

that can make cuts, based on expert advice, which will ultimately limit access to diagnostic tests, including tests such as mammograms, which became very controversial. The Secretary of Health and Human Services came out immediately and said: We will never allow that to go into effect.

Not even the Secretary of Health and Human Services, under this provision, could reverse the decision of this unelected, unaccounted board which may well—I would say probably will in some cases—limit a person's access to diagnostic tests and procedures that could save their life even though their personal physician, in consultation with that patient, may say: This is what you need. When you give that power to the government, not only to render expert advice but then to decide whether to pay or not to pay for a procedure, then the government—namely, some bureaucrat in Washington, DC—is going to make the decisions based on a cost-benefit analysis.

OK, on a cost analysis, we can afford, according to the decision of the U.S. Preventive Services Task Force, to lose women to breast cancer—women between the age of 40 and 49—because we don't think they need a mammogram. And on a cost-benefit analysis, they may say: Tough luck. But that is not where we should go with this legislation.

Many health care providers are concerned about the Medicare Payment Advisory Commission. According to a letter from 20 medical speciality groups, they said:

> We are writing today to reiterate our serious concerns with several provisions that were included in the health care reform bill . . . and to let you know that if these concerns are not adequately addressed when the health care reform package is brought to the Senate floor, we will have no other choice but to oppose the bill.

Included in those concerns was the ''establishment of an Independent Medicare Commission whose recommendations could become law without congressional action . . . ''

According to a letter from the American Medical Association today:

> AMA policy specifically opposes any provision that would empower an independent commission to mandate payment cuts for physicians. . . . Further, the provision does not apply equally to all health care stakeholders, and for the first four years significant portions of the Medicare program would be walled off for savings . . .

This is an example of another trade association that basically decided to cut a deal with the administration behind closed doors, and they have been prevented from some of these cuts under this Medicare Commission while physicians have not been accorded similar treatment, and they do not think it is fair. They think it is unfair, and I agree with them.

This letter goes on to say:

> In addition, Medicare spending targets must reflect appropriate increases in volume that may be a result of policy changes, innovations that improve care, greater longevity, and unanticipated spending for such things as influenza pandemics. These are critical issues with the potential for significant adverse consequences for the program, which must be properly addressed through a transparent process that allows for notice and comment.

Sounds to me as if the American Medical Association thinks this is a lousy idea, and I agree with them.

Artificial budget targets that the Medicare advisory board would have to meet leave virtually no room for medical innovation. It is unbelievable what medical science in America and across the world has done to increase people's quality of life—their longevity as a result of heart disease, for example. People who would have died in the seventies are today living healthy because they are taking prescription medications to keep their cholesterol in check, and they have access to innovative surgical procedures, such as stents and other things that can not only improve their quality of life but their longevity as well.

If we have the Medicare advisory board saying: We are not going to pay for some of these things, it will crush medical innovation and have a direct impact on quality of life and longevity. What if we find a cure for Alzheimer's in 2020, but because this board says: It is too expensive, we are not going to pay for it, you are out of luck. What if there are things we cannot anticipate today, which we know there will be because who ever heard of the H1N1 virus or swine flu just a year ago?

Some of my colleagues have said an ''independent board,'' such as the Medicare advisory board, would insulate health care payment decisions from politics. But the very charter of the Medicare advisory board was the result of a deal cut behind closed doors with the White House, a political deal, and it has a lot of reasons why, as we can tell, I don't think it is going to work well.

According to Congress Daily:

> Hospitals would be exempt from the [board's] ax, according to the committee staff and hospital representatives, because they already negotiated a cost-cutting agreement with [the chairman of the Finance Committee] and the White House. ''It's something that we worked out with the committee, which considered our sacrifices,'' said Richard Coorsh, spokesman for the Federation of American Hospitals. A committee aide and a spokeswoman for the American Hospital Association reiterated that hospitals received a pass—

They were protected from 4 years of cuts—

> based on the $155 billion cost-cutting deal already in place.

Is that the kind of politics we want to encourage behind closed doors—deals cut to protect one sector of the health care industry and sacrifice another while denying people access to health care? That is the kind of politics I would think we would want to avoid.

The truth is, the Reid bill gives more control over personal health decisions to Washington, DC, where politics will always play a role in determining winners and losers when the government is in control because people are going to come to see their Members of Congress and say: Will you help us? We are your constituents. And Members of Congress are always going to try to be responsive, if they can, within the bounds of ethics to their constituents.

This needs to be not a process that is dictated by politics but on the merits and on the basis of preserving the sacred doctor-patient relationship. If we really want to insulate health care from politics, we need to give more control to patients—to patients, to families, to mothers and fathers, sons and daughters—to make health care decisions in consultation with their physician, not nameless, faceless, unaccountable bureaucrats.

I filed an amendment to completely strike the Medicare advisory board from the Reid bill. I urge my colleagues to support it at the appropriate time. The Medicare advisory board empowers bureaucrats to make personal medical decisions instead of patients, whose power to determine their own future, in consultation with their doctor, we ought to be preserving.

The Medicare advisory board is an attempt to justify the $½ trillion pillaging of Medicare from America's seniors to create a new entitlement program. We should fix Medicare's nearly $38 trillion in unfunded liabilities, not steal from a program that is already scheduled to go insolvent in 2017.

At a time of insolvent entitlement programs, record budget deficits, and unsustainable national debt, this country simply cannot afford a $2.5 trillion spending binge on an ill-conceived Washington health care takeover.

I yield the floor.

Mr. GREGG addressed the Chair.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, it is the tradition in this body that a person seeking recognition gets recognized, is it not?

The PRESIDING OFFICER. It is, and I say the Senator from California was here earlier.

Mrs. FEINSTEIN. If I might, Madam President, my understanding was we alternate, go from side to side. I have been sitting here waiting.

Mr. GREGG. Madam President, I believe I have the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, I ask unanimous consent that at the conclusion of remarks of the Senator from California, I be recognized.

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

The Senator from California.

AMENDMENT NO. 2791

Mrs. FEINSTEIN. Madam President, I admire the Senator's gentility. I thank him very much.

I rise to say a few words on behalf of the Mikulski amendment, but before I do, I wish to make a generic statement.

Those of us who are women have essentially had to fight for virtually everything we have received. When this Nation was founded, women could not inherit property and women could not receive a higher education. In fact, for over half this Nation's life, women could not vote. It was not until 1920, after perseverance and demonstrating, that women achieved the right to vote. Women could not serve in battle in the military, and today we now have the first female general. So it has all been a fight.

Senator MIKULSKI and Senator BOXER in the House in the 1980s carried this fight. Those of us in the 1990s who came here added to it. You, Madam President, have added to it in your remarks earlier. The battle is over whether women have adequate prevention services provided by this bill. I thank Senator MIKULSKI and Senator BOXER for their leadership and for their perseverance and their willingness to discuss the importance of preventive health care for women. Also, I thank Senator SHAHEEN, Senator MURRAY, and Senator GILLIBRAND, joined by Senators HARKIN, CARDIN, DODD, and others, for coming to the floor and helping women with this battle.

The fact is, women have different health needs than men, and these needs often generate additional costs. Women of childbearing age spend 68 percent more in out-of-pocket health care costs than men. Most people don't know that, but it is actually true. So we believe all women—all women—should have access to the same affordable preventive health care services as women who serve in Congress, no question. The amendment offered by Senator MIKULSKI—and she is a champion for us—will ensure that is, in fact, the case. It will require insurance plans to cover at no cost basic preventive services and screenings for women. This may include mammograms, Pap smears, family planning, screenings to detect postpartum depression, and other annual women's health screenings. In other words, the amendment increases access to the basic services that are a part of every woman's health care needs at some point in her life.

Let me address one point because there is a side-by-side amendment submitted by the Senator from Alaska. Nothing in our bill would address abortion coverage. Abortion has never been defined as a preventive service. The amendment could expand access to family planning services—the type of care women need to avoid abortions in the first place.

As I mentioned, the Senator from Alaska has offered an alternative version of this proposal. But regardless of the merits or problems with her proposal, it remains a kind of budget buster. According to the CBO, the amendment would cost $30.6 billion over 10 years. Adopting this amendment would require us to spend some of the surplus raised by the CLASS Act or some of the budget surpluses in the bill. The underlying bill, as written, reduces the budget deficit by $130 billion in the first 10 years and as much as $650 billion in the second 10 years. This is a very important thing, in my view, and we need to maintain these savings. The Mikulski amendment would do that. It costs $940 million over 10 years as opposed to the $24 billion to $30 billion in the Murkowski amendment.

The Mikulski amendment is, I believe, the best way to expand access to preventive care for women, while keeping this bill fiscally responsible.

We often like to think of the United States as a world leader in health care, with the best and the most efficient system. But the facts actually do not bear this out. The United States spends more per capita on health care than other industrialized nations but in fact has worse results. According to the Commonwealth Fund, the United States ranks No. 15 in avoidable mortality. That means avoidable death. This analysis measures how many people in each country survive a potentially fatal yet treatable medical condition. The United States lags behind France, Japan, Spain, Sweden, Italy, Australia, Canada, and several other nations.

According to the World Health Organization, the United States ranks No. 24 in the world in healthy life expectancy. This term measures how many years a person can expect to live at full health—robust health. The United States again trails Japan, Australia, France, Sweden, and many other countries.

These statistics show we are not spending our health care resources wisely. The system is failing to identify and treat people with conditions early on that can be controlled. Part of the answer, without question, is expanding coverage. Too many Americans cannot afford basic health care because they lack basic health insurance. But another piece of the puzzle is ensuring this coverage provides affordable access to preventive care—the ability to be screened early—and that is what the Mikulski amendment will accomplish.

Women need preventive care—screenings and tests—so that potentially serious or fatal illnesses can be found early and treated effectively. We all know individuals who have benefitted from this type of care—a mammogram that suddenly identifies an early cancer before it has spread or before it has metastasized; a Pap smear that finds precancerous cells that can be removed before they progress to cancer and cause serious health problems; cholesterol testing or a blood pressure reading that suggests a person might have cardiovascular disease which can be controlled with medication or lifestyle changes. This is how health care should work—a problem found early and addressed early. The Mikulski amendment will give women more access to this type of preventive care.

Statistics about life expectancy and avoidable mortality can make it easy to forget that we are talking about real patients and real people who die too young because they lack access to health care. Physicians for Reproductive Choice and Health shared the following story, which comes from Dr. William Leininger in California, and here is what he says:

> In my last year of residency, I cared for a mother of two who had been treated for cervical cancer when she was 23. At that time, she was covered by her husband's insurance, but it was an abusive relationship and she lost her health insurance when they divorced. For the next 5 years, she had no health insurance and never received follow-up care, which would have revealed that her cancer had returned. She eventually remarried and regained health insurance, but by the time she came back to see me, her cancer had spread. She had two children from her previous marriage, and her driving motivation during her last rounds of palliative care was to survive long enough to ensure that her abusive ex-husband wouldn't gain custody of her children after her death. She succeeded. She was 28 years old when she died.

Cases like these explain why the United States trails behind much of the industrialized world in life expectancy. For this woman, divorce meant the loss of her health coverage, which meant she could not afford followup care to address her cancer—a type of cancer that is often curable if found early. And that is where prevention comes in. So this tragic story illustrates the need to improve our system so women can still afford health insurance after they divorce or lose their jobs. And it shows why health reform must adequately cover all the preventive services women need to stay healthy.

The Mikulski amendment is a fight—I am surprised, but it is a fight—but it will help expand access to preventive care while keeping the bill fiscally responsible. To me, it is a no-brainer. If you can prevent illness, you should. In and of itself it will end up being a cost savings. So I have a very difficult time understanding why the other side of the aisle won't accept a measure that is more fiscally responsible by far than their measure, will do the job, and will give women preventive care and begin to change that statistic which shows that, among other nations, we do so badly.

I thank the Presiding Officer for coming to the floor and speaking out on this, and I hope there are enough people in this body who recognize that virtually everything women have gotten in history has been the product of a fight, and this is one of those.

I yield the floor.

The PRESIDING OFFICER (Mr. CARDIN). The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent that the next Republican speaker be the Senator from Louisiana, Senator VITTER.

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

Mr. GREGG. Mr. President, at this point I rise to speak generally about

the bill and specifically about this Medicare proposal—the proposal in the bill and the motion that has been offered by Senator MCCAIN, which I think is an excellent idea.

Let's start with the size of this bill. It is unusual that we would be considering a bill of this size and not have had more time to take a look at it, but the bill itself—and I am glad that the chairman of the Finance Committee has essentially agreed with this earlier today—costs $2.5 trillion when it is fully implemented—$2.5 trillion. When my budget staff took a look at this bill—and we only had a brief time to do it, obviously, last week—and came up with that number, people on the other side of the aisle said, regrettably: No, that is a bogus number. The number is $840 billion, it is not a $2.5 trillion bill. However, it is $2.5 trillion when it is fully implemented. When the programmatic activity of this bill is under full steam, over a 10-year period, it will cost over $2.5 trillion. That is huge—huge.

In an earlier colloquy, I heard the chairman of the Finance Committee—who does such a good job as chairman—make the point: Well, it is fully paid for. It is fully paid for in each 10-year period. That is true, literally. I give him credit for that. But two questions are raised by that fact. The first is this: Why would you expand the Federal Government by $2.5 trillion when we can't afford the government we have?

The resources that are being used to pay for this, should they ever come to fruition, are resources which should probably be used to make Medicare solvent or more solvent or, alternatively, to reduce our debt and deficit situation, as we confront it as a nation. We know for a fact that every year for the next 10 years—even before this bill is put in place—we are going to run a $1 trillion deficit every year, because that is what President Obama has suggested. We know for a fact that our public debt is going to go from 35 percent of our gross national product up to 80 percent of our gross national product within the next 6 years without this bill being passed. We know we are in a position where we are headed down a road which is basically going to hand to our children a nation that is fiscally insolvent because of the amount of debt put on their back by our generation through spending and not paying for it.

So why would we increase the government now by another $2.5 trillion when we can't afford the government we have? That is the question I think we have to ask ourselves. Isn't there a better way to try to address the issue of health care reform without this massive expansion of a new entitlement—creating a brandnew entitlement which is going to cost such an extraordinary amount of money and dramatically expand Medicaid, which is where most of the spending comes from in this bill—a massive expansion of Medicaid and a massive new entitlement created that we don't have today?

This bill, when it is fully implemented, will take the size of the Federal Government from about 20 percent of GDP or a little less—where it has historically been ever since the post-World War II period—up to about 24 or 25 percent of GDP. To accomplish that, and claim you are not going to increase the deficit, requires a real leap of faith. Because it means that to pay for this—and this is why the McCain motion is so important—you are going to have to reduce Medicare spending by $1 trillion, when this bill is fully implemented—$1 trillion over a 10-year window. In fact, during the period from 2010 to 2029, Medicare spending will be reduced in this bill by $3 trillion.

Those dollars will not be used to make Medicare more solvent. And we know we have serious problems with Medicare. Those dollars will be used to create a brandnew entitlement and to dramatically increase the size of government for people who do not pay into the hospital insurance fund; for people who have not paid Medicare taxes, for the most part but, rather, for a whole new population of people going under expanded Medicaid and people getting this new entitlement under the public plan. So if you are going to reduce Medicare spending in the first 10 years by $450 billion, and the second 10 years fully implemented—there is some overlap there, but fully implemented $1 trillion, and then over a 19-year period, the two decades, by $3 trillion, instead of using those monies—those seniors' dollars—to try to make Medicare more solvent, they are going to be used for the purposes of expanding and creating a new entitlement and expanding Medicaid.

This is hard to accept as either being fair to our senior population or being good policy from a fiscal standpoint. Why is that? Because if we look at the Medicare situation, we know Medicare as it is structured today has an unfunded liability of $55 trillion—$55 trillion. That means in the Medicare system we do not know how we are going to pay $55 trillion worth of benefits we know we are now obligated for.

The answer we get from the other side of the aisle is: Well, this $55 trillion number goes down, because this bill cuts Medicare and, therefore, the benefit structure reduces. But do the revenues, or the reduction in that, go toward the purpose of making Medicare more solvent? No. Those monies are taken and spent. Those monies are taken and used to create a larger government. They aren't used to reduce the deficit or to reduce the debt, all of which is being driven, in large part, by this $55 trillion worth of unfunded liability as we go forward. No, they are being used to create a brandnew entitlement which has nothing to do with seniors, and a brandnew entitlement which is going to be paid for, in large part, by seniors, or by a reduction in their benefit structure.

That makes very little sense, because essentially you are taking money out of the Medicare system and using it to expand the government, when in fact what we should be doing, if you are going to take money out of the Medicare system, is you should be using it to reduce the obligations of the government—the debt obligation—so the Medicare system becomes more affordable. That is not the goal here, however.

Then, of course, there is the practical aspect of this. We know these types of proposals are plug numbers to a great degree, because we know this Congress is not going to stand up to a $½ trillion cut in Medicare over the next 10 years and a $3 trillion cut in Medicare over the next 20 years. Why do we know that? I know it from personal experience. I was chairman of the Budget Committee the last time we tried to address the fact that we have an outyear liability in Medicare that is not affordable—this $55 trillion number. We know it is not affordable. We know we have to do something about it. So I suggested, when I was chairman of the Budget Committee, that we reduce Medicare spending, or its rate of growth—not actual spending, its rate of growth—by $10 billion over a 5-year period, less than 1 percent of Medicare spending. My suggestion was that we do that by requiring—primarily we get most of that money by requiring senior citizens who are wealthy to pay a reasonable proportion of their Part D premium and then take those moneys and basically try to make Medicare a little more solvent with it. We got no votes from the other side of the aisle—none, zero—on that proposal.

Now they come forward with a representation that they are going to reduce Medicare spending and benefits to seniors by $3 trillion over the next 20 years and $400-some-odd billion over the next 10 years, and they expect this to be taken seriously? Of course not. This is all going to end up being unpaid-for expenditures in expansion of these programs.

These brandnew entitlements that are being put in this bill and this expansion of other entitlements that do not deal with Medicare, by the way, are going to end up being in large part paid for by creating more debt and passing it on to our children. As I mentioned earlier, that is a fairly big problem for our kids. They are going to get a country, as it is today, that has about $70 trillion in unfunded liability just in the Medicare and Medicaid accounts, to say nothing of the other deficits we are running up around here. Now we are going to throw another huge amount on their backs.

Some percentage of this $2.5 trillion—probably a majority of it—will end up being added to the deficit and debt as we move out into the outyears even though it is represented that it is not going to be. The only way you can claim you are going to pay for this, of course, is with these Medicare cuts and

these tax increases that are in this bill, and these fee increases. We are going to spend a little time on the tax increases and fee increases and the speciousness of those proposals, but right now we are focusing on Medicare.

In any event, what we have is a bill that takes government and explodes its size. We already have a government that is pretty big—20 percent of our economy. You are exploding it to 24 percent of our economy, and then you are saying you are going to pay for that by dramatically reducing Medicare spending? It does not make any philosophical sense, and it certainly does not pass the test of what happens around here politically.

In addition, there is the issue of how this bill got to a score in the first 10 years that made it look as if it was more fiscally responsible. I have heard people from the other side. Again, I respect the chairman of the Finance Committee for acknowledging that this bill, when fully implemented, is a $2.5 trillion bill. But a lot of folks are claiming this is just an $843 billion bill, that is all it is in the first 10 years, that is all it costs. There are so many major budget gimmicks in this bill that accomplish that score that Bernie Madoff would be embarrassed—embarrassed by what this bill does in the area of gamesmanship.

Let's start with the fact that it begins most of the fees, most of the taxes, and most of the Medicare cuts in the first year of the 10 years, but it does not begin the spending on the new program, the new entitlements, until the fourth and fifth year. So they are matching 4 and 5 years of spending against 10 years of income and Medicare cuts and claiming that therefore there is a balance.

Ironically, it is represented and rumored—and I admit this is a rumor—that originally they were going to start the spending in the third year under this bill. Of course, nobody knew what the bill was because it was written in private and nobody got to see it. But then they got a score from CBO that said it didn't work that way, so they simply moved the spending back a year and started it in the fourth year. They sent it back to CBO, and CBO said: If you take a year of spending out in the 10 years and you still have the 10 years of income from the taxes, fees, and cuts in Medicare, you get a better score. We will give you a better score. You will get closer to balance. It is a pretty outrageous little game of hide the pea under the shell.

This is probably the single biggest—in my experience, and I have been on the Budget Committee for quite a while—in my experience, it is the single biggest gaming of the budget system I have ever seen around here. But it is not the only one; there is something here called the CLASS Act.

Mr. HATCH. Will the Senator yield?

Mr. GREGG. I will be happy to yield to the Senator from Utah for purposes of a question.

Mr. HATCH. What is the current cost of our health care across the board in this country, without this bill?

Mr. GREGG. It is about 16 to 17 percent of our gross national product.

Mr. HATCH. That is $2.5 trillion?

Mr. GREGG. That is correct.

Mr. HATCH. The Senator is saying they are going to add, if you extrapolate it out over another 10 years, $2.5 trillion.

Mr. GREGG. It takes the spending from 16 to 17 percent to about 20 percent of GDP.

Mr. HATCH. If I understand my colleague correctly, he is saying, to reach this outlandish figure of $843 billion, literally they do not implement the program until 2014 and even beyond that to a degree, but they do implement the tax increases?

Mr. GREGG. The Senator from Utah, of course, being a senior member of the Finance Committee, is very familiar with those numbers, and that is absolutely correct.

Mr. HATCH. Is that one of the budget gimmicks my colleague is talking about?

Mr. GREGG. I think that is the biggest in the context of what it generates in the way of Pyrrhic, nonexistent savings because it basically says we are really not spending—because it doesn't fully implement the plan in the first year, it says we are not spending that much money. In fact, we know that when the plan is fully implemented, it is a $2.45 trillion not a $840 billion bill.

Mr. HATCH. Am I correct that the Democrats have said—and they seem to be unified on this bill—that literally this bill is budget neutral? But as I understand it, in order to get to the budget neutrality, they are socking it to a program that has about $38 trillion in unfunded liabilities called Medicare—to the tune of almost $500 billion or $½ trillion in order to pay for this? Am I correct on that? No. 2, who is going to lose out when they start taking $500 billion out of Medicare? And what are they going to do with that $500 billion? Are they going to put it into something else? Are they using this just as a budgetary gimmick? What is happening here? As the ranking member on the Budget Committee today, you really could help all of us understand this better.

Mr. BAUCUS. Will the Senator yield for a question?

Mr. GREGG. If I can first answer the question of the Senator from Utah, and then I will be happy to answer the chairman of the Finance Committee.

The Senator from Utah basically is correct in his assumption. Essentially, they are claiming an approximately $400-some-odd billion savings in Medicare over 10 years which they are then using to finance the spending in this bill over the last 5 years, 5 to 6 years of the 10-year window. In the end, after you fully implement this bill and you fully implement the Medicare cuts, it represents $3 trillion of Medicare reductions over a 20-year period.

Where does it come from? It comes from two different accounts, primarily. One is, just about anybody who is on Medicare Advantage today—about 25 percent of those people will probably completely lose their Medicare Advantage insurance, and it is 12,000 people in New Hampshire, so say 4,000 people.

Mr. HATCH. How many people on Medicare are on Medicare Advantage?

Mr. GREGG. I believe 11 million people.

Mr. HATCH. That will be what percentage of people on Medicare?

Mr. GREGG. About 25 percent of those people will lose their Medicare insurance under this proposal, mostly in rural areas. And second, because there is $160 billion of savings scored. You can't save that type of money in Medicare Advantage unless people don't get the Medicare Advantage advantage.

Second, it comes in significant reductions in provider payments. How do provider payments get paid for when they are cut, I ask the Senator from Utah. I suspect it is because less health care is provided.

Mr. HATCH. How does that affect the doctors?

Mr. GREGG. It certainly affects the hospitals, and it probably affects the doctors. I have heard the Senator from Montana say they are going to straighten out the doctor problem down the road, but that is another $250 billion of spending which we don't know where they are going to get the money from. But, yes, it would affect, in my opinion, all providers—doctors, hospitals, and other people who provide health care to seniors. You cannot take $450 billion out of the Medicare system and not affect people's Medicare.

Mr. HATCH. Am I wrong in saying Medicare is already headed toward insolvency and that it has up to almost $38 trillion in unfunded liability over the years for our young people to have to pay for?

Mr. GREGG. The Senator from Utah is correct again. The Medicare system is headed toward insolvency, and it goes cash-negative in 2013, I believe—maybe it is 2012—in the sense that it is paying out less than it takes in, and it has an unfunded liability that exceeds, actually, $38 trillion now. I think it is up around——

Mr. HATCH. Then how can our friends on the other side take $½ trillion out of Medicare, which is headed toward insolvency, to use for some programs they want to now institute anew?

Mr. GREGG. I think the Senator from Utah has asked one of the core questions about this bill. Why would you use Medicare savings, reductions in Medicare benefits, which will definitely affect recipients, for the purposes of creating a new program rather than for the purposes of making health care more solvent if you are going to do that in the first place? And are these savings ever going to really come about? One wonders about that also.

Mr. HATCH. I heard someone say today on the floor—I don't know who it was, I can't remember—that Medicare Advantage really isn't part of Medicare. Is that true?

Mr. GREGG. Actually, I would yield to the Senator from Utah on that issue—not the floor but yield on that question because I think the Senator from Utah was there when Medicare Advantage was drafted as a law.

Mr. HATCH. I was there in the Medicare modernization conference, along with the distinguished chairman of the committee, Senator BAUCUS, and others, when we did that because we were not getting health care to rural America. The Medicare+Choice plan didn't work. Doctors would not take patients. Hospitals could not pay; they could not take patients. There were all kinds of difficulties in rural America. So we did Medicare Advantage, and all of a sudden we were able to take care of those people. Yes, it costs a little more, but that is because we went into the rural areas to do it.

But this would basically decimate Medicare Advantage, wouldn't it, what is being proposed here? And that is part of Medicare.

Mr. GREGG. I believe it is a legal part of Medicare, Medicare Advantage.

Mr. HATCH. No question about it.

Mr. GREGG. And this would have a massively disruptive effect on people who get Medicare Advantage because you are going to reduce it—the scoring is there will be a reduction in Medicare Advantage payments of approximately $162 billion, I believe it is, and there is no way you are going to keep getting the advantages of Medicare Advantage if you have that type of reduction in payments.

Mr. HATCH. How can they take $½ trillion out of Medicare? That is not all Medicare Advantage. Medicare Advantage is only part of that, the deductions they will make there. But how can they do that and still run Medicare in a solvent, constructive, decent, and honorable fashion?

Mr. GREGG. If the Senator will allow me to respond, the problem here is we have rolled the Medicare issue into this major health reform bill—or the other side has—and they have used Medicare as a piggy bank for the purposes of trying to create a brandnew entitlement which has nothing to do with senior citizens. Yes, Medicare needs to be addressed. It needs to be reformed. The benefit structure probably has to be reformed. But we should not use those dollars for the purposes of expanding the government with a brandnew entitlement. We should use those dollars to shore up Medicare so we don't have this massive insolvency.

Mr. HATCH. You mean they are not using this $500 billion to shore up Medicare and to help it during this period of possible insolvency with a $38 trillion unfunded liability? They are not using it for that purpose?

Mr. GREGG. That is correct.

Mr. HATCH. For what purpose are they using it?

Mr. GREGG. They are using to fund the underlying bill, and the underlying bill expands a variety of initiatives in the area of Medicaid and in the area of a brandnew entitlement for people who are uninsured to subsidize the government plan.

Mr. HATCH. You were going to talk about the CLASS Act.

Mr. GREGG. The CLASS Act is another classic gimmick of budgetary shenanigans which I would like to speak to, briefly. I know the Senator from Montana had a question or maybe he has gone past that point and we have answered all his questions. I can move on to the CLASS Act.

Mr. BAUCUS. I would like to hear you talk about the CLASS Act. I am no fan of the CLASS Act myself so why don't you proceed.

Mr. GREGG. I thank the Senator for his forthrightness on that. The CLASS Act needs to be explained. It is a great title. We come up with these wonderful ''motherhood of titles.'' We attach them to things and then suddenly they take on a persona that has no relationship to what they actually do. The CLASS Act is a long-term care insurance program which will be government run. It is another takeover of private sector activity by the Federal Government. But what is extraordinarily irresponsible in this bill is, we all know in long-term care insurance that you buy it when you are in your thirties and your forties. You probably don't buy it when you are in your twenties. You buy it in your thirties, forties, and fifties. You start paying in premiums then. But you don't take the benefits. The cost of those insurance products don't incur to the insurer until people actually go into the retirement home situation, which is in their late sixties and seventies, most likely eighties in our culture today, where many people are working well into their seventies. So there is a large period of people paying in, and then 30 or 40 years later, they start to take out.

What has happened in this bill, which is a classic Ponzi scheme—in fact, ironically, the chairman of the Budget Committee did call it a Ponzi scheme, the Senator from North Dakota, Mr. CONRAD—they are scoring these years when people are paying into this new program and, because the program doesn't exist, everybody who pays into it, starting with day one, the beneficiaries of that program aren't going to occur until probably 30 or 40 years later. They are taking all the money that is paid in when people are in their thirties, forties, fifties, and sixties as premiums. They are taking that money and they are scoring it as revenue under this bill and they are spending it on other programmatic initiatives for the purposes of claiming the bill is balanced. It adds up to about $212 billion over that 20-year period, 2010 to 2029.

OK. So you spend all the premium money. What happens when these people do go into the nursing home, do require long-term care when they become 75, 80, 90 years old? There is no money. It has been spent. It has been spent on something else, on a new entitlement, on expanding care to people under Medicaid, on whatever the bill has in it. So we are going to have this huge bill that is going to come due to our kids one more time. We already are sticking them with $12 trillion of debt right now, and we are going to raise the debt ceiling, sometime in the next month, to, I don't know what it is going to be, but I have heard rumors it may be as high as 13 more trillion. We know we have another $9 trillion of debt coming at us just by the budgets projected for the next 10 years. Now we are going to, 30 years from now, have this huge bill come in as the people who decided to buy into the CLASS Act suddenly go into the retirement home. There will not be any money there for them. It is gone. It will have been spent by a prior generation to make this bill balanced.

The CLASS Act has been described as a Ponzi scheme relative to its effect on the budget. It is using dollars which should be segregated and protected under an insurance program. If this were an insurance company, for example, they would actually have to invest those dollars in something that would be an asset which would be available to pay for the person when they go into the nursing home so they are actuarially sound. But that is not what happens under this bill. Under this bill, those dollars go out the door as soon as they come in for the purposes of representing that this bill is in fiscal balance. It is not. It is not in fiscal balance, obviously.

Even if you were to accept these incredible activities of budgetary gimmickry, the fundamental problem with this bill is it grows the government by $2.5 trillion, and we can't afford that when we already have a government that well exceeds our capacity to pay for it. Inevitably, we will pass on to these young pages, as they go into their earning careers and raise their families, a government that is so expensive, they will be unable to buy a home, send their kids to college or do the things they wish to do that give one a quality of life.

I have certainly taken more than my fair share of time at this point. The Senator from Louisiana was going to go next.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, it has been a very interesting discussion, listening to the Senator from New Hampshire. Several points. One, the underlying bill is clearly not a net increase in government spending on health care. The numbers are bandied about by those on the other side—$1 trillion, $2.5 trillion, et cetera. I do acknowledge and thank the Senator from New Hampshire for saying, yes, it is all paid for. He did say that. He did agree this is all paid for. So I just hope when other Senators on that side of the aisle

start talking about this big cost, $1 trillion, $2 trillion, whatever, that they do admit it is paid for. The ranking member of the Senate Budget Committee flatly said: Yes, it is all paid for. I would hope other Members on that side of the aisle heed the statement of the Senator from New Hampshire, ranking member of the Senate Budget Committee, for saying it is all paid for.

But don't take my word for it or his word. It is what the CBO says. In fact, let me quote from a letter to Senator REID not too long ago:

> The CBO expects that during the decade following the 10-year budget window, the increases and decreases in Federal budgetary commitment to health care stemming from this legislation would roughly balance out so that there would be no significant change in that commitment.

That is, a commitment to health care, to government health care spending, no change basically. It is flat. Although it is a little better than flat because the subsequent CBO letter has said the underlying bill achieves about $130 billion in deficit reduction over 10 years and one-quarter of a percent of GDP reduction in the next 10 years. The Senator from New Hampshire talks about large deficits this country is facing. That is true. Frankly, all of us in the Senate have a responsibility to try to reduce that budget deficit as best and as reasonably as we possibly can. Bear in mind, this underlying health care bill helps reduce the budget deficit. Sometimes people on the other side like to suggest that $1 trillion over 10 years will add to the budget deficit. Again, we have definitely established it does not add to the budget deficit at all, not one thin dime.

In addition, we actually reduce the budget deficit through health care reform, through this underlying legislation. We all know the Medicare trust fund is in jeopardy, in part, because baby boomers are retiring more but also because health care costs are going up at such a rapid rate. That is health care costs for everybody. It is health care costs for me, for every Senator, for every senior, for businesses. Let's not forget, we spend in America about 60 percent more per person on health care than the next most expensive country, about 50 to 60 percent more per person. The trend is going in the wrong direction. We are going to spend about $33 trillion in America on health care over the next 10 years. That is going to be somewhat evenly divided between public expenditures and private. Every other country in the world has figured out ways to limit the rate of growth of increase in health care spending. We haven't. We are the only industrialized country—in fact, developing country—that hasn't figured out how to get some handle on the rate of growth of increase in health care spending.

One could say: Gee, let's forget about it. Just let the present trend continue. We all bandy about different figures. One I am fond of at least remembering is the average health care insurance policy in America today costs about $13,000. If we do nothing over 8 years, it will be $30,000. That is a much higher rate of increase than income for Americans. It means the disparity between wages of the average American and what they are paying on health care will widen all the more if we do nothing. We have to do something. This legislation is a good-faith effort to begin to get a handle on the rate of growth of spending in this country.

The Senator from New Hampshire was being honest, frankly. Some on the other side are being not quite so honest. He is basically saying: Yes, it is true we are not cutting beneficiary cuts, although he talks about Medicare Advantage. Let me point out that there is nothing in this legislation that requires any reductions in any beneficiary cuts. In fact, guaranteed benefits under Medicare are expressly not to be cut under the express language of this bill. The portion we are talking about is Medicare Advantage. The fact is, there is nothing in this bill that requires any cuts at all in Medicare Advantage payments. Those Medicare Advantage payments are in addition to the guaranteed Medicare payments, such as gym memberships, things such as that which are not part of traditional Medicare.

Why do I say there is nothing in there that requires cuts for those extras? That is because the decision on what benefits or what extras Medicare Advantage plans have to give the guaranteed benefits, that is by law. But the decision as to what extras should go to their members is a decision based not upon us in the government, in Congress, not upon the HHS Secretary; it is based on the corporate officers of these companies. They are overpaid, Medicare Advantage plans, right now. Everybody knows they are overpaid. Even they, privately, will tell you they are overpaid. They are overpaid based upon legislation that Congress passed in 2003, the Medicare Part D, by setting these high benchmarks. They are overpaid. The MedPAC commission also said they are overpaid to the tune of about between 14 and 18 percent. So the reductions that are provided for in this bill, in Medicare Advantage plans, the effect of those reductions is up to the officers of those plans.

They could cut premiums people otherwise pay. They could cut benefits to help themselves, help their salaries. They could cut stockholders. They could cut administrative costs.

They can decide what they want to do. That is solely a decision of the executives of Medicare Advantage plans. Private insurance plans is what they are. They are private insurance plans, so there is nothing here that says the fringes, the extras, have to be cut at all. Those executives could keep those fringes and maybe have a little less return to their stockholders or maybe make some savings in their administrative costs, maybe not increase their salaries. There is nothing here that requires those fringes, those extras, to be cut, nothing whatsoever.

The Senator from New Hampshire says: Oh, it is about $400 billion to $500 billion of reduced payments to providers in this legislation. That is true. Well, let's look and see what the consequences of that are. First of all, that means the Medicare trust fund's solvency is extended. It is more flush with cash. I would think all Senators here would like to extend the life of the Medicare trust fund. A good way to do that is by what we are doing in this bill, saving about $450 billion over 10 years that otherwise would be paid to Medicare providers is not being paid, and those benefits inure to the trust fund.

There is no dispute—none whatsoever—that this legislation extends the life of the Medicare trust fund by another 5 years. That is because of those changes in the structure and also because there are no cuts in benefits. There are no cuts in benefits, I say to Senators. Although sometimes Senators on that side of the aisle like to either say or strongly imply there are cuts in benefits, there are no cuts in benefits. There are no cuts in the guaranteed benefits with the basic benefits, and there are no required cuts for the fringes or the extras because the officers can make that decision not to cut, if they want to. That is their choice, as I have explained a few minutes ago.

Let's look to see what the other side proposed not too many years ago back in 1997. They proposed cutting the Medicare benefit structure, cutting payments to providers, big time—big time. They proposed a 12.4-percent cut to providers back in 1997, when they were in charge. They did that in part to save the Medicare trust fund, to extend the life of the Medicare trust fund.

I have a hard time understanding why back then it was a good thing to do, which was about three times more of a cut—let's see, twice as heavy a cut to Medicare providers back then, in 1997, than it is today. Nobody over there has explained why it was the right thing to do back then but not the right thing to do today, when the goal is the same. The goal is the same; that is, to extend the solvency of the trust fund.

One could say—I think the Senator from New Hampshire did say—well, let's take those savings, which do extend the solvency of the trust fund, but not—he said—provide another program. I think he wants to use that to cut the deficit. That is what I think he wants to do.

That is a very basic, fundamental, values question I think this country should face; that is, do we want to set up a system where virtually all Americans have health insurance? We are the only industrialized country in the world that does not have a system where its citizens have health insurance—the only industrialized country

in the world. It is a very basic question. I think we should ask ourselves as Americans: In every other industrialized country, health insurance, health care is a right. That is the starting point. In every other country that has a health care system, health care is a right—that everybody should have health care.

Of course, it is true, people are different. Some are tall, some are short. Some are very athletically endowed, some are not. Some are smart, some are not so smart. But health care does not care—that is a way to put it—whether you are dumb, smart, tall, skinny. It affects everybody; that is, diseases affect everybody, and everybody needs health care regardless of your station in life, regardless of your income, regardless of whether you are an egghead, you are brilliant, or an athlete. It makes no difference whatsoever. We are Americans.

I frankly believe other countries on that point have it right; that is, that they treat all their citizens basically equally because disease is indiscriminate—who is going to get disease—accidents are indiscriminate—who is going to get in an accident—and so forth. So we could take this $400 billion, $500 billion and reduce the deficit with it and forget any health insurance coverage. That would be an option. That is a legitimate question we could ask ourselves. I frankly think the better choice is to take that $400 billion, $500 billion, which does extend the solvency of the trust fund, and help set up a way, help set up a system so all Americans have health insurance. We do it in a way that reduces the budget deficit. We do it in a way that reduces the budget deficit in the first 10 years and also in the next 10 years.

I again repeat, if trimming the rate of growth of provider payments was OK back in 1997—that was twice as much as today back then to extend the solvency of the Medicare trust fund—why isn't it OK today to do half as much to extend the life of the trust fund, in this case for 5 more years, and at the same time help provide health insurance benefits for people who deserve it?

Let's not forget, hospitals want us to do this. They want everyone to have health insurance. Doctors want us to have a system where everybody has health insurance, whether it is Medicaid or it is private health insurance. All the providers want it. The pharmaceutical industry does, the home health industry does, the hospice industry does. The durable medical equipment manufacturers want it. They all want it because they know it is the right thing to do. They also know they are not going to get hurt.

I heard some reference here that some HHS actuary, commenting on the House bill, said, oh, gee, it might scare providers and whatnot, but we actually got subsequent information which showed that letter—that actuary admitted it is extremely variable, what he came up with. There are lots of factors he did not take into consideration. I also have statements from hospital administrators saying no way are they going to be allowed.

In fact, let's remind ourselves of this: It was not too many weeks ago, a couple months ago—remember that meeting—when all the health care providers and the insurance industry went to the White House? They were all over there. What did they pledge to President Obama to help get health care reform passed? That they would cut their reimbursements by $2 trillion over 10 years. They would cut. They agreed to cut their payments that Uncle Sam makes to them in the health care system by $2 trillion over 10 years. It was widely reported in the papers.

What did we do in this bill? We reduced the rate of increase in payments to providers, not by $2 trillion, not by $1 trillion, less than $½ trillion over that same 10-year period. So if they could commit back then to $2 trillion, you would think, my gosh, this is a quarter of that. That is not too bad and not going to hurt anybody, and providers are not going to be leaving.

I might add too, I have a letter from AARP to the majority leader dated today. It has been handed to me. In part it says:

> The legislation before the Senate properly focuses on provider reimbursement reforms. . . . Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

This is a letter today from the American Association of Retired People. I will re-read that portion. It is addressed to Senator REID:

> The legislation before the Senate properly focuses on provider reimbursement reforms. . . .

And, man, we need about a week or so to talk about all the reforms in this bill that are so important so we have a better health care system focusing more on quality than we currently do in the United States system. Again:

> Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

In the letter they also say:

> AARP believes that savings can be found in Medicare through smart, targeted changes aimed at improving health care delivery, eliminating waste and inefficiency, and aggressively weeding out fraud and abuse.

That is important. It is very important. I might add, too, that every person today who pays a Part B premium—every American today—every senior today who pays that quarter, that 25 percent of Part B today, pays also for the waste that is in the system today, especially under Part B. So if we get the waste out, we also will be able to reduce that Part B premium payment that seniors have to pay too. I think that is a good thing.

So the more you dig into this bill, the more you see the good features. I do not think all the good features have been pointed out in this bill. One of our jobs here is to point out what they are, so when this legislation passes—mark my words, this legislation is going to be enacted. It is going to be enacted, I will not say exactly when, but certainly, if not this month, it will be signed by the President either this month or next month—then Americans are going to start to see: Oh, gee, there is a lot in there that is good. I didn't know about that. That is good. I like that. It may not be perfect, but they started in the right direction. That is pretty good. They are going to like it.

I hear all these references to polls around here, and that is because of all the confusion, in part. But once it is passed and people look to see what is in it—they will look to see what is in it because that is the law. They are forced to look to see what is in it because that is the law.

I know some of my colleagues on the other side of the aisle may say: Yes, when they look to see what is in it, they will see how bad it is. I disagree. That is not my view. My view is, the more this legislation is subjected to the light of day, the disinfectant of sunshine, which shows what is in this bill, the more people are going to say: Hey, that was a good thing they did back then in December or January.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Mr. President, I rise to talk about a very important topic on the floor right now, along with the Medicare issue; that is, preventive screenings and services, particularly for women. I want to focus on a very specific and important example of that, which is breast cancer screening through mammography, and also through the practice of self-examination.

This is very timely because 2 weeks ago, a U.S. government-endorsed panel issued new recommendations on this topic, which I believe, along with tens of millions of Americans, is a major step in the wrong direction. I think we need to focus on this recent action and talk about this and fix it in the context of this health care reform debate.

What am I talking about? Well, on Tuesday, November 17—literally just a couple weeks ago—the U.S. Preventive Services Task Force, which is an official government-sanctioned body—a task force about preventive medicine—issued new recommendations regarding breast cancer screening for women, including the use of mammography.

These new recommendations they came out with a couple weeks ago are a big step backward, a big retrenchment in terms of what the current state of knowledge is and what their previous recommendations were. Their new recommendations, just out 2 weeks ago, do four things that take a big step back on breast cancer screening.

No. 1, for women between the ages of 40 and 49, rather than get a routine mammogram every 2 years to screen for breast cancer, the task force said: Forget about that. We do not recommend that anymore. We step back from that recommendation.

No. 2, for women aged 50 to 74, the previous recommendation was to get a routine mammogram to screen against breast cancer every year. The task force, 2 weeks ago, stepped back from that and said: No, every other year is probably good enough. So not every year: every other year.

No. 3, for women over the age of 75, the previous recommendation was to have routine screening at least every 2 years. The new recommendation from the task force steps back from that and says: No, we do not recommend routine screening over the age of 75.

And, No. 4, the task force 2 weeks ago said: We no longer recommend breast self-examination by women to detect lumps to get treatment early. We do not believe in that. We do not think the science is clear on that. We step back from that.

Those are four huge changes in their previous recommendations. Those are four huge, new recommendations completely at odds with what I believe is the clear consensus in the medical community and the treatment community.

When I first read about these new U.S. Preventive Services Task Force recommendations, around November 17, I had the immediate reaction I just enunciated, but I said: I am not an expert. I am not a doctor. I am not a medical expert. I want to hear from folks who are much closer to this crucial issue than me. So my wife and I convened a roundtable discussion in Baton Rouge, LA. We had it on Monday, November 23. It was at the Mary Bird Perkins Cancer Center. They were very kind to host it. It was cohosted by Women's Hospital in Baton Rouge. We had a great roundtable discussion featuring a lot of different people, including oncologists, other MDs, other medical experts, and including, maybe most importantly, several breast cancer survivors who literally lived through this issue themselves. Those breast cancer survivors were all women who got breast cancer and had it detected relatively early, in their forties. So they are exactly the group of people these new recommendations would work against because the new recommendations say don't get regular mammography screening in your forties.

Again, I was interested in hearing from the real experts, both medical experts and the survivors, what they thought about it. I wasn't very surprised, quite frankly, when they all had exactly the same reaction I did to these new U.S. Preventive Service Task Force recommendations. Everybody to a person said this is a big step backward. This will make us move in the wrong direction. Increased screening, early detection is a leading reason we are winning increasingly the fight against breast cancer. It is a leading reason we are doing so much better in this fight.

In that one room at the Mary Bird Perkins Cancer Center, in a sense we had a snapshot through history and proof of the great gains we have made, including through early screening because, as I said, we had these survivors, all a supercause for celebration: Folks who had detected their cancer, most of them relatively early; all of them first got it and detected it either in their forties or some in their thirties. Unfortunately, in the same room, we had a life experience on the other end of the spectrum going back 40-plus years. That is my wife Wendy who lost her mother to breast cancer when she was 6 years old. One of the reasons is simple and straightforward and directly related to what we are talking about.

Back in the late 1960s when Wendy lost her mom to breast cancer there wasn't this same routine. There wasn't this emphasis on screening. There wasn't the recommendation for annual mammograms. There wasn't the educational push for self-examination. There wasn't that focus, and because of that, far more women, tragically, including Wendy's mother, died.

We have made huge progress since then. Again, the very life experiences in that one room in Baton Rouge proved that. The medical doctors and the oncologists, the other experts, as well as the breast cancer survivors, all made that point.

So I am standing on the Senate floor to urge us to take focused, specific action to legislatively repeal any impact of these new recommendations by the U.S. Preventive Services Task Force issued in November.

This topic is on the Senate floor. It is on the floor through the Mikulski amendment. There is probably going to be a Republican alternative to that Mikulski amendment. My concern is, in terms of everything on the floor now, none of it directly, specifically takes back the impact of those new recommendations. I think that is the first matter we should all come together on, 100 to nothing, on this topic.

We can have a broader debate. We can have differences about the best approach to prevention and screening. But the first concrete, focused thing we should do right now on the Senate floor today is come together, 100 to nothing, to legislatively overrule any impact of those new recommendations. That is, again, what I have been hearing from experts not just in Baton Rouge, not just in that one room, but across the country; experts in terms of oncologists, other medical doctors, leaders of the cancer associations across the country and, perhaps most importantly, breast cancer survivors. I daresay that is what every Member of this body has heard from their States since those new recommendations came out around November 17.

So, again, whatever we do in this broader debate, I have a very simple, basic, focused suggestion. Let's show the American people we can come together around something on which I believe we all agree.

There is an expression: It is mom and apple pie. Well, this should be considered mom and apple pie because it is literally about mom and our wives and our daughters and, obviously, half the population. So let's come together around this issue, and let's legislatively overrule any legal impact, any legal consequence of these new task force recommendations of the U.S. Preventive Service Task Force.

That is what my Vitter amendment, No. 2808, does. I had hoped the amendments on the Senate floor on this general topic would do that already. Unfortunately, the one that is pending now, at least the Mikulski amendment, does not do that. In fact, in some ways it points to the new recommendations of the task force and holds up those new recommendations. Our current law holds up the current recommendations. I think because the new recommendations they promulgated around November 17 are so egregious, such a bad idea, because the consensus around the country starting with experts and oncologists is so clear that we should negate any impact of them. So, again, my Vitter amendment No. 2808, which is currently filed as a second-degree amendment to the Mikulski amendment, would do that.

Let me be perfectly clear and read my text because it is very short:

> For the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

So what it does is simple. It says we are erasing, we are canceling out, any effect of those new recommendations made by the task force in and around November 2009. We are saying that never happened because the consensus is so clear against it.

Again, I expected the Mikulski amendment to do that directly. It doesn't do that. It does other things about prevention, which is fine. We can debate those points. We can have a discussion about that. But I think we need to all come together to absolutely, categorically, specifically, legislatively take back, overrule these new recommendations.

I am certainly eager to work with everyone in this body starting with Senator MIKULSKI, starting with Senator MURKOWSKI, whom I believe may offer a Republican alternative to include this language. I hope this language, which seems to me is a no-brainer given the consensus on the topic, can be included in both of those amendments. It should be just accepted and included in the Mikulski amendment. It should be accepted and included in the Murkowski amendment. That would be my goal so that whatever happens on these votes, we come together in a unified way. Literally, it would in essence be 100 to nothing, to say: No, time out. These new recommendations of the U.S. Preventive Services Task Force from November of

this year are a huge step backwards, a huge mistake. That is what the experts are saying. That is what oncologists are saying. That is what cancer specialists are saying. That is what leaders of cancer associations are saying. That is what, perhaps most importantly, breast cancer survivors are saying.

We can look at history in this country in the last several decades and happily point to real progress in this fight. One of the causes of that good news, that improvement since the late 1960s when my wife Wendy's mom passed away from breast cancer, clearly one of the underlying reasons, clearly one of the leading causes is dramatic improvement in this prevention and screening, using mammography, also educating about self-examination.

So, again, I have this second-degree amendment. My hope and my goal would be that this language, which should be noncontroversial, would be accepted on it, as well as any Republican alternative, and that whatever happens in terms of those votes, we come together and make crystal-clear that this task force of unelected bureaucrats—didn't include a single oncologist, by the way—made a big mistake and we are going to make sure those new recommendations don't have any impact in terms of law, in terms of government programs, in terms of legal impact on insurance companies.

Again, I look forward to working with everyone on the floor, including Senator MIKULSKI, including Senator MURKOWSKI and others to pass this language. It should be a no-brainer. It is mom and apple pie. Let's pass it and at least in this focused way come together and do the right thing in direct reaction to something that just happened 2 weeks ago.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I certainly appreciate Senator VITTER's empathy for victims of breast cancer, for people who obviously should be tested for breast cancer, in many cases more frequently than they are. I am sorry about Wendy's mother's death from breast cancer.

I think, though, that Senator VITTER missed the larger point. While most of us in this Chamber disagree with the finding of that Bush-appointed commission—committee, commission, task force—I think the bigger question is that a whole lot of the status quo which Senator VITTER has defended, sort of ad hominem, the bigger question is under the status quo so many women aren't getting tested for breast cancer. It is estimated that 4,000 breast cancer deaths could be prevented just by increasing the percentage of women who receive breast cancer screening.

That is why the Mikulski amendment is so important. It is important because in this country today, if you take a group of 1,000 women who have breast cancer and who have insurance, and 1,000 women who have breast cancer who don't have insurance, those who don't have insurance are 40 percent more likely to die. So the issue is that committee—I think that commission made a mistake. We pretty much, most of us here, think that commission made a mistake. I am not sure why those people whom President Bush put on the commission made the decision they did. It should have been oncologists sitting; Senator VITTER is right about that.

The larger point is that women without insurance don't get tested, and women without insurance are 40 percent more likely to die of breast cancer than those with insurance. At the same time, as the Presiding Officer knows, in the State of Maryland, women typically pay more for their insurance than men do on the average.

So if we are going to do this right, it means we need insurance reform, which is what this legislation does. No more preexisting conditions, no more men and women who have their insurance canceled because they got too sick last year and had too many expenses and the insurance companies practiced rescission and they cut them off. No more if I have insurance and if I have a child born with a preexisting condition do I lose my insurance.

I come to the floor pretty much every day reading letters from people in Ohio—from Galion and Girard and Gallipolis and Lima, all over my State. Typically, people were pretty happy with their insurance if they had written me a year ago, these people. But today these people writing found out their insurance doesn't cover what they thought it did. They end up losing their insurance because of a preexisting condition. They can't get insurance because they once had breast cancer. They have had this discrimination against them because of gender or geography or disability. That is what is important about the bill and what is important about the Mikulski amendment.

That is why I would hope Senator VITTER, as he is pushing for assistance for women with breast cancer—I applaud him for that—would go deeper than just dismissing the recommendations of one government commission and that, in fact, he would advocate for better testing, more frequent testing for women who are not getting tested often enough today, and that the rates for women would be comparable to the rates for men. That is, again, why the Mikulski amendment is so important.

I will repeat: The health reform legislation as is will finally put an end to discrimination, discrimination that charges women significantly higher premiums because they have had children.

It is considered a preexisting condition by some insurance companies if a woman had a C-section because she might get pregnant again and she is going to have another C-section and that costs more. A woman with a C-section has a preexisting condition. A woman who has been—in some cases, with some insurance companies' policies—victimized by domestic violence has a preexisting condition because the boyfriend, the husband or whoever hit her the one time, the insurance companies would suggest, is going to do it again. So she has a preexisting condition. What kind of health care system is that?

That is why I suggest Senator VITTER support the Mikulski amendment and support this legislation. In fact, it will put rules on insurance policies so people will be treated in a different way than they have been in the past.

Let me talk, for a moment, specifically about the Mikulski amendment and why it is so important. It will ensure that women are able to access needed preventive care and screenings at no additional cost. One of the things, in spite of the McCain amendment—and I appreciated Senator BAUCUS's comments a minute ago about how ironic it is. I was in the House of Representatives for 14 years and in the Senate now for the last 3 or so. I have heard so many colleagues eviscerate Medicare. They have tried to cut Medicare, privatize it, and come at it from all different directions repeatedly over these last 15 years. Now they want to tell us they are the ones who want to protect Medicare. In fact, this legislation saves money and saves lives, and this legislation saves Medicare.

One of the things this legislation does for Medicare beneficiaries is it will begin to provide these preventive care screenings so seniors will pay no copay. It is not cutting Medicare and services, as my friends on the other side say—all those who are opposed to every part of the bill, most of whom have tried to slow this legislation down. We cannot even vote on the McCain amendment. We are ready to do it, but the Republicans don't seem to want to move forward on this legislation.

Let me go back to why the Mikulski amendment makes so much sense. All health care plans would cover comprehensive women's preventive care and screenings, requiring that recommended services be covered at no cost to women. We know that to get preventive screenings and care—if we make them at no cost, the chances of people getting them are significantly higher. More than half of women delay or avoid preventive care because of the costs. One in five women at age 50 has not received a mammogram in the past 2 years.

That isn't because the Commission, appointed by the former President Bush, made this decision; it is not because of their bureaucratic decision that Senator VITTER rails about, and many of us agree with; it is not because 1 in 5 women age 50 has not received a mammogram; it is that they don't have insurance, in most cases, and they cannot afford the mammogram.

In 2009, some 40,000 women will lose their lives to breast cancer; 4,000 breast cancer deaths, one-tenth of those could have been prevented by increasing these preventive screenings. These kinds of mammograms, this preventive care, and these doctor visits will be covered for free for women.

This amendment would broaden the comprehensive set of women's health services that health insurance companies must cover and pay for.

For instance, it would ensure that women of all ages are able to receive annual mammograms, covered by their insurer. It would encourage coverage of pregnancy and postpartum depression screenings, Pap smears, screenings for domestic violence, and annual women's health screenings. It makes so much sense. It would save the lives of women, and it means women would suffer from a lot less illnesses. It will save money for the health care system because these illnesses will be detected much earlier, and women will get the kind of care they should. That is what this whole legislation is about and what the Mikulski amendment will add to.

This amendment will remove any and all financial barriers to preventive care so we can diagnose diseases and illnesses early—when we have the best chance at being able to save lives, obviously.

Understand again, this legislation and the Mikulski amendment are supported by the National Organization for Women, the National Partnership of Women and Families, the American Cancer Society Cancer Action Network, and all kinds of women's organizations. They understand this is the best thing for women in this country.

I hope the Senate can proceed to a vote on this amendment. I hope my Republican colleagues will not just talk about the bad decision of this Commission—and most of us think it was a bad decision—but actually do something about it, something substantive, and give women in this country a fairer shake from health care insurance companies and cover these preventive services and cancer screenings. It will make a big difference if we can move forward and expand preventive health care services to women.

I yield the floor.

The PRESIDING OFFICER (Mr. MERKLEY). The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, I wish to pick up where Senator BROWN left off. I will describe one of my real patients, but I will not use her real name. I will call her ''Sheila.'' Sheila was 32 years old. She came in with a breast mass. I examined it and thought it was a cyst. I sent her to get an ultrasound, which confirmed a cyst. OK. We did a mammogram to make sure. The mammogram said it looks like a cyst. The standard of care for somebody with a cyst is to watch it expectantly, unless it is painful, because 99 percent of them are benign cysts. I had the good fortune to do a needle drainage on her cyst 3 days after she had her mammogram. There were highly malignant cells within the cyst. She has since died.

The reason I wanted to tell the story about Sheila is because what the Senator from Ohio, in supporting the Mikulski amendment, doesn't recognize is, we don't allow the Preventive Services Task Force to set the rules and guidelines. We do something worse: We let the Secretary of HHS set the guidelines.

The people who ought to be setting the guidelines are not the government; they are the professional societies that know the literature, know the standards of care, know the best practices; and, in fact, the Mikulski amendment doesn't mandate mammograms for women. It leaves it to HRSA, the Health Resources Services Administration, which has no guidelines on it today whatsoever.

So what you are saying with the Mikulski amendment is, we want the government to, once again, decide—all of us are rejecting what the Preventive Services Task Force has said, but instead we are going to shift and pivot and say we will let the HRSA decide what your care should be.

The other aspect of the Mikulski amendment I fully agree with. I don't think there ought to be a copay on any preventive services. I agree 100 percent. But the last place we ought to be making decisions about care and process and procedure is in a government agency that, No. 1, is going to look at cost as much as at preventive effectiveness.

If the truth be known, the Preventive Services Task Force, from a cost standpoint—as a practicing physician, I know how to read what they put out—from a cost standpoint, it is exactly right. From a clinical standpoint, they are exactly wrong, because if you happen to be under 50 and didn't have a screening mammogram and your cancer was missed, to you, they are 100 percent wrong. You see, the government cannot practice medicine effectively. What we are trying to do in this bill throughout is have the government practice medicine, whether it is the comparative effectiveness panel or the Medicare Payment Advisory Commission.

What we have asked is for the government to make decisions.

Let me tell you what that is. That is the government standing between me and my patient. It is denying me the ability to use my knowledge, my training, my 25 years of well-earned gray hair, and combine that with family history, social history, psychological history, where it might be important, and clinical science, and me putting my hand on a patient such as I did Sheila. Most physicians would never have stuck a needle in that cyst, and she would not have lived the 12 years that she lived. She would have lived 1 or 2 years. But she got 12 years of life because clinical judgment wasn't deferred or denied by a government agency.

There is a wonderful member of the British Parliament who happens to be a physician. When we were debating the issue of the comparative effectiveness panel, which will be applied to whatever HRSA or the Secretary does, I asked him: What about the national institute of comparative effectiveness in England? Here is what he said: As a physician, it ruins my relationship with my patient because no longer is my patient 100 percent my concern. Now my patient is 80 percent my concern and the government is 20 percent of my concern. So what I do is I take my eye off my patient 20 percent of the time to make sure I am complying with what the national institute of comparative effectiveness says—even if it is not in my patient's best interest.

When we pass a bill that is going to subterfuge or undermine the advocacy of physicians for their patients, the wonderful health care we have in this country will decline. There are a lot of other things about the bill I don't agree with. But the No. 1 thing, as a practicing physician, that I disagree with is the very fact—the thing I am most opposed to as a practicing physician—I like best practices. I use Vanderbilt in my practice. I like them. They make me more efficient and make me a better doctor. But they are not mandated for me when I see something that in my judgment and in the art of medicine I get to go the other way because I know what is best for my patient.

What we have in this bill is what we passed with the stimulus bill, the comparative effectiveness panel—which is utilized in this bill—and we have the Medicare Payment Advisory Commission saying you have to cut. Where do we cut? Whose breast cancer screening do we cut next year? When we have the Commission saying we have to, unless we act affirmatively in another way, we are dividing the loyalty of every physician in this country away from their patients. They are no longer a 100-percent advocate for their patients. This is a government-centered bill. It is not a patient-centered bill.

Going back to the Mikulski amendment and what will come with the Murkowski amendment, the Murkowski amendment is far better. It does everything Mikulski does but doesn't divide the loyalty or advocacy of the physician. Here is what it does. The Murkowski amendment says nobody steps between you and your doctor—nobody, not an insurance company, not Medicare or Medicaid. We use as a reference the professional societies in this country who do know best, whether it be for mammograms and the American College of Surgeons, the American College of OB/GYNs, the American College of Oncology, the American Academy of Internal Medicine or the American College of Physicians, which have come to a consensus in terms of what best practices are but

don't mandate what will or will not be paid for when, in fact, the art of medicine is applied to save somebody's life, such as Sheila's.

For you see, if this bill passed, Sheila would have lived 2 years instead of 12. Ten years was really important to her family. She got to see the children I delivered for her grow up. One of them she got to see married.

If we decide the government is going to practice medicine, which is what this bill does—the government steps between the patient and their caregiver, deciding in Washington what we will do—what you will have is good outcomes 80 percent of the time and disasters 20 percent of the time. That is not what we want.

I do not deny that there are plenty of problems in my profession in terms of not being as good as we should be, of not having our eye on the ball some of the time, of making mistakes some of the time. I do not deny that. But what I do embrace is most people who go into the field of medicine go in for exactly the right reason; that is, to help people. It is so ironic to me that we have a bill before us that limits and discourages and takes away the most altruistic of all efforts, which is to do 100 percent the best right thing for your patient.

The reason having HRSA or the Secretary set guidelines is bad is because most patients do not fit the textbook. Here is what the textbook says, but this patient has this condition, this history, and this finding that are different. What we have done in this bill is, multiple times, take the learned judgment of caregivers and say: You will bow to what the Federal Government says; you will bow to what HRSA says; you will bow to what the Secretary of HHS says. Seventy-five times in this bill, there are new programs created; 6,950 times in this bill are requirements for the Secretary to set up new rules and regulations. If you do not think that will put the government between you and your care, you have no understanding of health care in this country and you have no understanding of the problems we face today because of Medicare and Medicaid rules that interrupt and limit the ability for us to care in the best way for our patients.

I am for the prevention aspects of the Mikulski amendment. I think it is a great idea. As a matter of fact, it should not be just about women. It should be about screening for prostate cancer for men as well. It should be about treadmills for people with high cholesterol. It should be about true preventive measures. Why were they not included? Because what we have done under the Mikulski amendment is $892 million over 10 years. We want to do this for one group but we will not do it for the other.

If you think the government will not get in between, let me give three examples right now which violate Federal law today. The Center for Medicare and Medicaid Services today violates Federal law. They ration the following three things:

If, in fact, you are elderly and you have a complication with your colon and you are a high-risk patient to have a perforation if you were to have a colonoscopy—that is when we go in with a fiber optic light to look at the colon—Medicare denies the ability for you to have a CT automated, camera-centered, swallowed-pill colonoscopy, which is available. The technology is proven and is being used outside of Medicare. You cannot have a video colonoscopy by way of a remote-control camera. Why did CMS eliminate that? They eliminated it because it costs too much. So if you are 87 years old and you have a mass in your colon and you cannot have a regular colonoscopy, you cannot even buy this procedure; it is against the law because Medicare forbids it.

No. 2—and this has happened to me numerous times—women with severe osteoporosis—a loss of calcium in their bones at 50 years of age—diagnosed with a DEXA scan in a screening prevention so they do not get a collapsed vertebra or break a hip, you put them on a medicine. The medicines are expensive, there is no question, but they really do work. Some medicines work for some people; other medicines work for others. Once you do a DEXA scan, under Medicare rules, you cannot do another one for 2 years. So you cannot check to see if the medicine is working after 6 months, to see if you see an improvement in the calcification of a woman's bones, because Medicare said it is too expensive and we are doing too many of them. Rather than go after the fraud in DEXA scans, what they did was ration the care.

Here we have a woman and you have diagnosed her properly. You have started her on the medicine, but you have to wait 2 years. What happens during that period of time if you are given a medicine that is not working effectively? Because it did not work in her case, you have to wait 2 years and her osteoporosis advances and she falls and breaks her hip because Medicare said we were doing too many of them?

Take what CMS did to all the oncologists in this country. They said we are paying too much money for EPOGEN. EPOGEN is an acronym for erythropoietin, which is a chemical that is kicked out by your kidneys to cause you to make red blood cells. When you get chemotherapy for breast cancer or colon cancer, like I have had, sometimes that chemotherapy not only kills your cancer but it kills your blood cells. Because we were using too much EPOGEN, Medicare put out a rule rationing EPOGEN and said: Unless you have a hemoglobin of X amount, you cannot get a shot of EPOGEN, and by the way, you cannot take your own money and buy it either. The doctor will get fined if he gives it to you if you don't meet the guideline. What happens? For 80 percent of the patients, it worked fine. But for those patients who have other comorbid—other conditions, such as congestive heart failure or chronic obstructive pulmonary disease—emphysema—where significant drops in hemoglobin can cause organ failures in other parts of the body, there was no exception made by CMS for a physician to make a judgment and say: This rule should not apply here because this patient is going to end up in the hospital.

My oncologist told me a story of one of his patients who could not get EPOGEN. It ended up that their heart failure was exacerbated because they got anemic from the chemotherapy, ended up on a ventilator in ICU, and died. Why did they die? Because they got heart failure. Why did they get heart failure? Because they got too anemic. Why did they get too anemic? Because Medicare would not allow the doctors to give them the medicine.

What is wrong with the bill, what is wrong with the Mikulski amendment is we rely on government bureaucracies to make the decisions about care rather than the trained, learned, experienced, truly caring caregivers in this country to make those decisions. Instead of going after the fraud in Medicare, which is well in excess of $90 billion a year, we decided we will ration care.

The authors of this bill are going to say: No, that is not true. But when I offered amendments in committee to prohibit rationing of Medicare services—to prohibit it—it was voted down. Every person who voted for moving on this bill voted against the rationing. Why would they do that? Because ultimately the feeling is: We know better. Washington knows better. We know your patients better. We know how to practice medicine better. We are going to take ivory tower doctors who do not have real practices anymore, we are going to take retired researchers, and we are going to tell you how to practice. And we are going to save money by limiting what you can get.

The chairman of the Finance Committee has said we do not truly cut Medicare Advantage, that the services are not reduced. The chairman's own bill, on page 869, subtitle C, part C—I won't go through reading it—reduces Medicare Advantage payments. The differential from $135 to—I will read it to the chairman. The chairman is shaking his head. Let me read it to him. Let me also reference what CBO has said. I will be happy to yield to the chairman if he wants to talk now.

Mr. BAUCUS. As soon as I get the page number, I guess I would like to ask the Senator from Oklahoma a question.

Mr. COBURN. I will be happy to yield for a question.

Mr. BAUCUS. What page?

Mr. COBURN. Page 869, subtitle C, part C.

Mr. BAUCUS. I don't have it with me right now, but there are no required reductions in fringes or extras—

Mr. COBURN. No required reductions in what?

Mr. BAUCUS. Fringes, such as gym memberships, and extras such as that. The bill basically provides that there be no reductions in guaranteed Medicare payments. There is a long list of what guaranteed Medicare payments are.

Even the Medicare Advantage companies, which are private companies with officers and they have stockholders—they have to report to their board of directors, and they have all these administrative costs, very huge admin costs. The reductions to Medicare Advantage—the application of reductions to Medicare Advantage plans are at the discretion of the officers. The officers can decide they are not going to cut the fringes; that is, the fringes and the extras that are beyond, in addition to the guaranteed Medicare benefits.

If an officer wants to, it is his discretion, I am assuming—

Mr. COBURN. Reclaiming my time, I ask unanimous consent to have printed in the RECORD CBO 11/21/2009, which shows an average from $135 down to $51 per month on the average Medicare Advantage beneficiary.

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

ESTIMATED EFFECTS OF THE MEDICARE ADVANTAGE (MA) PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON ENROLLMENT IN MA PLANS AND ON FEDERAL SUBSIDIES FOR ENROLLEES IN MA PLANS OF BENEFITS NOT COVERED BY MEDICARE

Under Current Law

	Enrollment in MA Plans (millions)		Average Subsidy of Extra Benefits Not Covered by Medicare (dollars per month)	
	2009	2019	2009	2019
All Areas	10.6	13.9	87	135
Areas with Bids that Average Less than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	4.7	6.9	120	172
Areas with Bids that Average More than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	5.9	7.0	61	98

Under the Patient Protection and Affordable Care Act

	Reduction in enrollment in MA plans, 2019		Net reduction in Medicare spending 2010–2019 Billions of dollars	Average subsidy of extra benefits not covered by Medicare, 2019 Dollars per month
	Percent	Millions		
All Areas	−18	−2.6	105	49
Areas with Bids that Average Less than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	−29	−2.0	[a] −62	51
Areas with Bids that Average More than 100 Percent of Spending Per Beneficiary in the Fee-for-Service Sector	−9	−0.6	−43	47

[a] The estimate of a $105 billion net reduction in Medicare spending over the 2010–2019 period reflects a $118 billion reduction in Medicare payments that would be offset, in part, by a $13 billion reduction in Part B premium receipts.

Note: Under current law, extra benefits include health care services net covered by Medicare, such as vision care and dental care, and subsidies of beneficiaries' out-of-pocket costs for Part B or Part D premiums or cost sharing for Medicare-covered benefits. Under the Patient Protection and Affordable Care Act, extra benefits would include health care services not covered by Medicare and subsidies of beneficiaries' out-of-pocket costs for cost sharing for Medicare-covered benefits.

Mr. COBURN. The fact is, if you like what you have, you cannot keep it, for 2.6 million Americans. You can say that is not true. That is what CBO says. Here are their numbers. They sent the report to the chairman.

Mr. BAUCUS. Will the Senator yield?

Mr. COBURN. I will be happy to yield.

Mr. BAUCUS. It is true—first of all, we need to back up. Isn't it true that the MedPAC commission came to the conclusion that the Medicare Advantage plans are overpaid?

Mr. COBURN. Absolutely. I agree with the chairman.

Mr. BAUCUS. It is also true that it is their recommendation that the Medicare plans overpaid by the amount of 14 percent.

Mr. COBURN. I don't know the actual amount. I agree with the chairman that they are overpaid.

Mr. BAUCUS. That is true. They are overpaid.

Mr. COBURN. Yes.

Mr. BAUCUS. If they are overpaid, doesn't that necessarily mean there are reductions in payments attributable to each beneficiary by definition?

Mr. COBURN. I disagree with that.

Mr. BAUCUS. If they are overpaid—

Mr. COBURN. Here is what I would say. This morning, the claim made by the chairman and Senator DODD is that Medicare Advantage is not Medicare. Medicare Advantage is Medicare law. It was signed into law. It is a part of Medicare. The chairman would agree with that?

Mr. BAUCUS. Absolutely. In 2003, I made the mistake and agreed to give the Medicare Advantage plans way more money than they deserved. And as the Senator from Oklahoma has said, they are overpaid.

Mr. COBURN. I agree with the chairman. You won't hear that from me. How did we get there? How did we get there? How did we get there, to where they are overpaid? We have an organization called the Center for Medicare and Medicaid Services. They are the ones who let the contract, are they not? They, in fact, are. Twenty-five percent of the overpayment has to be rebated to CMS today; the Senator would agree with that? Seventy-five percent for extra benefits, 25 percent rebate. How did we get to where they are overpaid? Because we have a government-centered organization that is incompetent in terms of how they accomplished the implementation of that bill.

What was said by Senator DODD this morning—and I confronted him already on it, but it bears repeating—is that the Patients' Choice Act eliminates the dollars without eliminating the services because it mandates competitive bidding with no elimination in services for Medicare Advantage. So if you want to save money, competitively bid rather than go through eight pages of reductions year by year in the payments that go back to Medicare Advantage.

We have this complicated formula that nobody who listens to this debate would understand. I know the chairman understands it because he helped write it. But the fact is 2.6 million Americans, according to CBO, will see a significant change in their Medicare benefits. Medicare Advantage is Medicare Part C. We have had a kind of a differential made that it isn't really Medicare. It is Medicare. And 20 percent of the people in this country who are on Medicare are on Medicare Part C—Medicare Advantage—and they like it. And why do they like it? Because most of them don't have enough money to buy a supplemental Medicare policy to cover the costs that are associated with deductibles and copays and outliers. So I agree with the chairman that Medicare Advantage is overpaid, but I disagree with the way you are going about getting there.

I also disagree with taking any of the money that is now being spent on Medicare Part C and creating another program. I think all that money ought to be put back into the longevity of Medicare.

In case you don't understand how impactful that is, we now owe, in the next 75 years—actually, we don't owe it, because none of the Senators sitting here will be around. Our kids are going to get to pay back $44 trillion in money for Medicare we will have spent, that we allowed to grow, in fraud, close to $100 billion a year and then did nothing about it. This bill does essentially nothing about that $100 billion a year, or $1 trillion every 10 years. If we were to eliminate that—which this bill does not—we would markedly extend the life and lower the debt that is going to come to our children.

That leads me to the other important aspect of the health care debate. We know when you take out the funny accounting—the Enron accounting—in this bill, and you match up revenues with expenses, you are talking about a $2.5 trillion bill. The chairman of the

Finance Committee readily admits he has it paid for, and CBO says you have it paid for. But how does he pay for it? He pays for it with the 2.6 million people who like what they have today and who are going to lose what they have today. He pays for it by raising Medicare taxes. Then the Medicare taxes he raises he doesn't spend on Medicare, he spends that on a new entitlement program. Think about what we are doing. Is there a better way to accomplish what we are doing?

I thank the chairman for indulging me and allowing me to continue this long. I will wind up with a couple of statements and then share the floor with him.

You know, after practicing medicine for 25 years, I know we have a lot of problems in health care, and I appreciate the efforts of the chairman of the Finance Committee to try to find a solution for them. It is not a bipartisan solution, but it is a solution. And it is a solution that grows the government. It puts the government in charge of health care and creates blind bureaucracies that step between you and your doctor. That is one way of doing it. But wouldn't a better way be to do the following: Let's incentivize people to do the right thing, rather than building bureaucracies and mandating how they will do it. Wouldn't it be better to incentivize tort reform in the States? Wouldn't it be better to incentivize physicians based on outcomes? Wouldn't it be better to incentivize good behavior by medical supply companies, DME, drug companies, hospitals, physicians, through accountable care organizations, through transparency for both quality and price?

We don't have any of that in here. What we have is a government-centered bureaucracy that, according to CBO figures, will add 25,000 Federal employees to implement this program—25,000. If you call the Federal Government, how long does it take you now to get an answer? Yet we are going to add 25,000 employees just in health care. That is an extrapolation of the amount of agencies, dividing what CBO says per agency and per cost they will come up with. Wouldn't it be better to fix the things that are broken, rather than to try to fix all of health care?

I heard one of my colleagues today say on the floor, and I think it is true, that people in America are upset with us, and I think rightly so. I apologize to the American people for my arrogance. I apologize to the American people for the arrogance of this bill; the thinking that we got it right; that we can fix it in Washington; that we don't have to listen to the people out there; that we don't have to listen to the people who are actually experiencing the consequences of what we are going to do. I apologize for the arrogance of saying we can create a $2.5 trillion program and that we know best. Well, you know what, we don't know what is best.

As Senator ALEXANDER has said so many times, what needs to happen is we need to start over. We need to protect the best of American medicine. And what is the best? Well, if you get sick anywhere in the world, this is the best place in the world to get sick, whether you have insurance or not. If you have heart disease or atherosclerotic disease, this is the best place in the world. It costs too much, there is no question, but it is the best place. If you have cancer, you are one-third more likely to live and be cured of that cancer living in this country than anywhere else in the world—for any cancer. It just costs too much.

This bill doesn't address the true causes of the cost. What are the true causes of the cost? Well, No. 1, we know Medicare and Medicaid underpay and so we get a cost shift that is $1,700 per year per family in this country. So you get to pay three taxes in this country on health care: You pay your regular income tax, which goes to pay for Medicaid, and it also now starting to pay for Medicare as well; you have to pay 1.45 percent, plus your employer gets to pay 1.45 percent of every dollar you earn for Medicare; and then your health insurance costs $1,700 more per year because Medicaid and Medicare don't compensate for the actual cost of the care because of the government-centered role that is played in terms of the mandates, the rules, and regulations.

We have a tort system in this country that costs upward of $200 billion in waste a year, which is 8 percent of the cost. Ninety percent of all cases are settled with no wrong found at all on the part of caregivers, and of the remaining 10 percent only 3 percent find anything wrong. Of 97 percent of all the cases, only 10 percent go to trial, and 73 percent of that 10 percent are found in favor of the providers. So we spend all this money practicing defensive medicine and there is not one thing in this bill to fix that problem. That is 8 percent.

Take your health care premium, or your percentage of your health care premium, and apply 8 percent, and that is going down the drain because I am ordering tests you don't need but I need to protect myself in case somebody tries to extort money from me with a lawsuit that I know is going to get thrown out, but I have to have it there to prove it. And then we have inefficiencies.

Ultimately, what we need to do is to protect what is good, incentivize the correct behavior in what is wrong, and go after the fraud in health care with a vengeance—put doctors in jail, hospital administrators in jail. Don't slap them with a fine and ban them from Medicare. Put them in jail. The people who are stealing our grandkids' money, up to $100 billion a year, need to go to jail. We play pay and chase. We pay everybody and then we try to figure out whether they deserve to get paid. Nobody else does that, but the government does, and that is who we are getting ready to put in charge of another $2.5 trillion worth of health care?

One of the reasons health care is in trouble in this country is that 61 percent of all the health care is run through the government today. Look at TRICARE for our military, look at VA care, look at Indian health care, at SCHIP and Medicaid. There is an estimate of $15 billion a year in fraud in New York City alone on Medicaid. That is one estimate, per year, in one city on Medicaid. And then Medicare. And we are going to say those are running so good that we ought to move another $2.5 trillion, or 15 percent of health care, to where we are at 76 percent of all health care is run by the government? I reject that out of hand until we can demonstrate we are good at what we do.

What we ought to be doing is turning it back. The private sector isn't the answer to everything. I agree with that. I can't stand 80 percent of the insurance bureaucrats I deal with. But at least I have a fighting chance, because they will call me back when I need to do something for a patient. I never get a call back from Medicare. They do not call me back. The State doesn't call me back on Medicaid when I need to do something. So I go on and do it and find somebody else to pay for it. That is the kind of system we have today.

Think about the mothers in this country in a Medicaid system where 40 percent of the primary care doctors in this country won't see their children. That is Medicaid. That is realistic Medicaid today in our country. So they have a sick kid, but they can't get in to a doctor, even though they have insurance. They have Medicaid, but they can't get in. Why can't they get in? Because only 1 in 50 doctors last year who graduated from medical school goes into primary care. We have created an abrupt shortage in primary care. And, No. 2, the payment is not enough to pay for the overhead to see the child. So you have a weepy woman who is worried about her sick kid, and care is delayed if you can't get in. It doesn't matter if you have Medicaid if you can't be seen. So what happens? She goes to the emergency room. What happens in the emergency room? We spend three or four times as much as we should, because that is an emergency department. The doctor has no knowledge of the child or the mother. He doesn't want to get sued, so we have a 40-percent defensive medicine cost in the emergency room.

The answer is not more government health care. The answer is creating the incentives for people to do the right thing. The only way we get things under control in health care in this country and the only way we create access for people in this country is to decrease the cost of health care. This bill doesn't decrease the cost of health care. If we want to make sure we do what is best for American medicine while we fix what is wrong, we will do it one significant part at a time. I can't imagine dealing with thousands, tens of thousands of more bureaucrats in

health care, and I can't imagine the impact it is going to have between me and my patients. It is going to severely impact them. Do I want everybody in this country to have available care? Yes; 15 percent of my practice was gratis, for people who had no care, who had no money. That is true with a lot of physicians out there in this country. It is true with a lot of labs. It is true with a lot of hospitals. It is true with a lot of the providers in this country. They are caring people.

We are going to tie them up. We are going to put regulations and ropes around them. We are going to mandate rules and regulations, and we, in our arrogant wisdom, are going to tell Americans how they are going to get their health care. I certainly hope not. But I am not thinking about me. I am thinking about our kids and our grandkids.

I will end with one last comment. Thomson-Reuters, in a study put out October 9 of this year—it is a very well-respected firm—their estimate of the $2.4 trillion that we spend on health care per year in this country is that between $600 and $850 billion of it is pure waste. Defensive medicine costs and malpractice is between $250 billion to $325 billion by their estimate. Not one thing in this bill to address that—not one thing.

Fraud, there is between $125 and $175 billion per year—insignificant in this bill, $2 billion to $3 billion.

Administrative inefficiency, 17 percent—between $100 and $150 billion wasted on paperwork in health care every year.

Provider errors—that is me—between $75 and $100 billion; that is either wrong diagnosis or failure to treat appropriately. It is the smallest of all.

What are we doing? We are going to tell the providers—the hospitals, the medical device companies, the drug companies, the doctors, the radiologists, the labs, the physical therapists—we are going to tell them how to do it. That is not where the problem is.

My hope is that the American people will come to their senses and say: Wait a minute. Slow down. Stop. Fix the important things. Fix the worst thing first, the next thing second, the next thing third, the next thing fourth. The unintended consequences of this bill are going to be unbelievable. Nobody is smart enough to figure all this out—nobody. Nobody on my staff, nobody on the Finance Committee, nobody in Majority Leader REID's office can predict all the unintended consequences that are going to come about because of this bill.

The chairman has been awfully patient, and I see my colleague here to offer an amendment. With that, I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Oregon is recognized.

Mr. MERKLEY. Mr. President, I rise today to share a few thoughts about our health care proposal and also to address the amendment of my good friend from Maryland, Senator MIKULSKI. We have heard the word ''arrogant'' echo in this Chamber. ''The bill before us is arrogant.''

I come to it with a somewhat different perspective. For 10 years, as a representative of a working class neighborhood back in Oregon, as a State legislator, I have heard a lot of stories from America's working families—from the working families in my House district back home, a lot of stories regarding health care. There is a lot of concern that they can't afford health care. There is a lot of concern that their children do not have appropriate coverage. There is a lot of concern that their health care is tied to their job, and if they lose their job they are going to lose their health care.

There is a huge amount of stress for America's families who understand if you have health care you have to worry about losing it, and if you don't have it you have to worry about getting sick. That is why we are here today in this Chamber debating health care, because so many of us have heard from our constituents, so many of us know from our personal experience what a dysfunctional, broken health care system we have in America.

Sometimes, listening to this conversation on the Senate floor, you would think this is a rather complicated debate. But the heart of this bill is not that complicated. The heart of this bill is that every single American should have access to affordable, quality health care, and that we can take a model that has worked very well for the Federal employees of our Nation, a model that encourages competition, a model that says let's create a marketplace where every individual, every small business that currently struggles to get health care and has to pay a huge premium for health care—enable them to join a health care pool that will negotiate a good deal on their behalf.

I think every American who has tried to get health care on their own, every small business that is paying a 15- to 20-percent premium because they don't have the clout of a large business, understands if they could join with other businesses, if they could join with other individuals, they would get a lot better deal.

Americans understand if there is a large pool of citizens who are seeking health insurance that insurers are going to be attracted to market their goods. We have seen that in the Federal employees system, where insurers come and compete. It turns the tables. It takes the power away from the insurance companies and it gives the power to the American citizen because now the citizen is in charge. Now the citizen gets to choose between health care providers instead of having to search for anyone from whom they can possibly get a policy.

I do not find that it is arrogant to try to create a system in which individuals and small businesses get health care that is more affordable. I don't find that a bill that says we are going to invest in prevention is arrogant, that is smart. I don't find a bill that says we are going to create incentives to do disease management arrogant, so someone suffering from diabetes has the disease managed rather than ending up with an expensive amputation of their foot. That is intelligent, that is not arrogant.

I don't find that having a bill that says every single American is going to find affordable health care, and if they are too poor to afford it we will provide a subsidy to assist them, to get everyone in the door, that is not arrogant. That is saying we are all in this together as citizens and that health care is a fundamental factor in the quality of life. It is a fundamental factor in the pursuit of happiness. It is not arrogant to find for fundamental access to health care.

I rise specifically to address the amendment offered by my good friend from Maryland, Senator MIKULSKI. The legislation we are considering has many parts that make health care more affordable and available, that expand access; many parts to hold insurance companies accountable. But a big part of health care reform also deals with helping people avoid illness or injury in the first place. That is what Senator MIKULSKI's amendment does and why it is so important that it be included in this package.

Preventive screening saves lives. That is a fact. Early detection saves lives. That is a fact. Too many women forgo both because of the cost.

I want to share a story from a physician in Oregon. The physician is Dr. Linda Harris. I am going to quote her story in full. It is not that long. She says:

> I work one day a week at our county's public health department. There I met Sue, a 31-year-old woman who came in with pelvic pain and bleeding. She proved to have extremely aggressive cervical cancer that was stage IV when I diagnosed it.

She continues:

> When Sue was 18 she had a tubal ligation after she gave birth to her only child. As a single mom she did not have the financial resources to have more children. She concentrated on raising her daughter. Sue always worked, sometimes 2 jobs at once, but never the kind of job that offered health insurance. But because she had a tubal ligation she did not qualify for our State's family planning expansion project that provides free annual exams, Pap smears and contraceptive services to many of our clients.

The doctor continues:

> Cervical cancer is an entirely preventable disease. Pap smears almost always find it in its preinvasive form, but Sue never came in for a Pap smear or an annual exam. Her lack of affordable access to basic health care proved fatal. When Sue died of cervical cancer her daughter was 13.

That is the completion of the story that the doctor shared. Sue should not be viewed as a statistic in a broken health care system. But, instead, we

should take her story to heart, about the importance of preventive services. Sue is one of 44,000 Americans who die each year because they lack insurance, according to a recent Harvard Medical School study.

Let me repeat that statistic because I think it is hard to get your hands around—44,000 Americans die each year because they lack insurance. I don't think it is arrogant to say we should build a health care system that gives every single American access to affordable, quality care so that 44,000 of our mothers and fathers, our sons and brothers, our daughters, our wives, our sisters—so that 44,000 of them do not die each year because they lack insurance.

Senator MIKULSKI's amendment will help keep this tragedy from happening to our families. To put it plainly, it will save lives. It does this by allowing the Health Resources and Services Administration to develop evidence-based guidelines to help bridge critical gaps in coverage and access to affordable preventive health services—the same approach the bill takes to address gaps in preventive services for children. This will guarantee women access to the kinds of screenings and tests that can prevent illnesses or stop them early.

As the American Cancer Society Cancer Action Network notes:

> Transforming our broken ''sick care'' system depends on an increased emphasis on detection and early prevention, enabling us to find diseases when they are easier to survive and less expensive to treat.

That last point is also important. Treating illnesses also saves money. With so much emphasis on the cost of health care, we should all agree that it is common sense to include reforms that lower health care costs for all Americans.

I was noticing that her amendment has a long list of organizations stating how important this is—the National Organization for Women, the National Partnership for Women and Families, the Religious Coalition for Reproductive Choice, the American Cancer Society-Cancer Action Network, the National Family Planning and Reproductive Health Association.

I applaud Senator MIKULSKI for offering this amendment. I urge my colleagues to remember the 44,000 Americans who die every year because they do not have access to insurance, because they do not have access to preventive services, and vote to include this important reform.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Ms. MURKOWSKI. Mr. President, I ask unanimous consent I be permitted to engage in colloquy with my Republican colleagues on an amendment I will be discussing.

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

Ms. MURKOWSKI. Mr. President, there has been a great deal of discussion this week certainly, and last week, with the announcement from the U.S. Preventive Services Task Force, the USPSTF, of their recommendations as they relate to mammograms and recommendation that women under the age of 50 do not need to be screened until they reach age 50, and then on attaining the age 50, every other year after that.

When these recommendations came out on November 16, it is fair to say they generated a level of controversy, a level of discussion and a level of confusion around the country by women from all walks of life. For many years now, women have operated under what we knew to be the standards, the protocols. If you had a history of breast cancer in your family, you took certain steps earlier, but the general recommendation was out there. Certainly, the guidelines we had been following, the assurances we were seeking as women were that we would be encouraged to engage in these screenings on an annual basis. They gave us all a level of confidence. When these new recommendations, these new guidelines came out just a couple weeks ago, I do think the level of confusion, the level of anxiety that was raised because of this announcement brought a focus to some of what we are talking about when we discuss health care reforms and should the government be involved in our health care.

I know I have received e-mails from friends, from relatives, girlfriends I haven't heard from in a while, talking with women, generally, about what do they think about this. I would hear story after story of the woman who discovered, at age 39, a lump, something that was off, something that was not right, and then the stories subsequent to that, the steps she took as an individual with her doctor. Again, the announcement that we now have these guidelines that this preventative screening task force has put in place and everything we thought we knew and understood about what we should be doing with our health has been unsettled brings us to the discussion today.

We have an amendment offered by the Senator from Maryland. I would like to offer a little bit later an amendment, but I would like to speak to the amendment now, if I may. I am proposing this as a side-by-side to the Mikulski amendment. This is designed to allow for an openness, a transparency on preventative services, not just mammograms. I don't want to limit it to only mammograms, because we know that preventive services in so many other aspects of our health are also equally key and also equally important. What I am looking to do with my amendment is to rely on the expertise, not of a government-appointed task force but to rely on the expertise of medical organizations and the experts, whether they are within the college of OB/GYNs or surgeons or oncologists, rely on them and their expertise to determine what services, what preventive services should be covered.

What we are seeking to do is allow for a level of information so an individual can select insurance coverage based on recommendations by these major professional medical organizations on preventative health services, whether it is mammography or for cervical cancer screening.

I think we learned from the announcement from the USPSTF, the Preventive Services Task Force, that when we have government engaging in the decisions as to our health care and what role they actually play, there is a great deal of concern and consternation. I have heard from many colleagues on both sides of the aisle: That task force was wrong. We think they have made a mistake in their recommendations.

What we are intending to do with this amendment is keep the government out of health care decision-making and allow the spotlight to be shown on the level of prevention coverage that patients will get under their health care plan, rather than relying on unelected individuals, basically individuals who are appointed by an administration to serve as part of this panel of 16, on the Preventive Services Task Force. My amendment specifies that all health plans must consult the recommendations and the guidelines of the professional medical organizations in determining what prevention benefits should be covered by all health insurance plans.

I know at least those of us who are on the Federal employees health benefits have an opportunity to subscribe to the Blue Cross/Blue Shield plan. This is their booklet that is out for 2010. This is under their standard basic option plan. Turn to preventive care for adults that is covered. They provide, under this particular plan, for cancer diagnostic tests and screening procedures for colorectal cancer tests, for prostate cancer, cervical cancer, mammograms, ultrasound, abdominal aneurysm. There is a list we can look to.

What we don't see laid out in this booklet or any of the other pamphlets that outline given plans out there is, OK, for instance, the breast cancer test, is there an age restriction. I am told under Blue Cross there is not. But it doesn't indicate that there. What do the experts recommend? It is not clear from what we receive. So what my amendment would do, in part, is to allow for this information to be directly made available to patients, to individuals who are looking at the plans, to make a determination as to what they will select.

If you go to the Web sites of these professional medical organizations, for instance, the American Congress of Obstetricians and Gynecologists, they recommend that cervical cancer screening should begin at age 21 years, regardless of sexual history. Cervical cytology screening is recommended

every 2 years for women between the ages of 21 and 29. The American Society of Clinical Oncology, as to the recommendations for mammography, urges all women beginning at age 40 to speak with their doctors about mammography, to understand the benefits and potential risks. By age 50, at the latest, they should be receiving mammograms. The American College of Surgeons, in their recommendations, recommend that women get a mammogram every year starting at age 40.

As an individual who is looking to make a determination as to what the experts are saying out there, what is being recommended, I would like to know that this information is made available to me to help me make these decisions. What our amendment would require is the plans would be required to provide this information directly to the individuals through the publications they produce on an annual basis. What we are talking about now is the doctors. It is the specialists who will be recommending what preventative services to cover, not those of us here in Washington, DC, in Congress, not the Secretary of Health and Social Services, who may or may not be a doctor or a medical professional, not a task force that has been appointed by an administration. We are trying to take the politics out of this and put it on the backs of the medical professionals who know and understand this. This is where I think we want to be putting the emphasis. This is where we want to be relying on the professionals, not the political folks.

Additionally, my amendment ensures that the Secretary of Health and Human Services shall not use any recommendations made by the U.S. Preventive Services Task Force to deny coverage of any items or services. This is the crux of so much of what we are discussing right now with these latest recommendations that came out by USPSTF. The big concern by both Republicans and Democrats and everyone is the insurance companies are going to be using these recommendations now to deny coverage to women under 50 or to a woman who is over 50, if she wants to have a mammogram every year; that she would only be allowed coverage for those mammograms every other year rather than on an annual basis. We want to take that away from the auspices, if you will, of the government. To suggest that we will deny coverage based on the recommendations of this government task force is not something I think most of us in this country are comfortable with.

We specify very clearly that the Secretary cannot use any recommendations from the USPSTF to deny coverage of any items or services. We also include in the amendment broad protections to prevent, again, the bureaucrats, the government folks at the Department of Health and Human Services, from denying care to patients based on the use of comparative effectiveness research.

Finally, we include a provision that ensures that the Secretary of Health and Human Services may not define or classify abortion or abortion services as preventative care or as preventative services.

This amendment is relatively straightforward. It relies, essentially, on the recommendation of practicing doctors, as opposed to the bureaucrats, to the politicians, to those in office. My amendment addresses the concern that the government will make coverage determinations for your health care decisions. What we are doing here, quite simply, is making it transparent, making clear that the preventive services recommended by the professional medical organizations are visible, are transparent. We require the insurance companies to disclose that information that is recommended and, again, recommended by the professionals.

This is a good compromise. It basically keeps the government out, and it keeps the doctors in. It requires the insurance companies to disclose the information to potential enrollees and allows for, again, a transparency that, to this point in time, has been lacking.

It has been suggested by at least one other Member on the floor earlier that my amendment would cost somewhere in the range of $30 billion. I would like to note for the record, we have not yet received a score on this. We fully believe it will be much less than has been suggested. When the statement was made, it was not with a full view of the amendment we have before us and is not consistent with that. I did wish to acknowledge that as we begin the discussion on my amendment.

Mr. ENZI. Mr. President, first, I wish to thank the Senator from Alaska for the tremendous work she has done on this issue and for the dozens of people she has talked to over the last couple days to try to come up with an amendment that would actually solve the problem everybody has been talking about.

I appreciate the Senator from Maryland recognizing this major flaw in the bill, and it is in the bill. The U.S. Preventive Services Task Force is in the bill. That is exactly the group that specified this new policy on mammograms that has upset people all across the country. It upset everybody so much that we have an amendment on the floor by the Senator from Maryland reacting to that and reacting to the fact that it is in the bill at the current time.

So I appreciate the Senator from Alaska coming up with a plan that actually is more comprehensive than the amendment from the Senator from Maryland because the Senator has had a little bit longer to work on it. I appreciate the words the Senator has in there that ''you cannot deny.'' The Senator is on the Health, Education, Labor, and Pensions Committee with me, and I know we have worked on this issue in committee. I hoped this kind of a realization would have been made at that time. We had some amendments where you could not deny based on this or the comparative effectiveness or could not prohibit based on it. We know all those amendments failed, meaning there was probably some intention to deny or to prohibit based on these groups.

So I appreciate the Senator bringing up the fact that it is the caregivers who will have some say in this so Washington cannot come between you and your doctor. I wish the Senator would go into a little bit of some of her background from Alaska because the Senator and Alaska have been very involved in breast cancer for a long time, and people ought to be aware of the kind of services that are available out there and what the costs of those services are.

Ms. MURKOWSKI. I appreciate the question from my colleague from Wyoming. The Senator knows, coming from a rural State, that our health care costs are typically higher, and it is not just an issue of cost, but it is an issue of access, and particularly in my State, where most of our communities are not connected by roads, it is very difficult to gain access to a provider. It is even more difficult to gain access, for instance, to mammography units.

I have been involved in this issue, in terms of women's health and cancer screening, for many decades now, primarily because my mother got started in it back when I was still in high school and saw a need to provide for breast cancer screening for women in rural areas, where they could not afford to fly into town, as we would call it, for the screenings. So she engaged in an effort—and continues to this day—to raise money for not only mobile mammography units but to figure out how we move those units from village to village.

Essentially, what they have been able to do, over the years, is you put that mobile mammography unit on the back of a barge and you take it up and down the river and you stop in every village and offer free screenings for women. You fly it into a village, where you are not on a river. We have been making this effort, again, for decades, working, chipping away slowly at the issue of breast cancer. We recognize it in our State. Particularly with our Alaska Native populations, we see higher levels of breast cancer than we would like. We are trying to reduce that.

But when these recommendations came out several weeks ago from the USPSTF, I will tell you, there was a buzz around my State amongst women about: Well, now what do I do? Where do I go? Do I need to go in for my screening? What should I do?

There is an article that was actually in the news just, I guess, a couple weeks ago, and it cites a comment from a doctor. Her comment was, the new recommendations were confusing patients who usually come in for their annual screenings. She said: My schedulers have called to schedule patients

to come in for their followup mammogram, and they have been told: Well, I don't have to do that now. This government group says I don't have to do that.

Mr. President and my colleague from Wyoming, maybe some do not. But what about those who are at risk? These are the ones whom I think we are continuing to hear from who say: Please, add some clarity to this.

Mr. ENZI. Mr. President, I know there is not any word that probably turns a family upside down as much as the word ''cancer,'' and it does not matter which form of cancer it is. It is just drastic because we do not know all the implications of it. Maybe someday we will. Maybe someday we will know how people get it, and we will be able to cure it with a vaccine. But, so far, what we have are some mechanisms for putting it into remission.

One of the reasons I know how upsetting that is and how it turns the world upside down is, 3½, 3¾ years ago my wife was diagnosed with colon cancer. She had screenings, but she listened to her body. She said: Something is the matter here. She kept going to doctors. So even if they do not recommend the screenings, if your body is saying something is the matter, pursue it until you are either convinced nothing is the matter or a doctor finds what is the matter. That is the advice she gives to everybody. These are things that need to be between the patient and the doctor.

Now that she is in remission, one of the things the doctor recommended was that she take Celebrex. That is something normally for arthritic pain, but what they found was in some patients that will keep polyps from growing that will turn into cancer in the colon, and we definitely do not want that to recur again. So she is taking that. But it is a constant fight with making sure that is an approved medication and that it can be done and that it will be paid for.

If that were just a task force recommendation—first of all, since she had the screening, they would say she does not have a problem and, later, she would die from it. But she was able to listen to her body, get the treatment she needed, and now is continuing to get the treatment without a task force saying: No, 99 percent of the people do not need that. Her doctor and she are able to determine what she needs.

On other screenings, once you have cancer, there are other times you need to have MRIs, other kinds of tests run. That, again, has to be up to the doctor and the patient to determine how often those are needed. Again, I know from talking to a number of people whom I know—not just ladies either—who have had cancer, once you have had cancer and you are in remission, you would actually prefer to have your screening a little bit earlier for the mental reassurance you get with it.

Again, from talking to people—and we have talked to more now because we are trying to give some reassurances to them when this terrible word comes up—when they go to the doctor, one of the first things that happens is they weigh in, they take your blood pressure. When you are waiting for a decision on how the blood test you got turned out or the MRI you got turned out or whatever it was, that blood pressure goes through the roof. Quite frequently, you cannot leave the doctor's office until you have—you went there for the information, so, of course, you stay for the information, but they will not let you leave until they do the blood pressure test again, to make sure it goes down below the critical stage. That is how much impact this has on people.

So I am glad the Senator did something that goes a little bit further, covers a few more things, and makes sure people have access to their doctor, to the tests they need, and not to be relying on some government bureaucracy to say: Well, in 99 percent of the cases or 85 percent of the cases—who knows how far down they will take it, depending on what the costs are. We do not want that to happen.

I think the Senator's amendment allows patients to get these preventive benefits and stops government bureaucrats and outside experts from ever blocking patients' access to those types of services.

I appreciate the Senator from Maryland who put up an amendment. I do not think it meets that standard. They still rely on government experts called the U.S. Preventive Services Task Force to decide what preventive benefits should be covered under private health insurance. This is the same Preventive Services Task Force that made this decision that women under the age of 50 should not receive annual mammograms.

In fact, I think I even remember in there that they were not necessarily recommending self-examination. Most people I know who are very young discovered it with self-examination. I certainly would not want them to quit doing that because there is a recommendation from somebody who does not understand them or their body.

Patients do want to receive preventive screenings. Sometimes they are a little reluctant to do it because nobody wants the possibility of hearing that word given to them.

Americans should be able to get screened for high blood pressure and diabetes when a doctor recommends they get these tests. I think the Senator and I agree they should be able to get colonoscopies, prostate exams, and mammograms, so they can prevent deadly cancers from progressing to the point where they are no longer curable. Many of these diseases are preventable or curable or can be put into remission if they are discovered early enough.

I think we agree with Senator MIKULSKI's goal that all Americans should be able to get preventive benefits, but we disagree that her amendment achieves that stated goal. Her amendment does not ensure access to mammograms for women who are under the age of 50. Part of that I am taking from an Associated Press article.

As most Americans know, last month the U.S. Preventive Services Task Force revised the recommendations for screening for breast cancer, advising women between the ages of 40 and 49 against receiving routine mammograms and women ages 50 and over to receive a mammogram just once every 2 years. The U.S. Preventive Services Task Force lowered its grade for these screenings to a C.

That sparked the political firestorm, as many women became confused about what services they could get and when they could get them. The health care bills before Congress further confused the issue because they rely heavily on the recommendations of the task force. That is what is in the bill. The underlying Reid bill says—and the Mikulski amendment restates—that all health plans must cover preventive services that receive an A or B grade from the task force. Let's see, we just said that was a C grade.

Because breast cancer screenings for women under the age of 50 are no longer classified by the task force as an A or B, plans would not have to cover those services. So Senator MIKULSKI drafted an amendment to try to fix this problem, but I think it confuses the matter some more.

I say to the Senator, I appreciate the effort you have gone to, to try to clarify that and expand it to some other areas—and to not add another layer of bureaucracy—by saying that all services and screenings must be covered by health plans.

However, the previous amendment does not have any guidelines that are specifically for women or prevention.

Ms. MURKOWSKI. If I may comment on the Senator's last statement, this is very important for people to understand. There has been much said about the Mikulski amendment and what it does or does not do. But it is very important for women to understand the Mikulski amendment will not provide for those mammograms for women who are younger than age 50. Her amendment specifically provides that it is ''evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force.''

So you go to the task force report, and as the Senator has noted, women who fall between the ages of 40 and 49 receive a grade of a C, and the recommendation is, specifically: Do not screen routinely. Individualized decision to begin biannual screening, according to the patient's context and values. But they have received a C designation by USPSTF.

According to the Mikulski amendment, those women who are younger than 50 years of age will not be eligible

or will not be covered under the mandatory screening requirement she has set forth in her amendment.

I think where she was trying to go was to ensure that these recommendations would not be used to deny coverage. She adds a paragraph stating that nothing shall preclude health plans from covering additional services recommended by the task force that are either not an A or a B recommendation. But the amendment does not require plans to cover services that are not an A or a B. In other words, if you are 45 years of age, you are in this C category, and the amendment does not require, then, that your preventive screening services be covered. So for those women who are in this age group—Congresswoman DEBBIE WASSERMAN SCHULTZ just went through a recent bout of cancer, and I think that was diagnosed at age 41. For those women who fall into this category, this amendment the Senator from Maryland has introduced does not address the concerns that have been raised by these recommendations coming out of this preventive task force. Again, I think we need to understand that what this amendment specifically allows for is first-dollar coverage for immunizations for children, children's health services as outlined with the HRSA—Human Resources Services Administration—guideline. But, in fact, the requirement to provide for screening coverage for women who are not in this A or B category—in other words, anybody younger than 50—we need to understand is not covered through this.

Our amendment, through allowing for a level of transparency, ensures that when you go to obtain your insurance, you can see very clearly what the professional medical organizations recommended are the guidelines and then what your insurer is proposing to offer you for your coverage. If it is not coverage you like, then shop around. This is what this insurance exchange is supposed to be all about.

Mr. ENZI. Mr. President, I congratulate the Senator from Alaska also.

Isn't it true that the Senator's amendment ensures that the Secretary of Health and Human Services won't be able to deny any of these services based on any recommendation? That is one of the things we have been concerned about. Again, that is an unelected bureaucrat who could come between you and your doctor and your health care. I know the Senator has covered that in her amendment, too, and I do appreciate it.

Ms. MURKOWSKI. It states very clearly on the second page that the Secretary shall not use any recommendation made by the U.S. Preventive Services Task Force to deny coverage and items serviced by a group health plan or a health insurance issuer. So, yes, we make it very clear that these recommendations from the USPSTF cannot be used to deny coverage.

I think the opportunity to have medical professionals, as this USPSTF is comprised of—we should have an entity that is kind of looking out and seeing what best practices are. But then that entity should not be the one that causes a determination as to whether coverage is going to be offered. You can use that as a resource, most certainly, just as we use as a resource the recommendation from, say, for instance, the American Congress of Obstetricians and Gynecologists, the American College of Surgeons, the American Society of Clinical Oncology, but it is not going to be the determining factor. I think that is where we need to make that separation, where my amendment separates from Senator MIKULSKI's.

Mr. ENZI. Mr. President, I also appreciate that the Senator from Alaska makes sure they can't deny care based on comparative effectiveness research, which actually was part of the stimulus bill that was run through at that point in time, and finally that the Senator's amendment includes a commonsense provision that would prohibit the Secretary from ever determining that abortion is a preventive service.

So I hope all of my colleagues, whether they are pro-life or pro-choice, would support this change to ensure that the controversial issues don't sidetrack the debate on the preventive issues because what we are talking about is the preventive issues, and I appreciate the Senator covering that.

Ms. MURKOWSKI. I am glad the Senator mentioned the issue of the abortion services. I think there is a vagueness in the amendment Senator MIKULSKI has offered. Some have suggested that it would allow those in the Human Resources Services Administration, HRSA, to define abortions as a preventive test, which could provide that health insurance plans then be mandated to cover it. That has generated some concern, obviously. Some have opposed the amendment, saying that if Congress were to grant any executive branch entity sweeping authority to define services that private plans must then cover, merely by declaring a given service to constitute preventive care, then that authority could be employed in the future to require all health plans to cover abortions.

So all we are doing with my amendment is just making very clear there are no vagaries, there is no second-guessing. It just makes very clear that the Secretary cannot make that determination that preventive services are to include abortion services.

Mr. ENZI. Mr. President, as I said before, my wife says that she had probably never mentioned the word ''colon'' twice in her whole life, and since then she has become an encyclopedia for people who have a very similar problem. She had a colonoscopy a short time before. She was still having problems, and they had said there is no problem, but she kept getting it checked until she found that there was a problem. So people need to listen to their bodies, and they need to listen to their doctors, and they shouldn't have a bureaucrat coming in between that. So I thank the Senator.

Ms. MURKOWSKI. I thank the Senator for the dialog here today. I think this is an important part of our discussion as we debate health care reform on the floor. We have had good conversations already yesterday and today about the cuts to Medicare, the impact we will feel as a nation if these substantive cuts advance. But I think this discussion—and we are narrowing it so much on what the recommendations have been from this task force, but I think it is a good preview of what the American people can expect if we move in the direction of government-run health care, of bureaucrats, whether it is the Secretary of Health and Human Services or whether it is task forces that have been appointed by those in the administration, who are then able to make that determination as to what is best for you and your health care and your family's health care.

I think the discussion we have had today about ensuring that it is not best left to these entities, these appointed entities to make these determinations, but let's leave it to—or let's allow the information to come to us from the medical professionals. Senator COBURN has spoken so eloquently on the floor about relying on those who really know and understand, who live this and who practice this, rather than us as politicians who want to be doctors. I don't want to be a doctor. I want to be able to rely on the good judgment of a provider I trust, and I want him or her to be able to make those decisions based on their understanding of me and my health care needs and what is best for me and what the best practices are that are out there, rather than having a task force telling them: That is the protocol for Lisa. She is 52. She is able to get a mammogram every other year now. I want to know that it is me and my doctor who are making these decisions.

I hope Members will take a look at the amendment I will offer and consider how it allows for truly that kind of openness, that kind of transparency, and gives individuals the freedom of choice in their health care that I think we all want.

With that, I thank my colleague from Wyoming, and I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Senator WHITEHOUSE, Senator STABENOW, Senator DODD, and I be allowed to engage in a colloquy.

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

The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. I thank the Presiding Officer. I am delighted to be on the floor, along with the distinguished chairman of the Finance Committee and the distinguished Senator from Michigan, who has worked so hard on these issues.

I am sure I am not going to be the only person to say this, but I would like to respond briefly to the colloquy that just took place between the Senator from Wyoming and the Senator from Alaska because, as I understand it, the Mikulski amendment provides for preventive services that are in the A and B category as a floor, not a ceiling, at a minimum, and it instructs the Health Resources and Services Administration to provide recommendations and guidelines for comprehensive women's preventive care and screenings. Once that is done, then all plans would be required to be totally apart from the A or the B.

In terms of the Health Resources and Services Administration being an entity that wants to get between you and your doctor, these are actually scientists, not bureaucrats. It is an independent panel.

I think it comes with some irony to hear the concern expressed on the other side of the aisle repeatedly about bureaucrats coming between Americans and their doctors and telling them what care they can and cannot have when my experience in Rhode Island leading up to this debate, the Presiding Officer's experience in Illinois leading up to this debate, Senator STABENOW's experience in Michigan leading up to this debate—all of our experience in our home States leading up to this debate—has been that the problem has been that the private for-profit insurance industry is out there denying care every chance it gets.

I think the distinguished Senator from Illinois was presiding when I told the story of a family member of mine who died recently who was diagnosed with a very serious condition. He went to the National Institutes of Health to get the best possible treatment. He got the best specialist on his particular diagnosis in the country, and when he took that back to New York, his insurance company said: I am sorry, that is not the indicated care. That is just one experience I have had. Hundreds of Rhode Islanders have been in touch with me about their nightmare stories over and over again, whether it is because you have a preexisting condition and they won't insure you; or once you get diagnosed, they won't authorize your doctor to proceed with the care you need; or even if you go ahead and get the care, they will do everything they can to avoid paying the doctor and create every kind of administrative, bureaucratic headache for the doctor. The private insurance industry is standing between you and the care you need.

I have not once—not once since I have been here—heard anybody on the other side of the aisle express any concern about the bureaucrat between you and your doctor as long as it is an insurance company bureaucrat. It seems to me they actually approve of bureaucrats getting between you and your doctor as long as it is a bureaucrat who is an insurance company bureaucrat who has a profit motive to deny you health care. Then it is OK. Then they don't complain. But when it is independent scientists working hard to generate the best science that can be done so that people get the best information to make decisions, then suddenly we hear about bureaucrats.

I think the people listening to this should have that history in mind as they evaluate this claim that we are trying to put bureaucrats between Americans and their doctors. By stripping the abuses away from the insurance company, this bill does more to relieve that problem than any other piece of legislation I can think of.

I yield to the distinguished Senator from Michigan.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. I thank my colleague from Rhode Island because I couldn't agree more with what he just said in terms of who is standing between, in this case, a woman and her doctor or any patient and their doctor.

Right now, I assume the Senator would agree with me that the first person, unfortunately, the doctor may have to call is the insurance company to see whether he can treat somebody, to see what it is going to cost, is it covered. Right now, we know that half the women in this country, in fact, postpone, delay getting the preventive care they need because they can't afford it. So the amendment from the distinguished Senator from Maryland is all about making sure women can get the preventive care we need, whether it is the mammogram, whether it is the cervical cancer screenings, whether it is focused on pregnancy.

Would the Senator from Rhode Island agree that right now in the marketplace, I understand that about 60 percent of the insurance companies in the individual market don't cover maternity care?

They don't cover prenatal care. They don't cover maternity care, labor and delivery, and health care through the first year of a child's life. That is standing between a woman, her child, and her doctor. That is the ultimate standing between a woman and her doctor, since they were not going to cover that.

I think one of the most important things we are doing in this legislation is to have as basic coverage—something as basic as maternity care. When we are 29th in the world in the number of babies that make it through the first year of life, that live through the first year of life, that is something we should all be extremely outraged about, concerned about.

This legislation is about expanding health care coverage, preventive care, making sure babies and moms can get prenatal care, that babies have every chance in the world to make it through the first year of life because we have adequate care there. Yet the ultimate standing between a woman and her doctor is the insurance company saying: We don't think maternity coverage is basic care.

Mr. WHITEHOUSE. If the Senator will yield.

Ms. STABENOW. Yes.

Mr. WHITEHOUSE. That is the business model of the private health insurance industry now. They want to cherry-pick out anybody who might be sick, and that is why we have the preexisting condition exclusion.

Then they have an absolute army of insurance company officials whose job it is to deny care. I went to the Cranston, RI, community health center a few months ago. It is a small community health center providing health care in the Cranston, RI, area. It doesn't have a great big budget. I asked them how difficult it is to deal with the insurance companies in order to get approval and get claims paid. They said: Well, Senator, 50 percent of our personnel are engaged not in providing health care but in fighting with the insurance industry to get permission for care and to get claims paid.

Ms. STABENOW. Will the Senator repeat that to me? That is astounding. He said 50 percent?

Mr. WHITEHOUSE. Yes. Half of the staff of the community health center was dedicated to fighting with the insurance industry, and the other half was actually providing the health care.

In addition, they had to have a contract for experts, consultants, to help fight against the insurance industry. That was another $200,000—$200,000 for a little community health center, plus half of their staff.

What we have seen in the past 8 years is that the administrative expense of the insurance industry has doubled. That is what they are doing. It is like an arms race. They put on more people to try to prevent you from getting care because it saves them money when they do. They have a profit motive to deny people.

In the case of a member of my family whom they tried to deny, he had the fortitude to fight back and eventually they caved. But for every person like him who fights and gets the coverage they paid for and are entitled to, some will be too ill, too frightened, too old, too weak, too confused, or some simply don't have the resources, when they are burdened with a terrible diagnosis like that, to fight on two fronts. So they give up and the insurance company makes money.

It is systematized. Not once have I heard anybody on the other side of the aisle in the Senate complain about that. It is a scandal across this country. It is the way they do business. I don't think there is a person on the Senate floor who hasn't heard a story of a friend or a loved one or somebody they know and care about who has been through that process. It is not hypothetical. It is happening now, and it is happening to all of us. But it is only when we come in and try to fight that suddenly this concern is raised, this ''oh my gosh, you are going to get bureaucrats.'' But they happen to have no

profit motive. They will work for the government and will be trying to do the right thing and be experts. But suddenly it is no good.

Ms. STABENOW. As the Senator has said eloquently, we have all had situations like this happen in our families. Everybody listening and everybody involved in the Senate family has certainly had that happen to us. I have found it very interesting; every Tuesday morning we invite people from Michigan who are in town, to come by and we do something called ''Good Morning, Michigan.''

Not long ago, a woman came in and said:

> I'm finally excited. I am 65 and now I can choose my own doctor because I am going to be on Medicare.

Medicare is a single-payer, government-run health care system. I could not get my mother's Medicare card away from her if I had to wrestle her to the ground because, in fact, it has worked. It is focused on providing health care. That is their mission.

One of the things I think is indicative of the whole for-profit health care system—by the way, we are the only ones in the world who have a for-profit health care system—is when they talk as an industry, they talk about the ''medical loss ratio.'' The medical loss ratio is how much they have to pay out on your health care. So the language of the insurance industry—now, it is different if there is a car accident or if your home is on fire. We understand you don't want to pay out for a car accident or for a home fire. But in this case, we have an institution set up, through which most of us—we have over 82 percent of us in the private for-profit insurance market through our employers. We are in a system where the provider, the insurance company, calls it a ''medical loss'' if they have to pay out on your insurance. I think that alone is something that, to me, sends a very big red flag, if they are trying to keep their medical loss ratio down.

We have in this legislation been doing things to keep that up. We want them to be paying out for most of the dollars paid on a premium in health care so the people are getting the health care they are paying for. That is what this legislation is all about. But as my friend from Rhode Island has indicated, point by point, when we look at every amendment in the Finance Committee—I would say virtually every amendment from our colleagues on the Republican side—and when we look at the amendments so far on the floor of the Senate, the first two being offered are about protecting the for-profit insurance companies, making sure excessive payments that are currently going out for for-profit companies under Medicare continue; making sure we are protecting the industry's ability—not the doctor's ability to decide what care you need, when you need it, and so on, but the insurance company's ability to decide what they will pay for, what is covered, when you will get it—and, by the way, if you get too sick, they will find a technicality and they will drop you.

All of those things we are addressing are to protect patients, protect taxpayers, consumers, in this legislation. Would the Senator not agree?

Mr. WHITEHOUSE. I do.

Ms. STABENOW. The sign behind the Senator is right. It is about saving lives, money, and Medicare.

Mr. WHITEHOUSE. As the Senator noted, there is an astonishing similarity between the interests of the private health insurance industry and the arguments made by our friends on the other side on the floor. It is amazing. They are identical, virtually, to one another. I have yet to hear an argument about health care coming from the other side of the aisle that does not reflect the interests and the welfare of the private insurance industry, about which for years I never heard them complain while they were denying care.

We have another example beyond Medicare. I am struck that today is the first day since the President's speech in which he announced another 30,000 men and women will be going over to Afghanistan in addition to the ones there. All of us in the Senate and in America are proud of our soldiers. We wish them well. Those of us who have visited Afghanistan know how challenging an environment it is and how difficult it is to be away from one's family. There can be no doubt in our minds that we want the best for our men and women in the service. Everybody agrees we want the best for them. Our friends on the other side also want the best for them.

When we give them health care, what do we give them that we think is the best? We give them government health care through TRICARE and through the Veterans' Administration. I have not heard a lot of complaining about that, about stripping our veterans out of the Veterans' Administration and letting them go to the tender mercies of the private health insurance industry because when there is not an issue that involves the essential interests of the private health insurance industry, then they will do the right thing and recognize that is best for our service men and women. That is best for our veterans and, of course, we all support that. It makes perfect sense. It belies the arguments we are hearing today.

Ms. STABENOW. I totally agree with the Senator. I thank him for his comments. What I find even more perplexing is that what we have on the floor is not a single-payer system, even though some of us would support that. It is not. It is, in fact, building on the private system but creating more accountability. We are not saying there would not be a private insurance industry. What we are doing is saying that small businesses and individuals who cannot find affordable insurance today should be able to pool together in a larger risk pool. That has been, in fact, a Republican and Democratic idea going back years.

We are saying if they want to be able to ask us to cover these folks, we are saying to the insurance companies they have to stop the insurance abuses. We are not saying they can't offer insurance. In fact, this is a model like the Federal employee health care model, where people who don't have insurance today can get a better deal in a group pool, like a big business and a small business and individuals will purchase from private insurance companies. Many of us believe there ought to be a public option in there as well. But we are talking about private insurance companies participating.

All we are saying is, wait a minute. If you are going to have access to the individuals that now will have the opportunity to buy insurance, we want those rates to be down, and we want them to be affordable. We want to make sure there are no preexisting conditions. We want to know that if somebody pays a premium every month, and then somebody gets sick, that they don't get dropped on some technicality. We want to make sure that women aren't charged twice as much as men, which in many cases is happening today. Sometimes there is less coverage. We want to make sure maternity care is considered basic, that women's health is considered a basic part of a health insurance policy. We are not saying we are eliminating the private sector. We are not going to the VA model or even the Medicare model.

This is reasonable, modest, and should be widely supported on a bipartisan basis. These ideas have come from both Democrats and Republicans over the years, and yet we still get arguments that are wholly and completely protecting the interests of an industry that we are, in fact, trying to engage and provide affordable health care insurance.

Mr. BAUCUS. Mr. President, who has the floor? We are all talking.

The PRESIDING OFFICER. The Senator from Montana is recognized. A colloquy was going on and it was terrific.

Mr. BAUCUS. I ask my colleagues, is it not true that basically in America, although all of America spends about $2.5 trillion on health care, basically it is 50/50. It is 41 or 42 percent public and about 60 percent private. We in America have roughly a 50–50 system today; is that right?

Ms. STABENOW. I say to our colleague that I believe that is the case. In my State, we have 60 percent in the private market through employers.

Mr. BAUCUS. This legislation before us basically retains that current division. What we are doing is coming up with uniquely American ideas. We are not Great Britain, France, or Canada. We are roughly 50–50—a little more private in fact. In 2007, it was 46 percent public and about 54 percent private. Roughly, that is where we are. It might change ever so slightly. But we are not those other countries, we are America.

This legislation before us maintains that philosophy; is that correct?

Ms. STABENOW. Absolutely. In fact, I think it invites the private sector to participate in a new marketplace.

Mr. WHITEHOUSE. If I may interject, I add that it is a relatively familiar American principle to put public and private agencies side by side in competition, in fair competition, and let the best for the consumer win. We see it in public universities. Many of us have States with public universities that we are very proud of. They compete with private universities. I think every one of us has a public university in our State, and it is a model that works very well in education. Many of us—unfortunately not in Rhode Island—have public power authorities that compete with the private power industry.

In fact, some of the most ardent opponents of a public option go home and buy their electricity from a public electric cooperative or a public power authority. We see it in workers compensation insurance. A lot of health care is delivered through workers compensation insurance.

Mr. BAUCUS. But isn't that a pretty good system—don't put too many eggs in one basket? Doesn't each keep the others on their toes a little bit?

Mr. WHITEHOUSE. I think it is the oldest principle of competition, as the distinguished chairman of the Finance Committee pointed out.

Mr. BAUCUS. Doesn't this legislation provide for more competition than currently exists?

Mr. WHITEHOUSE. I think it does.

Mr. BAUCUS. For example, with exchanges, with health insurance market reform and with the ratings reform.

Mr. WHITEHOUSE. All of those, and a public option. All of that adds to a better environment. One of the interesting things about this is you only have a good and fair market. America is founded on market principles. We all believe in market principles. One of the things about the market is that people will cheat on it if there are not rules around the market. If you don't make sure that the bread is good, honest, healthy bread, some rascal will come and will sell cheap, lousy, contaminated bread in the market. You have to have discipline and walls to protect the integrity of the market.

That is what the health insurance market has lacked. That is overdue. I think it will enliven the market in health insurance and animate the market principle.

Mr. BAUCUS. I ask my colleagues, is there anything in this legislation which will interfere with the doctor-patient relationship; that is, to date people choose their own doctors, whichever doctor they want. They can, by and large, go to the hospital they want, although the doctor may send them to another hospital. Is there anything in this legislation that diminishes that freedom of choice patients would have to choose their doctor?

Mr. WHITEHOUSE. Nothing.

Ms. STABENOW. If I may add, I think one of the most telling ways to approach that is the fact that the American Medical Association, the physicians in this country, support what we are doing. They are the last ones who would support putting somebody—somebody else, I should say, because I believe we have insurance company bureaucrats frequently between our doctors and patients—but they would not be supporting us if it were doing what we have been hearing it is doing.

Mr. BAUCUS. What about the procedures doctors might want to choose for their patients? Is there anything in this legislation which interferes with the decision a physician might make as to which procedure to prescribe, in consultation with his or her patient?

Ms. STABENOW. As a member of the Finance Committee with the distinguished chairman, we have heard nothing. We have written nothing that would in any way interfere with procedures. In fact, I believe through the fact we are making insurance more affordable, we are going to make more procedures available because more people will be able to afford to get the care they need.

Mr. WHITEHOUSE. The American Academy of Family Physicians and the American Nurses Association support this legislation because they know that instead of interfering between the doctor and the patient, we are actually lifting out the interference that presently exists at the hands of the private insurance for-profit industry between the patient and the doctor. They want to see this, and that is one of the important reasons.

Another important reason, something the distinguished chairman of the Finance Committee is very responsible for, beginning all the way back at the start of this year when the Finance Committee, under his leadership, had the ''prepare to launch'' full-day effort on delivery system reform.

What you will see is doctors empowered in new ways to provide better care, to have better information.

Mr. BAUCUS. I might ask my friend—that is very true—Could he explain maybe how doctors may be, in this legislation, empowered to have better information to help them provide even better care? What are some of the provisions?

Mr. WHITEHOUSE. There are a great number of ways and much of it is thanks to the chairman's leadership and Chairman DODD on the HELP Committee. We put together a strong package melded by Leader REID. The main ingredients are taking advantage of electronic health records so you are not running around with a paper record, you are not having to fill out that clipboard again, they are not having to do another expensive MRI because they cannot access the one you had last week. If you have drugs you are taking, the drug interactions that might harm you will be caught by the computer and signal the doctor so they can be aware of it and make a decision whether to change the medication. The electronic health record is a part of that.

Investment in quality reform is a huge issue. Hospital-acquired infections are prevalent throughout this country. They cost about $60,000 each on average. They are completely preventable. Nobody knows this better than Senator STABENOW from Michigan because it was in her home State that the Keystone Project began, which has since migrated around the country. It has gone statewide in my home State through the Rhode Island Quality Institute. It has been written up by the health care writer Dr. Atul Gawande in the New Yorker magazine. What the information from Senator STABENOW's home State of Michigan shows is that in 15 months, they saved 1,500 lives in intensive care units and over $150 million by better procedures to prevent hospital-acquired infections.

Ms. STABENOW. If I may add to that—and I thank the chairman for putting in language on the Keystone initiative in the bill—in this bill, we are, in fact, expanding what has been learned about saving lives and saving money by focusing on cutting down on infections in the intensive care units, by focusing on surgical procedures, things that actually will save dollars, don't cost a lot, and save lives. But they involve thinking a little differently, working a little bit differently as a team. Our physicians, hospitals, and nurses have found that if they made quality a priority, it became a priority.

There are so many things in this legislation that will save money, save lives, increase quality, and that is what this is all about, which is why so broadly we see the health care community, all the providers, nurses, doctors, and so on, supporting what we are doing.

Mr. BAUCUS. I think it is important not to overpromise because some of these initiatives, some of these programs will take a little time to take effect. In fact, some of the provisions do not take effect for a couple, 3 years. But still, wouldn't my colleagues agree that some of these are going to probably yield tremendous dividends in the future, especially generally the focus on quality, not outcomes, reimbursing physicians and hospitals based on quality, not outcomes, the pilot projects, the bundling, the counter care organizations and other similar efforts in this legislation. One of the two or both may want to comment on that point. I think it is a point worth making.

Mr. WHITEHOUSE. It is a very important point. Again, this is not something that emerged suddenly or overnight. The distinguished Senator from the Finance Committee has been working hard on this a long time, back even before ''prepare to launch,'' which is an early reflection of the work he has been doing.

As we look at this bill, and as people who have been watching this debate have seen, this legislation saves lives, saves money, and saves medicine. We can vouch for that through the findings of the Congressional Budget Office. But the Congressional Budget Office has been very conservative in its scoring.

Mr. BAUCUS. Very.

Mr. WHITEHOUSE. There is a letter the CBO wrote to Senator CONRAD. There is testimony and a colloquy he engaged in with me in the Budget Committee that makes clear that beyond the savings that are clear from this legislation, there is a promise of immense further savings. What he said is:

> Changes in government policy—

Such as these——

> have the potential to yield large reductions in both national health expenditures and Federal health care spending without harming health. Moreover, many experts agree on some general directions in which the government's health policies could move.

The chairman of the Finance Committee has developed those general directions through those hearings and it is now in the legislation. But the conclusion he reaches is:

> The specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning.

The MIT report that came out the other day, Professor Gerber, Dr. Gerber said the toolbox to achieve these savings through experimentation and learning is in this bill. I think his phrase was everything you could ask for is in this bill.

As the distinguished chairman of the Finance Committee knows better than I do, there are big numbers at stake here. If you look at what President Obama's Council on Economic Advisers has estimated, there is $700 billion a year—when we talk numbers, we usually multiply by 10 because it is a 10-year window. So when people say there is this much in the bill, it is over 10 years. This is 1 year, $700 billion in waste.

The New England Health Care Institute estimated $850 billion annually in excess costs and waste. The Lewin Group, which has a relatively good opinion around here, and George Bush's former Treasury Secretary, Secretary O'Neill, have estimated it is over $1 trillion a year. So whether it is $700 billion or $850 billion or $1 trillion, even if these tools in the toolbox that we will refine through learning and experimentation achieve only a third, it is $200 billion or $300 billion a year.

Mr. BAUCUS. Right. Some people are worried, perhaps, gee, there they go back there in Congress. They talk about waste—which is good; we want to get rid of waste. But then when they talk about waste, they talk about cutting out the waste, some think: Gee, if they are cutting out the waste and they are cutting health care reimbursements, gee, won't that hurt health care in America? Won't that harm health care in America? Won't that reduce quality? If they are cutting so much, $600 billion, $700 billion, $800 billion—that is a lot of money—aren't they going to start cutting quality health care in America?

I see my good friend, the chairman of the HELP Committee, on the floor. He may want to join in this discussion as well, adding different points as to why the legislation we are putting together increases quality, does not cut quality, but it increases quality at the same time it reduces waste. I wonder if my colleagues might comment on all of that because it is an extremely, I think, important point to drive home our legislation improves quality health care.

Mr. DODD. I was going to raise the point, I say to my colleague and chairman of the Finance Committee, that there are a lot of good things about our health care system. We want to start off acknowledging that our providers, doctors do a magnificent, wonderful job. But we also know the system is fundamentally broken because it is based on quantity rather than quality.

That is my question. There is a question mark at the end of it. It is my opinion that is what it is. In other words, doctors and hospitals—the system—are rewarded based on how many patients you see, how many hospital beds are filled, how many tests get done, how many screenings are provided along the way. So it is all based on quantity. The more quantity you have, the system survives. Inherent in that is the question, if that is what drives the system, only quantity, then obviously what you are going to end up doing is have a sick care system, not a health care system.

If we asked, what are you trying to do over all—to fundamentally shift from a quantity-based system to a quality-based system where we try to keep people out of doctors' offices, out of hospitals, out of situations where they need to be there. That is what we are trying to achieve. To do that, we need to incentivize the system in reverse. The incentives today are to fill all these places. We are trying to incentivize by keeping people healthier, living a better health style, stopping smoking, losing weight, eating better food—all of these things that are not only good for you but overall save money. Am I wrong?

Mr. BAUCUS. I think my colleague is exactly right. As he was speaking, I was thinking of that article a lot of us have referred to often, the June 1 New Yorker article by Atul Gawande, comparing El Paso, TX, and McAllen, TX. They are both border towns. In El Paso, health care expenditures per person are about half what they are in McAllen. And yet the outcomes in El Paso are better than they are in McAllen.

One might ask: Why in the world is that happening? Why is there twice as much spent in McAllen than El Paso and the outcomes are different? The answer is we have a system which allows the McAllens in the system, that allows payment in basic quantity and volume as opposed to quality.

I believe it depends on the community what the culture is. Some communities have a culture of patient-focused care. The current system allows that, but, unfortunately, if the culture in the community is more to make money, our reimbursement system today allows for that as well. So I think one of the things we are trying to do is to get more quality in the system—reimbursement to pay doctors and hospitals—more quality, as you have said—and that is going to even out a lot of the geographic disparities that have occurred in the country over time and so the quality will increase and the cost and the waste will decrease.

Mr. DODD. One last question I wished to raise, if I could, because our colleague from Montana said something yesterday that I think deserves being repeated, as I understood him, on the point he just made about the Gawande piece, which did that comparison between McAllen, TX, in Hidalgo County, which is the poorest county in the United States, and El Paso, and then I think you talked about Minnesota as well.

There is a fellow by the name of Don Berwick, a doctor who is an expert on integrated care, and one of the things he says—and I think you said this yesterday it deserves being repeated—it isn't just at the Cleveland Clinic or the Mayo Clinic where this happens—that kind of culture that exists at community hospitals and small hospitals all over the country where they have figured out integrated care; that is where doctors and hospitals have figured out how to provide services and reduce costs.

I have 31 hospitals in my State, and similar to all our colleagues, I have been visiting many of them and talking to people. Manchester Community Hospital is a very small hospital in Manchester, CT—a community hospital—and they have reduced costs and increased quality because they have figured out, between the provider physicians and the hospital, how to do that. My point is—and your point is—this is happening all across America in many places, and we need to be rewarding that when it occurs.

Mr. BAUCUS. There is no doubt about that. In fact, it is interesting the Senator mentioned his name because not too long ago I asked him that question. I said: Why, Dr. Berwick, is it that in some communities they get it and some they do not? His answer was that sometimes there is somebody—maybe it is a hospital or someone who is a pretty dominant player—who kind of starts it out and gets it right, and that is true.

He invited 10 integrated systems to Washington, DC, to kind of talk over what works and what doesn't work.

These are not the big-named institutions; they are the lesser named institutions. In fact, one of them I can probably say is the Billings Clinic, in Billings, MT—not too widely known, but they participated last year—the same process and integration with the docs, the acute care, and the postacute care. They have significantly cut costs, they have significantly improved the quality, and they are very proud of what they have done.

Mr. WHITEHOUSE. May I offer a specific example from the bill as an illustration of this?

One of the very few areas in which the Congressional Budget Office is prepared to document savings from these quality improvements is in the area of hospital readmissions. The chairman of the Finance Committee worked very hard to get hospital readmission language in his bill, I think we had it in the HELP bill as well, Chairman DODD, and it is in the bill Leader REID put together. What it does is it strips, over 10 years, $7 billion—I think is the number—$7 billion of money that hospitals would otherwise be paid when somebody gets out of the hospital and is readmitted within 30 days for the same condition.

The reason they are willing to apply those savings is because now you can demonstrate that if you have better prerelease planning, then people will go out and they will do better on their own. They will do better at home or they will do better in a nursing home, and therefore they will not come back. So you save lives because the health care is better, and you save money because they do not come back to the hospital. You improve on the front end. The hospital will do that. They will invest and improve on the front end because they don't want to pay on the back end if they are not recovering their costs with the readmission. It is a win-win for everyone. The individual American who has to be readmitted to the hospital and undergo, once again, all the procedures and all the risks that being in a hospital entails because he or she didn't get a proper discharge plan is not helped out by having to go back to the hospital.

Mr. BAUCUS. I have very direct experience in this. My mother was in the hospital 3 years ago—in another hospital, not the Billings Clinic—and there was no discharge plan. There was no way to help deliver health care for her when she left the hospital and went into a rehab center—sort of a nursing home. Sure enough, she didn't get the proper meds, she didn't get the proper attention, the doctor did not see her every day or after that, and, lo and behold, she had to be readmitted to the hospital. She had a gastrointestinal issue, and, sure enough, they took care of her back in the hospital. But once she was discharged, they did it right. They improved upon the mistakes they had made.

So I saw it firsthand, and it irritated the dickens out of me, frankly, in seeing how they did not pay sufficient attention to my mother. If this happens to my mother, my gosh, I bet it is even worse in lots of other situations.

Mr. DODD. If my colleagues will yield, I wished to thank Senator WHITEHOUSE, who was on our committee for the duration of our markup and he did a stunning job. He was a very valuable member of the committee and he made some wonderful suggestions to our bill all the way through the process.

I was told the other night by a friend of mine—Jack Conners, who is very involved in Boston and sits on the board and chairs the board of the hospitals in Boston—I think my colleague from Rhode Island may recognize the name—the average elderly person discharged from the hospital gets, on average, four medications—on average. Within 1 month, that individual, in most cases living alone, maybe with someone else, but on in years and so less capable of understanding it all, is basically not taking the four medications—or only taking parts of them—and finding themselves right back in the hospital as a readmission.

In our bill, we do a little bit to address that, and I think there is some effort in the Finance Committee bill through telemedicine—there are ways now through technology to provide some advice. This might not be a bad idea in terms of employment issues. It wouldn't take much to train people to be a home health care provider and to stop in. Your mother was in a nursing home, but most people end up in their apartment.

Mr. BAUCUS. Well, she is now home and getting great attention. I made sure of that.

Mr. DODD. We could help people who are being discharged, and the savings, by employing some people to do it, I think, would vastly be less than the cost of sending them back to the hospital.

Mr. BAUCUS. An example of that. I was talking to the head of Denver Health. It is an integrated system. I have forgotten the name, but she was so enthusiastic about the integration she performed with Denver Health. I will give you one small example, and it is one you just mentioned. She said: We have patients here—heart patients—and when they are discharged we ask them: Are you taking your meds? Are you controlling your blood pressure? Are you taking your medication to control your blood pressure?

They say: Oh, yeah, yeah, yeah, I am taking my meds.

She says: Well, why is your blood pressure so high?

The response is: Well, I, I, I. Because they are integrated, they check with their pharmacy, which is part of their system, to check the refill rate of the patients. Sure enough, they find their patient's refill history shows they were not taking their meds. So they get the patients back and they say: You are not taking your meds.

They say: Oh, I guess I wasn't.

They tell them: We are checking on you.

So, sure enough, they take their meds, and they have a much better outcome, generally, with their cardio patients because of that integration.

Mr. DODD. It works.

Mr. WHITEHOUSE. Part of what the distinguished chairman worked so hard on was to put in place the program so we will be able to begin to reimburse doctors for those kinds of discussions.

Mr. BAUCUS. Absolutely.

Mr. WHITEHOUSE. Right now, our payment system is driving them away from having that kind of simple discussion. It doesn't always support the electronic prescribing that would let you know they are not picking up their meds. But President Obama did a great job on that, with the electronic health record funding he put through.

But this question of doing what you are paid to do, if all you are paid for are procedures, then the hospital doing the discharge summary, if they couldn't get paid for that, but they did get paid when the person came back and was readmitted and maybe $40,000, $50,000 a day, it doesn't take too long to figure out where their effort is going to be. It is not going to be in those areas that save money for the system but hurt them financially because we have set up the payment system with all these perverse incentives.

Mr. BAUCUS. I don't know how much longer my colleague wanted to speak, but some time ago I know Senator HATCH wanted to speak at 5 o'clock, so I am trying to be traffic cop here.

Mr. DODD. If I could, Mr. Chairman, make the case—because I think it needs to be said and, unfortunately, over, over, and over again—because it is argued on the other side that we are cutting back on providers of the hospitals, for instance. That is accurate. We are doing that. If that is all we were doing, the complaint would have great legitimacy. But what we have done in this bill is to try to create a justification for that and provide the resources that make those savings reasonable. If you are having fewer readmissions in a hospital, which the hospitals support, if you are doing the kinds of things we are talking about to keep people healthy so they do not go back in, then these numbers become realistic numbers.

It is not just saying we are cutting out funding. We are improving systems in bill. People pick up the bill all the time and say: Look at all the pages. It is because a lot of thought has gone into this to do exactly what Senator WHITEHOUSE and the chairman of the committee talked about all day yesterday. This isn't just a bunch of language here. It goes to the heart of this and how we intend to accommodate the interests of the individual by improving their quality and simultaneously reducing the cost.

Everyone has made those claims that is what we need to do—increase quality, reduce cost, increase access. So

you can't just say it and not explain how you do it. What we have done in our bill is explain how we do that, how we increase access, how we improve quality for the individual and institutions and simultaneously bring down cost. That is what we spent the last year working on, to achieve exactly what is in these pages that people weigh and pick up all the time. If they would look into them, they would see the kind of achievements we have reached.

Those achievements have been recognized by the most important organizations affecting older Americans—AARP and the Commission to Preserve Social Security and Medicare. They have examined this. These are not friends of ours. These are people who objectively analyze what we are doing, and it is their analysis, their conclusion, reached independently, along with many others, that we have been able to reduce these costs, these savings, in this bill and simultaneously increase access and improve quality.

That has been the goal we have all talked about for years. This bill comes as close to achieving the reality of those three missions than has ever been done by this Congress, or any Congress for that matter. So when people talk about these cuts in Medicare, they need to be honest enough for people to realize what we have done is to stabilize Medicare, extend its solvency, and guarantee those benefits to people who rely on Medicare. That has all been achieved in this bill.

So when people start with these scare tactics and language to the contrary, listen to those organizations who don't bring any political brief to this, who don't have an R or a D at the end of their names. Their organizations are designed, supported, financed by, and applauded by the very individuals who count on having a solid, sound Medicare system. These organizations unanimously—unanimously—have said that guaranteed benefits in this bill remain intact. We stabilize Medicare, and we provide the kind of programs that will save lives and increase the quality of life for people. It is not only about staying alive but the quality of life and being able to live a quality life, independently, for as many years as possible.

At the end of the day, we all die one at a time in this country. No matter what else we do, that is the final analysis. But to the extent you can extend life and improve the quality of life and save the kind of money we ought to, that is the goal of this bill, and we largely achieve it.

I applaud, again, the Finance Committee, and the chairman, Max Baucus, who helped us get through and navigate these very difficult waters, and I thank our colleague from Rhode Island for his articulating these issues as well as his contributions during the HELP Committee proceedings on this bill. He brought many sound and very positive ideas to the table.

I wish to take a minute or two as well, if I could, to respond to our colleague and friend from New Hampshire, who, at some length, talked about his problems with what we call the CLASS Act that was part of our HELP Committee bill. I wish to briefly address those comments.

The CLASS Act was an issue Senator Kennedy championed for many years—the idea of providing an independent, privately funded source of assistance to people who become disabled but who want to continue working and earn a salary; who do not want to be limited by the constraints of a Medicaid system, which is very undesirable. Not a nickel of public moneys are used. Individuals make the contribution. If it vests for 5 years, and if you are faced with those kinds of disability issues, you can then collect approximately $75 per day to provide for your needs—maybe a driver, maybe someone providing meals—but you then have the opportunity to continue working as an individual, without any limitations on what you can make or earn.

Again, no public money is involved. It builds up. Thanks to JUDD GREGG in our committee it is actuarially sound. He offered an amendment which insisted on the actuarial soundness of this program. The CLASS Act assists individuals who need long-term services and supports with such things as: assisted transportation, in-home meals, help with household chores, professional help getting ready for work, adult day care, and professional personal care. It also saves about $2 billion in Medicaid savings. There are very few provisions which almost instantaneously do that.

Again, these dollars have to remain for just this purpose. You cannot raid this fund for any other purpose—which was a concern legitimately raised by some, that this $75 billion may be used for other purposes. We have attempted to write into this legislation prohibitions to keep these moneys from being offered for any other purpose.

In fact, Senator GREGG, when he offered his amendment, said:

> I offered an amendment, which was ultimately accepted, that would require the CLASS Act premiums be based on a 75-year actuarial analysis of the program's costs. My amendment ensures that instead of promising more than we can deliver, the program will be fiscally solvent and we won't be passing the buck—or really passing the debt—to future generations. I'm pleased the HELP Committee unanimously accepted this amendment.

Which we did. I hear some of my colleagues say this bill did not have anything but technical amendments of the 161 Republican amendments I took during committee markup—this was one of the amendments, Senator GREGG's amendment, which we accepted unanimously. My colleague from Utah was of course a member of the committee. He diligently paid attention to every amendment that was offered and I know remembers as we adopted one of his amendments dealing with biologics in the committee that Senator Kennedy strongly supported in conjunction with Senator HATCH. But this CLASS Act is a unique and creative idea. We thank our colleague from Massachusetts, no longer with us, for coming up with and conceptualizing this idea that individuals, with their own money, contributing to a fund, could eventually draw down to provide these benefits should they become disabled. Individuals often want to continue working and being self-sufficient without getting into Medicaid, which limits your income, restrains you entirely.

Here is a totally privately funded program, no public money, just what you are willing to contribute over a period of years to protect against that eventuality that you might become disabled, so you can continue to function.

I have one case here, Sara Baker, a 33-year-old woman in my home State of Connecticut living in Norwalk. Two years ago Sara's mother, who was only 57 years old at the time, suddenly suffered a massive stroke. The stroke left the right side of her body completely paralyzed. She lost 100 percent of her speech. Sara recalls that fateful day when she got the call. I will quote her:

> I was living out west in Arizona—working, dating—living and loving my life. Then . . . I got the phone call. . . . In seconds, literally, my entire world fell apart. I swear I can still feel that feeling through my whole body when I think about it. So there I was in a state of complete and total lunacy, getting on a plane with one suitcase—home to Connecticut. Guess what? I never went back.

Sara's mother was transferred to a rehab hospital. Sara went to the hospital every single day for 2 months to be at her mother's side as she went through therapy. Sara's mother had worked as an RN for 17 years. Her mom and the hospital social worker both agreed, her health insurance was ''as good as they come.''

However, when it comes to long-term care, they don't come as good. Her mother was abruptly discharged from the rehab hospital after 60 days, when her insurance company decided she had made enough ''progress.''

Sara went 9 months without working, dipped into what savings she had, and then went into debt to provide the long-term services and supports her mother needed.

As she recalled, and I will quote her again:

> I made the whole house wheelchair accessible. I became a team of doctors, nurses, aides, and a homemaker. I helped her shower, get dressed, cut food, gave medicine, took her blood pressure. . . . What would have happened if I wasn't there? Basically, one of two things—I could have hired someone to come to the house, all out of pocket of course, or the State could have depleted her assets—her home, savings, everything—and she would have been put in a nursing home funded by Medicaid.

Stories like Sara's are not the exception, unfortunately. They happen every minute of every day, all across our country. They are common in my State

as well as any other State in the Nation. At any moment any one of us or someone we love can become disabled and need long-term services.

We also have an aging population. In my home State of Connecticut, the number of individuals 85 and over, the population most likely to need long-term care, will grow by more than 70 percent in the next 20 years.

Families such as Sara's are doing the right thing. They take care of each other, as most people understand we all would try and do. They do whatever they have to do. But the cost of long-term care can be devastating on middle-class working families. While 46 million Americans lack health insurance, more than 200 million lack any protection against the costs of long-term care. The CLASS Act will help fill that gap. It doesn't solve it all. It helps fill a gap. It is an essential part of health care reform. The CLASS Act will establish a voluntary—purely voluntary, there are no mandates on employers, no mandates on employees, no mandates on anyone—national insurance program.

If you decide, only you decide, voluntarily to contribute and participate in this, it happens. It is a long-term care insurance program financed by premium payments collected through payroll at the request of the individual, not a mandate on the employer. When individuals develop functional limitations, such as Sarah's mother, they can receive a cash benefit in the range of $75 a day, which comes to over $27,000 a year.

It is not intended to cover all the costs of long-term care but it could help many families like Sarah's. It could pay for respite care, allowing family caregivers to maintain employment. It could pay for home modifications. It could pay for assistive devices and equipment. It could pay for personal assistance services—allowing individuals with disabilities to maintain their independence, and community participation. It could allow individuals to stay in their homes versus having to go to a nursing home. It would prevent individuals from having to impoverish themselves by selling off everything they have, to then go through that title XIX window and become Medicaid recipients and then be constrained on what they could possibly earn.

Think about what if this young woman Sara had a family living out West, her own children instead of being single, how would she have done that? How would she have been able to pack up a whole family and move from the West to the East to take care of her mother in those days? Many families face these issues every day.

So while this proposal is not going to solve every problem, it is a very creative, innovative idea that does not involve a nickel of public money, not a nickel. It is all voluntary, depends upon the individual willing to make that contribution, to provide that level of assistance, Lord forbid they should end up in a situation where they find themselves disabled and need some long-term services to allow them to survive and be part of their community life, including going back to work, without impoverishing themselves, selling off everything they have in order to make themselves qualified for Medicaid assistance.

I applaud my colleague from Massachusetts. There are a lot of great things he did over the years. He was a champion of so much when it came to working families and their needs in health care. But this idea, the Kennedy idea of the CLASS Act, is one that has a wonderful legacy to it. It is the heart of this bill. It has been endorsed and supported by over 275 major organizations in the country. I have never seen a proposal such as this receive a level of support across the spectrum that the CLASS Act is getting.

I know there will be those who try to take this out of the bill. I will stand here hour after hour and defend this very creative, innovative idea that can make a difference in the lives of millions of our fellow citizens, not only today but for years to come.

I again thank Senator Kennedy and his remarkable staff who did such a wonderful job on this as well, and I thank Senator GREGG, even though he is critical of the program. Senator GREGG's ideas were adopted unanimously in our markup of the bill and provided the actuarial soundness of this proposal for a long 75 years to come. For that we are grateful to him, for offering those amendments which were adopted by every Republican and every Democrat on the committee at the time of our markup last summer.

I see my colleague from Utah, and I have great respect for my friend from Utah. He and I have worked on so many issues together. Either he would get me in trouble politically or I would get him in trouble politically when we went to work on things. The very first major piece of legislation I ever worked on in the Chamber was to establish some Federal support for families who needed it for childcare. It was a long, drawn-out battle, but the person who stood with me almost a quarter of a century ago to make that happen—and today it has almost become commonplace for people to get that kind of assistance—but as long as I live, I will never forget I had a partner named ORRIN HATCH who made that possible. Whatever differences we have—and that is not the only thing we have worked on together, but it was the very first thing I worked on and he joined me in that effort—it became the law of the land and today millions of families manage to navigate that difficult time of making sure their families are going to get proper care and attention while they go out and work hard and try to provide for them as well. I thank him for that and many other things as well.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I thank my colleague. There is no question he is a great Senator. I have always enjoyed working with him and we have done an awful lot together. I want to compliment Senator WHITEHOUSE too, a terrific human being and great addition to this Senate and I have a lot of respect for him. He gives me heartburn from time to time, as does Senator DODD. On the other hand, they are great people and very sincere. Our chairman of the committee, Max Baucus, is a wonderful man. He is trying to do the best he can under the circumstances. I applaud him for it. Senator STABENOW from Michigan and I have not seen eye to eye on a lot of things, but we always enjoy being around each other.

This is a great place, there is no question about it. We have great people here. But that doesn't make us any less unhappy about what we consider to be an awful bill.

But right now, today, let me talk about a few specific things. Today the senior Senator from Illinois came to the floor and spoke about my efforts to reduce the costs associated with medical malpractice liability. I don't think his statement should go unanswered. Not only were a number of his statements simply incorrect as factual matters, but some of them even bordered on being offensive. I am not offended, I can live with it, I can take criticism, but some of them I think were a little bit over the top.

First of all, he referred to the recent letter I received from the CBO which indicated that the government would realize significant savings by enacting some simple tort reform measures. I don't know anybody in America who has any brains who doesn't realize we have to do something about tort reform when it comes to health care. According to the CBO, these measures would reduce the deficit by $54 billion over 10 years. That is a lot of money. Private sector savings would be even more significant. According to the CBO, we would likely see a reduction of roughly $125 billion in private health care spending over the same 10-year period, and that, in my view, is a low estimate. Democrats apparently want the American people to think these numbers are so insignificant that this issue should be ignored in this health care bill, and I have to respectfully disagree.

I may be one of the few Senators in this body who actually tried medical malpractice cases. I actually defended them. I defended doctors, hospitals, nurses, health care practitioners. I understand them.

There are cases where there should be huge recoveries. I would be the first to admit it. I saw the wrong eye taken out, the wrong leg taken off, the wrong kidney. You only have two of each of those. You bet your bottom dollar we settled those for significant amounts of money. But I also saw that the vast majority of the cases were frivolous,

brought to get the defense costs which then only ranged from $50,000 to $200,000, depending on the jurisdiction. If a lawyer can get a number of those cases they can make a pretty good living by bringing those cases just to get the defense costs, which of course adds to all the costs of health care. There is no use kidding about it.

Furthermore, Senator DURBIN, the distinguished Senator from Illinois, cited the same CBO letter in order to claim that the tort reform measures supported by many on my side of the aisle would cause more people to die.

Give me a break.

I can only assume he is referring to the one paragraph in the CBO letter that addresses the effect of tort reform on health outcomes. In that single paragraph the CBO referred to three studies. One of these studies indicated that a reduction in malpractice lawsuits would lead to an increase in mortality rates—one of the three.

The other two studies cited by the CBO found that there would be no effects on health outcomes and no negative effects could be expected. So, let's be clear, the CBO did not reach a conclusion in this case. These studies were cited only to show that there is disagreement in this area and, once again, the majority of the studies cited said there would be no negative effects on health outcomes. Apparently, omitting data and studies that disagree with your conclusions is becoming common practice among policy makers these days.

In his speech earlier today, the distinguished Senator from Illinois also discounted the prominence of defensive medicine in our health care system, saying only that ''some doctors'' perform unnecessary and inappropriate procedures in order to avoid lawsuits. Once again, the facts would contradict this generalization. A number of studies demonstrate this. For example, a 2005 study of 800 Pennsylvania physicians—where I used to practice law—in high-risk specialties found that 93 percent of these physicians had practiced some form of defensive medicine. That was published in the Journal of the American Medical Association, June 1, 2005.

In addition, a 2002 nationwide survey of 300 physicians—this is the Harris Interactive ''Fear of Litigation Study''—found that 79 percent of physicians ordered more tests than are necessary. Think about that. If 79 percent are ordering more tests than are necessary, you can imagine the multibillions of dollars in unnecessary defensive medicine that comes from that. But that is not the end of that ''Fear of Litigation Study.'' Seventy-four percent of physicians referred patients to specialists who, in their judgment, did not need any such referral. Think about it—referring people to specialists that they knew they didn't need. Think of the cost, the billions of dollars in cost. Fifty-two percent of physicians suggested unnecessary invasive procedures. The word ''invasive'' is an important word. Fifty-two percent. Why? Because they are trying to protect themselves by making sure that everything could possibly be done. Forty-one percent of physicians prescribed unnecessary medications. This is a nationwide survey of 300 physicians.

The costs associated with defensive medicine are real—I would say unnecessary defensive medicine because I believe there are some defensive medicine approaches that we would want the doctors to do but not to the extent of these doctors ordering more tests than are necessary, ordering more specialists than are necessary, suggesting unnecessary invasive procedures, unnecessary medications. This is the medical profession itself that admits this.

In another study Pricewaterhouse found that defensive medicine accounts for approximately $210 billion every year or 10 percent of the total U.S. health care cost. Here are some more facts from the Pricewaterhouse study. Of the $2.2 trillion spent every year on health care in the United States, as much as $1.2 trillion can be attributed to wasteful spending—$1.2 trillion of $2.2 trillion. Yet, the Democrats want to deny that unnecessary defensive medicine is being utilized to a significant extent. According to this study, defensive medicine is the largest single area of waste in the health care system. It is on par with inefficient claim processing and care spent on preventable conditions.

Yet, despite these overwhelming numbers—and I know some Democrats will say that is Pricewaterhouse and they must have been doing it at the expense of somebody who had an interest. Pricewaterhouse and other accounting firms generally try to get it right. They got it right here. Those of us who were in that business can attest to it.

Yet, despite these overwhelming numbers, my friends on the other side have opted to overlook them and instead relate horrific stories associated with doctors' malpractice, apparently trying to imply that Republicans simply don't care about these truly tragic occurrences. However, nothing could be further from the truth. In fact, in all the proposals that have been offered during this debate, there has not been a single suggestion to prevent plaintiffs from obtaining the compensation for actual losses they have incurred, not one suggestion that they should. Instead, we have sought to impose some limits on the noneconomic damages. All economic damages damages awarded for actual loss, past, present, and future—are fine, fair game. We've sought only impose some limits on the noneconomic damages in order to define the playing field, encourage settlement, and introduce some level of predictability to the system.

It is no secret that personal injury lawyers—some of them—are prolific political contributors to those politicians who fight against tort reform. With a Democratic majority and a Democrat in the White House, their lobbying efforts during this Congress have reached unprecedented levels. Given this reality, it is obvious why trial lawyers have not been asked to give up anything in the current health care legislation.

Supporters of this health care bill will be asking the American people to pay higher health care premiums, for seniors to give up Medicare Advantage, which 25 percent of them have enlisted in, for businesses to pay higher taxes, for medical device manufacturers to pay more just to bring a device to the market that may save lives or make lives more worth living. The only group that has not been asked to sacrifice or change the way they do business happens to be the medical liability personal injury lawyers.

I would hope we would focus our efforts more on helping the American people than on preserving a fund-raising stream for politicians. Sadly, that doesn't appear to be happening in the current debate.

As I said, there are some very honest and decent attorneys out there who bring cases that are legitimate where there should be high rewards. But the vast majority, I can personally testify, are less than legitimate and the resulting costs are costing every American citizen an arm and a leg. It is something we ought to resolve. We ought to resolve it in a way that takes care of those who truly have injuries and get rid of these frivolous cases driving up the cost for every American.

Not too long ago, I talked to one of the leading heart specialists in Washington. He acknowledged, we all order a lot of tests and so forth that we don't need, that we know we don't need. But we do it so that the history we have of the patient shows we did everything possible to rule out everything that possibly could occur, even though we know we don't need to do it. To be honest, under the current system of lawsuits, I don't blame them. They are trying to protect themselves.

We should also discuss the shortage of doctors we have going into high-risk specialties. We have areas in this country where you can't get obstetricians and gynecologists to the people. Law schools will tell you, at least the ones I know, that there aren't that many young people going into obstetrics and gynecology today because they may not make as much money and the high cost of medical liability insurance is so high that they really can't afford to do it. And, of course, they don't want to get sued.

So much for that. I love my distinguished friend from Illinois, and he knows it. I care for him. But let me tell you, I think he knows better. He knows that I know better. I would be the first to come to bat for somebody who was truly injured because of the negligence of a physician. I don't have any problem with that at all.

I just thought I would make a few comments about this but, again, say

that I understand some of the excesses that go on on the floor. But that was an excess this morning, even though I know my dear friend is sincere and dedicated and one of the better lawyers in this body. Having said that, I will end on that particular subject.

Let me once again take a few minutes to talk about the Medicare provisions in this Democratic Party health care bill.

Throughout the health care debate, we have heard the President pledge not to ''mess'' with Medicare. Unfortunately, that is not the case with the bill before the Senate. To be clear, the Reid bill reduces Medicare by $465 billion to fund a new government program. Unfortunately, seniors and the disabled in the United States are the ones who suffer the consequences as a result of these reductions. Everyone knows Medicare is extremely important to 43 million seniors and disabled Americans covered by the Medicare Program.

Throughout my Senate service, I have fought to preserve and protect Medicare for both beneficiaries and providers. Medicare is already in trouble today. The program faces tremendous challenges in the very near future. The Medicare trust fund will be insolvent by 2017, and the program has more than $37 trillion in unfunded liabilities. This is going to be saddled onto our children and grandchildren.

The Reid bill will make the situation much worse. Why is that the case? Again, the Reid bill cuts Medicare to fund the creation of a new government entitlement program. More specifically, the Reid bill will cut nearly $135 billion from hospitals—where are they going to get this money?—$120 billion from Medicare Advantage, almost $15 billion from nursing homes, more than $40 billion from home health care agencies, and close to $8 billion from hospice providers. These cuts will threaten beneficiary access to care as Medicare providers find it more and more challenging to provide health services to Medicare patients. Many doctors are not taking Medicare patients now because of low reimbursement rates.

Let me stress to my colleagues that cutting Medicare to pay for a new government entitlement program is irresponsible. Any reductions to Medicare should be used to preserve the program, not to create a new government bureaucracy.

As I just said, the President has consistently pledged: We are not going to mess with Medicare. Once again, this is another example of a straightforward pledge that has been broken over the last 11 months. Maybe you cannot blame the President because he is not sitting in this body. The body is breaking it.

This bill strips more than $120 billion out of the Medicare Advantage Program that currently covers 10.6 million seniors or almost one out of four seniors in the Medicare Program. According to the Congressional Budget Office, under this bill the value of the so-called ''additional benefits,'' such as vision care and dental care, will decline from $135 to $42 by 2019. That is a reduction of more than 70 percent in benefits. You heard me right: 70 percent.

During the Finance Committee's consideration of health care reform, I offered an amendment to protect these benefits for our seniors, many of whom are low-income Americans and reside in rural States and rural areas. However, the majority party would not support this important amendment. The majority chose to skirt the President's pledge about no reduction in Medicare benefits for our seniors by characterizing the benefits being lost—vision care, dental care, and reduced hospital deductibles—as ''extra benefits.''

Let me make the point as clearly as I can. When we promise American seniors we will not reduce their benefits, let's be honest about that promise. So we are either going to protect benefits or not. It is that simple. Under this bill, if you are a senior who enjoys Medicare Advantage, the unfortunate answer is, no, they are not going to protect your benefits.

All day today, we had Members on the other side of the aisle claim that Medicare Advantage is not part of Medicare. This is absolutely—I have to tell you, it is absolutely unbelievable. I would invite every Member making this claim to turn to page 50 of the ''2010 Medicare and You Handbook.'' It says:

> A Medicare Advantage is another health coverage choice you may have—

Get these words—

> as part of Medicare.

Let me repeat that:

> A Medicare Advantage is another health coverage choice you may have as part of Medicare.

Hey, that is the Medicare ''2010 Medicare and You Handbook.'' Who is kidding whom about it not being part of Medicare?

So the bottom line is simple: If you are cutting Medicare Advantage benefits, you are cutting Medicare.

I also heard the distinguished Senator from Connecticut this morning mention that the bureaucrat-controlled Medicare Commission will not cut benefits in Part A and Part B. Well, once again, my friends on the other side are only telling you half the story. So much for transparency. On page 1,005 of this bill, it states in plain English:

> Include recommendations to reduce Medicare payments under C and D.

I am just waiting for Members on the other side of the aisle to come down and now claim that Part D is also not a part of Medicare. We all know it is.

It is also important to note that the Director of the nonpartisan Congressional Budget Office has told us in clear terms that this unfettered authority given to the Medicare Commission would result in higher premiums.

It is important details such as these that the majority does not want us to discuss and debate in full view of the American people. They call it slow-walking. They call it obstructionism. Making sure we take enough time to discuss a 2,074-page bill that will affect every American life and every American business is the sacred duty of every Senator in this Chamber. We will take as long as it takes to fully discuss this bill, and you can talk for a month about various parts of this bill that are outrageous and some that are really good, too, in all fairness—not many, however.

I have heard several Members from the other side of the aisle characterize the Medicare Advantage Program as a giveaway to the insurance industry. You know, when you cannot win an argument, you start blaming somebody else. So they want a government insurance company to take the place of the insurance industry. Well, maybe that is too much. They want it to compete with the insurance industry. But how do you compete with a government-sponsored entity? And there are comments that the so-called government plan will cost more than the current insurance businesses they are so criticizing. I am not happy with the insurance industry either, but, by gosh, let's be fair.

Let me give everyone watching at home a little history lesson on the creation of Medicare Advantage. I served as a member of the House-Senate conference committee which wrote the Medicare Modernization Act of 2003. The distinguished Senator from Montana would agree with me, it was months of hard, slogging work every day to try to come up with the Medicare Modernization Act of 2003. Among other things, this law created the Medicare Advantage Program. It gives people vision care, dental care, et cetera.

When conference committee members were negotiating the conference report back then, in 2003, several of us insisted that the Medicare Advantage Program was necessary in order to provide health care coverage choices to Medicare beneficiaries. At that time, there were many parts of the country where Medicare beneficiaries did not have adequate choices in coverage. In fact, the only choice offered to them was traditional fee-for-service Medicare, a one-size-fits-all, government-run health program.

By creating the Medicare Advantage Program, we were providing beneficiaries with choice in coverage and then empowering them to make their own health care decisions as opposed to the Federal Government making them for them. Today, every Medicare beneficiary may choose from several health plans.

We learned our lessons from Medicare+Choice, which was in effect at the time, and its predecessors. These plans collapsed, especially in rural areas, because Washington decided—

again, government got involved—to set artificially low payment rates. In fact, in my home State of Utah, all of the Medicare+Choice plans eventually ceased operations because they were all operating in the red. You cannot continue to do that. It was really stupid what we were expecting them to do. I fear history could repeat itself if we are not careful.

During the Medicare Modernization Act conference, we fixed the problem. We increased reimbursement rates so all Medicare beneficiaries, regardless of where they lived—be it Fillmore, UT, or New York City—had choice in coverage. Again, we did not want beneficiaries stuck with a one-size-fits-all, Washington-run government plan.

There were both Democrats and Republicans on that committee, by the way, and the leader was, of course, the distinguished Senator from Montana. I admire him for the way he led it, and I admire him for trying to present what I think is the most untenable case here on the floor during this debate. He is a loyal Democrat. He is doing the best he can, and he deserves a lot of credit for sitting through all those meetings and all of that markup and everything else and sitting day-in and day-out on the floor here.

Today, Medicare Advantage works. Every Medicare beneficiary has access to a Medicare Advantage plan, if they so choose, and close to 90 percent of Medicare beneficiaries participating in the program are satisfied with their health coverage. But that can all change should this health care reform legislation currently being considered become law.

In States such as Utah, Idaho, Colorado, New Mexico—just to mention some Western States—Wyoming, Montana—you can name every State—rural America was not well served, and we did Medicare Advantage.

Choice in coverage has made a difference in the lives of more than 10 million Americans nationwide—almost 11 million Americans. The so-called ''extra benefits'' I mentioned earlier are being portrayed as gym memberships as opposed to lower premiums, copayments, and deductibles.

To be clear, the Silver Sneakers Program is one that has made a difference in the lives of many seniors because it encourages them to get out of their homes and remain active. It is prevention at its best. It has been helpful to those with serious weight issues, and it has been invaluable to women suffering from osteoporosis and joint problems. In fact, I have received several hundred letters telling me how much Medicare Advantage beneficiaries appreciate this program. They benefit from it. Their lives are better. They use health care less. They do not milk the system. They basically have a better chance of living and living in greater health.

Throughout these debates, throughout these markups, throughout these hearings that have led us to this point, every health care bill I know of has a prevention and wellness section in the bill that will encourage things such as the Silver Sneakers Program that has benefited senior citizens so much and was not one of the major costs of Medicare Advantage.

Additionally, these beneficiaries receive other services such as coordinated chronic care management, which is important, coordinated chronic care management for seniors; dental coverage—really important for low-income seniors; vision care—can you imagine how important that is to people over 60 years of age? How about those who are over 70 or 80 years of age? And hearing aids—can you imagine how important that is to our senior citizens? This program helps these seniors, and it helps them the right way.

Let me read some letters from my constituents. These are real lives being affected by the cuts contemplated in the bill.

Remember, there is almost $500 billion cut by this bill from Medicare, which goes insolvent by 2017 and has an almost $38 trillion unfunded liability.

Let me read this letter from a constituent from Layton, UT:

> I recently received my healthcare updater for 2010. I am in a Med Advantage plan with Blue Cross/Blue Shield. Thanks to the cuts in this program by Medicare, my monthly premiums have risen by 49% and my office visit co-pay has increased 150%. Senator HATCH, I am on a fixed income and this has really presented a problem for me and many others I know on the same program. And, at my age I certainly can't find a job that would help cover the gap. I worked all my life to enjoy my retirement and thanks to the current economy I've lost a lot of those monies that were intended to help supplement my income.

This letter is from a constituent from Logan, UT, where the great Utah State University is:

> Please stop the erosion of Medicare Advantage for seniors. Very many of us are already denied proper medical and dental care not to mention those who cannot afford needed medications. Hardest hit are ones on Social Security who are just over the limit for extra help but cannot keep up with the rising medical costs that go way beyond the so-called ''cost of living increases'' which we are not getting this year anyway. If those in government who make these decisions had to live as we do day to day, I think we would find better conditions for seniors. The difference in decision making changes when you are hungry and cold your own self.

Here is a constituent from Pleasant Grove, UT:

> Please do not phase out the Medicare Advantage program, senior citizens need it. Our supplement insurance rates go up every year and our income does not keep pace with the cost of living.

Here is a constituent from Salt Lake City, UT:

> We met with our insurance agent this morning about the increased costs of our Medicare Advantage plans due to the health care reform bill now before Congress.
>
> Our premium costs have already been significantly increased with the coverage substantially decreased. We are in our 80s and cannot afford these increases and are hurt by the decreased coverage. We are writing to you to have you stop the cuts and restore the coverage to Medicare Advantage plans. This is an issue that is very important and very real to us at this point in our lives. Please stop the cuts and restore coverage.

I can't support any bill that would jeopardize health care coverage for Medicare beneficiaries. I truly believe if this bill before the Senate becomes law, Medicare beneficiaries' health care coverage could be in serious trouble.

I have been in the Senate for over 30 years—33 to be exact. I pride myself on being bipartisan. I have coauthored many bipartisan health care bills since I first joined the Senate in 1977. Almost everyone in this Chamber wants a health care reform bill to be enacted this year. I don't know of anybody on either side who would not like to get a health care bill enacted.

On our side, we would like to do it in a bipartisan way, but this bill is certainly not bipartisan. It hasn't been from the beginning. We want it to be done right. History has shown that to be done right, it needs to be a bipartisan bill that passes the Senate with a minimum of 75 to 80 votes. We did it in 2003 when we considered the Medicare prescription drug legislation, and I believe we can do it again today if we have the will and if we get rid of the partisanship. I doubt there has ever been a bill of this magnitude affecting so many American lives that has passed this Chamber on an almost—or maybe in a complete—straight party-line vote. The Senate is not the House of Representatives. This body has a different constitutional mandate than the House. We are the deliberative body. We are the body that has in the past and should today be working through these difficult issues to find clear consensus. True bipartisanship is what is needed.

In the past, the Senate has approved many bipartisan health care bills that have eventually been signed into law. I know a lot of them have been mine, along with great colleagues on the other side who deserve the credit as well. The Balanced Budget Act in 1997 included the Hatch-Kennedy SCHIP program. How about the Ryan White Act. I stood right here on the Senate floor and called it the Ryan White bill. His mother was sitting in the audience at the time. How about the Orphan Drug Act. When I got here we found that there were only two or three orphan drugs being developed. These are drugs for population groups of less than 250,000 people. It is clear that the pharmaceutical companies could not afford to do the pharmaceutical work to come up with treatments or cures for orphan conditions. So we put some incentives in there; we put some tax benefits in there. We did some things that were unique. If I recall it correctly, it was about a $14 million bill.

Today we have over 300 orphan drugs, some of which have become blockbuster drugs along the line. They wouldn't have been developed if it

hadn't been for that little, tiny orphan drug bill. That was a major bill when I was chairman of the Labor and Human Resources Committee. They now call it the Health, Education, Labor, and Pensions Committee.

How about the Americans With Disabilities Act. Tom Harkin stood there, I stood here, and we passed that bill through the Senate. It wasn't easy. There were people who thought it was too much Federal Government, too much this, too much that. But Senator HARKIN and I believed—as did a lot of Democrats and a lot of Republicans, as the final vote showed—that we should take care of persons with disabilities if they would meet certain qualifications.

How about the Hatch-Waxman Act. We passed that. Henry Waxman, a dear friend of mine, one of the most liberal people in all of the House of Representatives and who is currently the very powerful chairman of the Energy and Commerce Committee over there, we got together, put aside our differences, and we came up with Hatch-Waxman which basically almost everybody admits created the modern generic drug industry.

By the way, most people will admit that bill has saved at least $10 billion to consumers and more today, by the way, every year since 1984.

I could go on and on, but let me just say I have worked hard to try and bring our sides together so we can in a bipartisan way do what is right for the American people.

Let me just tell my colleagues, if the Senate passes this bill in its current form with a razor thin margin of 60 votes, this will become one more example of the arrogance of power being exerted since the Democrats secured a 60-vote majority in the Senate and took over the House and the White House. There are essentially no checks or balances found in Washington today, just an arrogance of power, with one party ramming through unpopular and devastating proposals such as this, one after another.

Well, let me say there is a better way to handle health care reform. For months I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraint while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the basis for sustainable, fiscally responsible, and bipartisan reform.

These include:

Reforming the health insurance market for every American by making sure no American is denied coverage simply based on a preexisting condition. Some of my colleagues on the other side have tried to blast the insurance industry, saying they are an evil, powerful industry. We need to reform them, no question about it, and we can do it if we work together.

Protecting the coverage for almost 85 percent of Americans who already have coverage they like by making that coverage more affordable. This means reducing costs by rewarding quality and coordinated care, giving families more information on the cost and choices of their coverage and treatment options, and—I said it earlier—discouraging frivolous lawsuits that have permeated our society and made the lives of a high percentage of our doctors, especially in those very difficult fields of medicine, painful and those fields not very popular to go into today. And, of course, we could promote prevention and wellness measures.

We could give States flexibility to design their own unique approaches to health care reform. Utah is not New York, Colorado is not New Jersey, New York is not Utah, and New Jersey is not Colorado. Each State has its own demographics and its own needs and its own problems. Why don't we get the people who know those States best to make health care work? I know the legislators closer to the people are going to be very responsive to the people in their respective States. I admit some States might not do very well, but most of them would do much better than what we will do here with some big albatross of a bill that really does not have bipartisan support.

Actually, in talking about New York, what works in New York will most likely not work in Colorado, let alone Utah. As we move forward on health care reform, it is important to recognize that every State has its own unique mix of demographics. Each State has developed its own institutions to address its challenges, and each has its own successes. We can have 50 State laboratories determining how to do health care in this country in accordance with their own demographics, and we could learn from the States that are successful. We could learn from the States that make mistakes. We could learn from the States that cross-breed ideas. We could make insurance so that it crosses State lines.

Can you imagine what that would do to costs? We could do it. But there is no desire to do that today with this partisan bill.

There is an enormous reservoir of expertise, experience, and field-tested reform. We should take advantage of that by placing States at the center of health care reform efforts so they can use approaches that best reflect their needs and their challenges.

My home State of Utah has taken important and aggressive steps toward sustainable health care reform. They already have an exchange. They are trying some very innovative things. By anybody's measure the State of Utah has a pretty good health care system. Is it perfect? No. But we could help it to be, with a fraction of the Federal dollars that this bill is going to cost. This bill over 10 years is at least $2.5 trillion, and I bet my bottom dollar it will be over $3 trillion. That is on top of $2.4 trillion we are already spending, half of which they claim may be not well spent. We know a large percentage of that is not well spent.

Like I say, my home State of Utah has taken important and aggressive steps toward sustainable health care reform. The current efforts to introduce the defined contribution health benefits system and implement the Utah health exchange are laudable accomplishments.

A vast majority of Americans—I believe this to be really true—agree a one-size-fits-all Washington government solution is not the right approach. That is why seniors and everybody else except a very few are up in arms about these bills. That is what this bill is bound to force on us: a one-size-fits-all, Washington-run, controlled government program. I am not just talking about the government option. That is a small part of the argument today. If we pass this bill, we will have Washington governing all of our lives with regard to health care. I can't think of a worse thing to do when I look at the mess they have made with some very good programs.

Unfortunately, the path we are taking in Washington right now is to simply spend another $2.5 trillion of taxpayer money to further expand the role of the Federal Government. I just wish the majority would take a step back, keep their arrogance of power in check, and truly work on a real bipartisan bill that all of us can be proud of. They have the media with them selling this bill as less than $1 trillion. Give me a break. Between now and 2014, yes, they will charge everybody the taxes they can get and the costs they can get, but the bill isn't implemented until 2014, and even some aspects not until 2015. That is the only way, with that budgetary gimmick, they could get the costs to allegedly be down below $900 billion. But even the CBO—certainly the Senate Budget Committee—acknowledges that if you extrapolate—I think my colleagues on the other side acknowledge that if you extrapolate it out over a full 10 years, you have at least $2.5 trillion and in some circumstances as much as $3 trillion.

How can we justify that? With the problems we have today, a $12 trillion national debt, going up to $17 trillion if we do things like this? How can we justify it? How can we stick our kids and our grandkids and our great grandkids—my wife and I have all three, by the way, kids, grandkids, and great-grandkids. How can we stick them with the cost of this bill? This is just one bill. I hate to tell you some of the other things that are being put forth in not only this body but the other. How come we do it on bills that are totally partisan bills?

If we look at what has happened, the HELP Committee, the Health, Education, Labor and Pensions Committee, came up with a totally partisan bill. Not one Republican was asked to contribute to it. They just came up with what they wanted to do. It was led by one staff on Capitol Hill. It is a very partisan bill. Then the House came up with their bill. Not one Republican, to

my knowledge, had even been asked to help, and it is a tremendously partisan bill—both of which are tremendously costly too.

Then the distinguished Senator from Montana tried to come up with a bill that would be bipartisan in the Finance Committee, but in the end, even with the Gang of 6—and I was in the original Gang of 7, but I couldn't stay because I knew what the bottom bill was going to be, and I knew I couldn't—I couldn't support it. So I voluntarily left, not because I wanted to cause any problems but because I didn't want to cause any problems. I found myself coming out of those meetings and decrying some of the ideas that were being pushed in those meetings. I just thought it was the honorable thing to do to absent myself from the Gang of 7. It became a Gang of 6 and then the three Republicans finally concluded that they couldn't support it either.

But I will give the distinguished chairman from Montana a great deal of credit because he sat through all of that. He worked through all of it. He worked through it in the committee, but then it became a partisan exercise in committee by and large.

Yes, there were a couple of amendments accepted: My gosh, look at that. Then what happened? They went to the majority leader's office in the Senate, and they brought the HELP bill and the bill from the Finance Committee, and they molded this bill, this 2,074-page bill with the help of the White House. Not one Republican I know of had anything to do with it, although I know my dear friend, the distinguished majority leader, did from time to time talk with at least one Republican, but only on, as far as I could see, one or two very important issues in the bill. There are literally thousands of important issues in this bill, not just one or two. There are some that are more important than others, but they are all important.

I am not willing to saddle the American people with this costly, overly expensive, bureaucratic nightmare this bill will be. I hope my colleagues on the other side will listen, and I hope we can start over on a step-by-step approach that takes in the needs of the respective States that is not a one-size-fits-all solution, that both Republicans and Democrats can work on, which will literally follow the principles of federalism and get this done in a way that all of us can be proud of.

I don't have any illusions and, thus far, it doesn't look like that will happen. But it should happen. That is the way it should be done. I warn my friends on the other side, if they succeed in passing this bill without bipartisan support—if they get one or two Republicans, I don't consider that bipartisan support. You should at least get 75 to 80 votes on a bill this large, which is one-sixth of the American economy, 17 percent of the American economy. You should have to get 75 to 80 votes minimally. It would even be better if you can get more, as we did with CHIP and other bills. On some we have gotten unanimous votes—on bills that cost money, by the way. Republicans have voted for them, too. Republicans will vote for a good bill even if it costs some money. We are not about to vote for something costing $2.5 trillion to $3 trillion. I don't think the American people are going to stand for it.

Beware, my friends, of what you are doing. I can tell you right now this isn't going to work. I want to make that point as clear as I can.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Illinois is recognized.

Mr. BURRIS. Mr. President, as a lifelong public servant, I have always believed in the fundamental greatness of this country. I am sure this is a belief shared by every single one of my colleagues in this body. It is what drove us to serve in the first place, just as it has driven generations of Americans to serve in many capacities throughout our history. Democrat or Republican, liberal or conservative, we are united by our underlying faith in the democratic process and our respect for the people we have come here to represent. That is what makes this country great, the belief that together we can make progress. Together, we can shape our own destiny. That is why we gather here in this august Chamber, to bring the voices of the American people to Washington, to the very center of our democracy.

Earl Warren, the late Chief Justice of the Supreme Court, articulated this very well:

> Legislators represent people, not trees or acres. Legislators are elected by voters, not farms or cities or economic interests.

He said this in reference to a court case about elected representatives at the State level, but his insight rings especially true here in the highest lawmaking body in the land.

I ask my colleagues to reflect upon this simple truth for a moment. We address one another as ''the Senator from Illinois'' or ''the Senator from Texas'' or ''the Senator from Colorado'' or ''the Senator from Utah,'' but we do not speak for towns, or companies, or lines on a map. Our solemn duty is to listen to the people we represent and give voice to their concerns and interests here in Washington. We strive to do this every day, but far too often partisan politics get in the way.

When it comes to difficult issues such as health care reform, the voices of the people sometimes get lost in all of the talk about Republicans versus Democrats, red States versus blue States. The media gets caught up in the horse race and, more often than we would wish, the atmosphere of partisanship follows us into this Chamber.

As our health care reform bill has cleared the first hurdle and moved to the Senate floor, I urge my colleagues to listen to the people—not just to the party leadership—as they decide how to vote. If they shut out the health care insurance lobbyists, the special interests, and the partisan tug of war, they might be surprised at what they will hear from the American people.

In my home State of Illinois, the weight of consensus is hard to ignore. Folks stop me on the streets, stop me in hallways outside of my office, talk to me on airplanes; they call, write, and e-mail. They contact me every way possible. The message is always the same: We need real health care reform. They are telling me don't give up and don't back down. That is because the American people overwhelmingly support reform. They need health care reform now—not tomorrow or next year, they need it now.

I urge my colleagues to think of the uninsured people in their own States. Think about that. Who are the ones who are uninsured? These are the folks who need reform the most. We have all heard at least a few of the heartbreaking stories. Sadly, we will never be able to hear them all because there are too many. So it is time for us to listen and to take a stand on their behalf. It is time to bring comprehensive health care reform to every State in the Union, because in my home State of Illinois, 15 percent of the population is uninsured. In the most advanced country on Earth, this is simply unacceptable. We need to dramatically expand access to quality, affordable health care. But it is not just a blue States issue, it is an American issue. This is a problem that touches all of us. In fact, as we look across the map, we see that many of our States that need the most help are actually the red States.

Eighteen percent of the people in Tennessee and Utah don't have health insurance and cannot get the quality care they need. The number of uninsured stands at 20 percent in Alaska, and it is nearly 21 percent in Georgia, Florida, and Wyoming. In Oklahoma, Nevada, and Louisiana, more than 22 percent of the total population is uninsured, and 24 percent without health insurance in Mississippi. More than a quarter of the population in New Mexico can't get health insurance. In the great State of Texas, almost 27 percent of the population has no health coverage. These numbers speak for themselves. We need to expand coverage to include more of these people.

A recent study conducted by Harvard University shows that the uninsured are almost twice as likely to die in the hospital as similar patients who do have insurance. This human cost is unacceptable, and the financial cost is too much to bear.

While my friends on the other side seek to delay and derail health care reform at this crucial juncture, this bill seeks to save the health of our citizens, to save the lives of Americans, and to save money in the way coverage is offered and delivered. By extending coverage to these individuals and increasing access to preventive care, we can

catch illnesses before they become serious.

That is why I am proud to support provisions such as the amendment offered by my colleague from the great State of Maryland, Senator MIKULSKI. This measure would guarantee women access to preventive care and health screenings at no cost. If more women could get regular screenings and tests, such as mammograms, we can catch illnesses such as breast cancer, heart disease, and diabetes. We can keep more people out of the emergency rooms, we can save lives, and we can save money.

The best way to expand access is to create a strong public option that will lower costs, increase competition, and restore accountability to the insurance industry.

I am fighting for every single Illinoisan to make sure they have access to quality, affordable health care, and to make sure they have real choices. I am fighting for every Illinoisan, because every one of us will benefit from comprehensive reform. But I recognize that those who are uninsured need help the most, and they need it now.

I ask my colleagues to consider this need and to think about how many of their constituents stand to benefit from our reform package.

It is no secret that my Republican friends seek to block and delay this legislation. Many of them represent the so-called red States, where opposing health care reform is seen as a good political move. In the cynical course of politics as usual, most of those red States will be written off because they typically support the Republican Party. But not this time. Health reform isn't about politics. It is not about one party or the other. It is about the lives that are at stake here that we are trying to help. It is about the people who suffer every day under a health care system that fails to live up to the promises of this great Nation.

When it comes to our health care legislation, a vote against reform is a vote against the people who so desperately need our help. That is why I am asking my Republican friends to rise above politics as usual when they make this choice.

Recently, some of my colleagues across the aisle have said our bill would slash Medicare. This is simply not the case. There is no cut in Medicare—no $465 billion cut. Our bill would do nothing of the kind. This is another cynical attempt to scare seniors into opposing health care reform. We have had enough of that.

The truth is this: According to the nonpartisan Congressional Budget Office, health care reform will lower seniors' Medicare premiums by $30 billion over the next 10 years by focusing on prevention and wellness, increasing efficiency and making the program more cost effective.

Our Republican friends can choose to engage in partisan games and spread fear and disinformation about health care reform, they can turn their backs on the people they swore to represent, or they can cast aside the tired constraints of partisanship and stand up for what is right. When they go home to the people who sent them to Washington, they can look those people in the eye and say: I fought for you. I stood up to the special interests, the campaign donors, and the political forces that tried to block reform. I didn't vote like a Senator who represents a red State or a blue State; I voted like a Senator who represented your State and all the good, hard-working people who desperately need this help.

That is the spirit that drove each of us to enter public service in the first place. That is what makes this country great, the belief that policy is decided by the interests of the people, not big corporations or political parties.

This country is more than just a set of lines on a map, and the more you cross those lines, the more you learn that ordinary Americans don't care who scores political points or who gets reelected. They care about results. They care about real costs and real health outcomes.

It is time for us to deliver. It is time to stand for the uninsured, the sick, the poor, and all those who cannot stand for themselves. I say to my colleagues, it is time to come together on the side of the American people and make health care reform a reality. This health care legislation that is being debated on this floor will save lives, it will save money, and it will save Medicare.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I ask unanimous consent that I and my two colleagues be able to engage in a colloquy.

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

Mr. ENSIGN. Mr. President, I would like to start by talking about the bill in general.

Mr. DURBIN. Mr. President, will the Senator from Nevada yield for a question before he starts?

Mr. ENSIGN. Yes.

Mr. DURBIN. Can the Senator give us an indication of how long he expects the colloquy to last?

Mr. ENSIGN. Maybe 40 minutes, somewhere in there.

Mr. DURBIN. I thank the Senator.

Mr. ENSIGN. Mr. President, there is a lot of talk about this bill. I wish to make some general comments about it. First, following the comments of my colleague from Illinois, he said there are not $½ trillion in Medicare cuts. According to the Congressional Budget Office, there are $464 billion to $465 billion in Medicare cuts. So maybe not quite $½ trillion, but we are certainly getting close.

There are, however, $½ trillion in new taxes in this bill, 84 percent of which will be paid by those making less than $200,000 a year, a direct violation of the campaign pledge made by President Barack Obama, then-Candidate Obama.

This bill will result in increased premiums and health care costs for millions of Americans. This is a massive government takeover of our health care system. As a matter of fact, according to the National Center for Policy Analysis, in this 2,074 page bill—there are almost 1,700, 1,697 to be exact—references to the Secretary of Health and Human Services, giving her the authority to create, determine, or define things relating to health care policy in this bill. Basically, we are placing a bureaucrat in charge of health care policy instead of the patient and the doctor making the choices in health care.

I believe we cannot just be against this bill. What I do believe in is a step-by-step approach, an incremental approach, some good ideas on which we should be able to come together.

I think both sides agree we should eliminate preexisting conditions. Somebody who played by the rules, had insurance, happened to get a disease, they should not be penalized, charged outrageous prices, or have their insurance dropped. I think we can all agree on that.

We should be able to agree that if you can buy auto insurance across State lines, you should be able to buy health insurance in the State where it is the cheapest. Individuals should be able to find a State that has a policy that fits them and their family and be able to buy it there. If you can save money and you happen to be uninsured, especially today, it seems to make sense. Let's have that as one of our incremental steps.

I also believe this bill covers some of it, but I believe we need to incentivize people to engage in healthier behaviors. Seventy-five percent of all health care costs are caused by people's behaviors. Let me repeat that. Three-quarters of all health care costs are driven by people's poor choices in their behavior.

For instance, smoking. On average, it is around $1,400 a year to insure a smoker versus a nonsmoker. For somebody who is obese versus somebody with the proper body weight, it is about the same, $1,400 a year. For somebody who does not control their cholesterol versus somebody on regulating medication, it is several hundred dollars a year. For somebody who does not control their blood pressure versus somebody who does—let's give incentives through lower premiums to encourage people to engage in healthier behaviors. That will save money for the entire health care system and our Country will have healthier people with better quality lives.

Currently, big businesses, because of their number of employees, are allowed to take advantage of purchasing power. We ought to allow individuals and small businesses to join together in

groups to take advantage of that purchasing power. They are called small business health plans.

I believe my colleagues are going to talk about an idea they have, something I talked about for years, the idea of medical liability reform. There are several models out there. They are going to talk about a loser pays model, which other countries have engaged in and they do not have nearly the frivolous lawsuits nor the defensive medicine we practice in this country.

How many doctors order unnecessary tests in the United States because of fear of frivolous lawsuits? Talk to any doctor, and they will tell you every one of them orders unnecessary tests simply to protect themselves against the possibility that a jury may say: Gee, why didn't you order this test even though it was not indicated at the time?

That accounts for a large amount of medical costs. As a matter of fact, the Congressional Budget Office said $100 billion between the private and public sector would be saved with a good medical liability reform bill.

I believe we need a patient-centered health care system, not an insurance company-centered health care system, not what this bill does, a government-centered health care system, where bureaucrats are in control of your health care. We need a patient-centered system.

Before us we have the Mikulski amendment. This is more of government-centered health care. There is a report out based on prevention that indicates that mammograms should not be paid for, basically, for women under 50 years of age, from 40 to 50 years of age, and women in the Medicare population age, the report indicates that they do not need annual mammograms. This was based mainly on cost. If you look at it from a cost standpoint, that is probably correct.

But think about it. If you are a woman and you get cancer and you could have had a mammogram diagnose it a lot earlier, you sure would rather have had that mammogram rather than have that mammogram denied.

The Senator from Maryland has proposed an amendment to try to fix the problem. The problem is, instead of one government entity determining whether somebody is going to get coverage, the amendment turns it over to the Secretary of Health and Human Services. Another government bureaucrat will determine whether something such as a mammogram will be paid for. According to the Associated Press, her amendment does not even mention mammograms.

Senator MURKOWSKI and Senator COBURN have come up with an alternative that actually puts the decision of whether to cover preventive services in the hands of experts in the field. Whether it be a mammogram for breast cancer, or an MRI, which most people think is going to be better than a mammogram for diagnosing breast cancer, or whether it is a test for prostate cancer for men. Those kinds of things should be determined by experts in the field, not by government bureaucrats.

The various colleges—the American College of Obstetrics and Gynecology, for instance, has come out with certain recommendations, along with the American College of Surgeons. Those are the experts with peer-reviewed science. Those are the individuals who should determine what the recommendations are as to whether we pay for preventive services, not government bureaucrats.

Unfortunately, the Mikulski amendment just gives that determination to a government bureaucrat. That is why we should reject the Mikulski amendment, and adopt the amendment offered by the Senator from Alaska, the Murkowski amendment puts the decision making in the hands of the of the experts, where that decision should be made.

Let me close with this point. We have seen a lot of comparisons where are people saying that other countries have a better health care system than the United States. Let me give you the example of cancer survival rates.

This chart compares the average cancer survival rates in the European Union and the United States, it makes the point as to whether a government bureaucrat is making a health decision or the doctor and the patient are making the health treatment decision.

For kidney cancer, the European Union has a 56 percent 5 year survival rate; the United States, 63 percent survival rate after 5 years. On colorectal cancer, about the same difference between the United States and the European Union. Look at breast cancer, 79 percent after 5 years in the European Union; 90 percent in the United States. The most dramatic difference is on prostate cancer, 78 percent survival after 5 years in the European Union; 99 percent survival rate in the United States.

These are dramatic differences. Where would you rather get your health care if you had one of these cancers? The United States or Europe?

Canada, has even worse results than this. As a matter of fact, Belinda Stronach, a member of the Canadian Parliament, led the charge against a private system side by side with the government-run system in Canada. She did not want the private system.

Tragically, a couple years later, she developed breast cancer. Did she stay in Canada to get treatment, where there is a government-run health care system? No. Where did she go? She came to the United States. She was actually treated at UCLA. Why, because we have a superior system of quality in the United States.

We have a problem with cost. Some of the incremental steps I talked about will address costs.

I wish to turn it over now to my colleagues who are going to talk about medical liability reform. Let's look out for the patient instead of the trial lawyers in the United States. Their idea on a loser pays system, I think, has a lot of merit, and it is something this body should consider very seriously.

I yield the floor to the Senator from Georgia, my good friend and colleague.

Mr. CHAMBLISS. Mr. President, I thank the Senator from Nevada for yielding. Senator GRAHAM and I do have an amendment we have filed today with respect to reforming the health care system in a real, meaningful way. It is an amendment that deals with tort reform, and it is a true loser pays system. We are going to talk about that in a few minutes.

Before I get to that, I wish to go back to some of the points the Senator from Nevada has talked about. I particularly appreciate his work on the mammogram issue, especially since this has been highlighted over the last couple weeks with regard to the recommendation that has come out of the independent board that advises HHS. I thank him for his work on that issue.

He is dead on. All of us know our wives are told every year, when they reach a certain age, they need to have a mammogram to make sure. Just like we do every year, go in and get a physical, they need to get their mammogram. The Senator talks about those kinds of checkups providing you with the kind of preventive health care that is going to hold down health care costs. I am a beneficiary of that. During a routine medical examination in 2004, it was determined I had prostate cancer. I was very fortunate it was picked up when it was, at an early stage. Instead of having to go through a lot of expensive procedures I might have had to go through, we were fortunate to be able to treat it. We are working on getting cured.

Senator ENSIGN is exactly right, this is the kind of test we need to make sure we encourage females to get and not put barriers in front of them.

Medicare is such a valuable insurance policy and program that 40 million Americans today take advantage of it. Mr. President, 1.2 million Georgians are Medicare beneficiaries. Again, I am one of those who is a Medicare beneficiary. So this is particularly important to me.

More importantly, in addition to these 40 million Medicare beneficiaries who are in the country today, there are another 80 million baby boomers who are headed toward Medicare coverage.

We have an independent Medicare Commission that was established by Congress years ago that is required to come to Congress every year and give Congress an update on the financial solvency of the Medicare Program. The purpose of that bipartisan Commission is to allow this body, along with our colleagues over in the House, the benefit of the work they do every year in looking at the amount of revenues that come in, in the form of the Medicare tax, and the outlays that go out, in the

form of payments to medical suppliers for our Medicare beneficiaries.

In the spring of this year, 2009, the independent Medicare Trustees Report reported back to Congress and said that unless real, meaningful reforms are made in the Medicare system, Medicare is going to start paying out more in benefits than it takes in in tax revenues in the year 2017.

Mr. President, what that means is that in 2017, Medicare is going to be insolvent, and it is just a matter of time before Medicare goes totally broke. And those individuals who are baby boomers, who have been paying into this program for 40 years, 50 years, or whatever it may be, are all of a sudden going to reach the Medicare age, where they expect to reap the benefits of the Medicare taxes they have been paying for all these years, and guess what. Not only are benefits going to be reduced, but unless something happens, unless there is meaningful reform and it is done in the right way, there is not going to be a Medicare Program.

I want to go back to something the junior Senator from Illinois said a few minutes ago. In talking about this issue of cuts in Medicare, he said this bill we have up for debate now that was filed by Senator REID does not have cuts in Medicare. He could not be more incorrect. And that is not a Republican statement. It is not a statement by anybody other than the Congressional Budget Office. I refer to a letter that has already been introduced during the course of this debate—a letter dated November 18—to the Honorable HARRY REID, the majority leader. I would refer the Senator to page 10 of that letter in which the Director of the Congressional Budget Office says this in reference to provisions affecting Medicare, Medicaid, and other programs:

> Other components of the legislation would alter spending under Medicare, Medicaid and other Federal programs. In total, CBO estimates that enacting these provisions would reduce direct spending by $491 billion over the 2010–2019 period.

Then the letter goes on, on this page alone, to delineate three areas where Medicare provisions are going to be reduced or cut, and I would specifically refer to them, but first is a fee-for-service sector, and this is other than physician services. It is going to be reduced by $192 billion over 10 years. The Medicare Advantage Program—a program that literally thousands of Georgians take advantage of today and millions of Americans take advantage of—is going to be reduced by $118 billion over 10 years, over the period 2010 to 2019. Medicaid and Medicare payments to hospitals—what we call disproportionate share payments, DSH payments—are going to be reduced or cut by $43 billion over 10 years.

What does a reduction in these benefits mean to each individual community or each individual State? I can tell you what it means to the local hospital in the rural area of Georgia where I live. The reduction in DSH payments is going to amount to a reduction in income at Colquitt Regional Medical Center in Moultrie, GA, by $16.8 million over a 10-year period. These cuts in Medicare are going to result in a reduction in payments to Emory Hospital in Atlanta in the amount of $367 million over a 10-year period.

So anybody who says these aren't cuts in Medicare spending simply has not read the bill and certainly has not read the letter from the Director of the Congressional Budget Office to Senator REID dated November 18, 2009.

I want to turn this over to my colleague from South Carolina after this final statement with reference to reductions in Medicare spending.

There is a specific reduction of $8 billion in this bill over a 10-year period in hospice benefits.

Again, we have heard a number of personal stories around here, and I have a particular personal story myself. My father-in-law died when he was 99 years old. It was 3 years ago. The last 2 years of his life, he lived in an assisted-living home and he had hospice come in 2 or 3 or 4 days a week, for whatever he needed. Had he not had the benefit of hospice, he would have had to go in a hospital, and no telling how much in the way of Medicare medical expenses he would have incurred. But thank goodness we had hospice available, and he spent 2 days in the hospital. Otherwise, he was able to live in his assisted-living home, have my wife go by and spend quality time with him, which she will tell you today were the best 2 to 3 years of her life as far as her relationship with her father was concerned, because she had hospice there to take care of him. Yet here we are talking about reducing a benefit by $8 billion that saved no telling how many thousands of dollars in the case of my family, and you can multiply that across America, and it is pretty easy to see we don't need to be reducing a benefit that is going to save us money in the long run.

I would like to turn it over to my friend from South Carolina, who also has some comments regarding Medicare, and then we will talk about our loser pays bill.

Mr. GRAHAM. I thank my friend from Georgia, and I will try to be brief.

I guess to say that we need to do health care reform is pretty obvious to a lot of people. The inflationary increases in the private sector, to businesses, particularly in the health care area, are unsustainable. A lot of individuals are having to pay for their own health care costs and are getting double-digit increases in premiums. In the public sector, the Medicare and Medicaid Programs are unsustainable. Medicare alone is $38 trillion underfunded.

Over the next 75 years, we have promised benefits to the baby-boom generation and current retirees, and we are $38 trillion short of being able to honor those benefits.

What has happened? We have created a government program that everyone likes, respects, and is trying to save, and actuarially it is not going to make it unless we reform it. So what have we done? In the name of health care reform, we have taken a program many senior citizens rely upon—all senior citizens, practically—and we have reduced the amount of money we are going to spend on that program and then taken the money from Medicare to create another program the government will eventually run. It makes no sense.

We need to look at saving Medicare from impending bankruptcy. Why would we reduce Medicare by $464 billion and take the money out of Medicare, which is already financially in trouble, to create a new program? It makes no sense to me. That is not what we should be trying to do, from my point of view, to reform health care.

The Medicare cuts Senator CHAMBLISS was talking about, they are real. The way our Democratic colleagues and friends try to get to revenue neutrality on the additional spending, to get it down to where it doesn't score in a deficit format, is they take $464 billion out of Medicare to offset the spending that is required by their bill.

Here is the question for the country: How many people in America really believe this Congress or any other Congress is actually going to reduce Medicare spending by $464 billion over 10 years? I would argue that if you believe that, you should not be driving. There is absolutely no history to justify that conclusion.

In the 111th Congress, there were 200 bills proposed—and I was probably on some of them—to increase the amount of payments to Medicare. In 1997, we passed a balanced budget agreement when President Clinton was President slowing down the growth rate of Medicare. That worked fine for a while, until doctors started complaining, along with hospitals, about the revenue reductions. Every year since about 1999, 2000, we have been forgiving the reductions that were due under the balanced budget agreement because none of us want to go back to our doctors and say we are going to honor those cuts that were created in 1997 because it is creating a burden on our doctors. Will that happen in the future? You better believe it will happen in the future. In 2007, Senators CORNYN and GREGG introduced an amendment to reduce Medicare spending by $33.8 billion under the reconciliation instructions. It got 23 votes. I remember not long ago the Republican majority proposed reducing Medicare by $10 billion. Not one Member of the Democratic Senate voted for that reduction. They had to fly the Vice President back from Pakistan to break a tie over $10 billion.

So my argument to the American people is quite simple: We are not going to reduce Medicare by $464 billion, and if we don't do that, the bill is not paid for, and that creates a problem of monumental proportions. If we

do reduce Medicare by $464 billion and take the money out of Medicare to create another government program, we will do a very dishonest thing to seniors. We are damned if we do and damned if we don't. And during the whole campaign, I don't remember anybody suggesting that we needed to cut Medicare to create health care reform for non-Medicare services, but that is exactly what we are doing.

To my Democratic colleagues: There will come a day when Republicans and Democrats are going to have to sit down and seriously deal with the underfunding of Medicare and with the impending bankruptcy of Medicare. Everything we are doing in this bill may make sense to save Medicare from bankruptcy, but it doesn't make sense to pay for another government-run health care program outside of Medicare. It makes no sense to take the savings we are trying to find in Medicare and not use them to save Medicare from what I think is going to be a budget disaster.

So let it be said that this attempt to pay for health care, to make it revenue neutral, will require the Congress to do something with Medicare that it has never done before and is not going to do in the future. So the whole concept is going to fall like a house of cards.

The way we have tried to pay for this bill has so many gimmicks in it, it would make an Enron accountant blush.

Now, as to tort reform, quite frankly, I used to practice law and did mostly plaintiffs' work. I am not a big fan of Washington taking over State legal systems. I prefer to let States do what they are best at doing and let the Federal Government do a few things well—and we are doing a lot of things poorly. But if we are going to take over the entire health care system, if that is going to be the option available to us, then we also need to nationalize the way we deal with lawsuits.

And to the AMA: There will come a day, if we keep going down the road here, where the Federal Government will determine how you get to be a doctor. There will be no State medical societies, and we will have a national system to police doctors. That is what is coming if we continue to nationalize health care.

So, with Senator CHAMBLISS, I have tried to come up with a more reasoned approach when it comes to legal reform. I have always believed people deserve their day in court. There is no better way to resolve a dispute than to have a jury do it. I would rather have a jury of independent-minded citizens decide a case than a bunch of politicians or any special interest group. So the jury trial, to me, is a sacrosanct concept that has served this country well.

But one thing I have always been perplexed about in America is that the risk of suing somebody is very one-sided. Most developed nations have a loser pays rule. I think you should have your day in court, but there ought to be a downside to bringing another person into the legal system. So I think a loser pays rule will do more to modify behavior than any attempt to cap damages. Let both wallets be on the table. You can have your day in court, but if you lose, you are going to have to pay some of the other side's legal cost, which will make you think twice.

As to the indigent person, most people who sue each other are not indigent. The judge would have the ability to modify the consequences of a loser pays rule, but we need to know going in that both wallets are on the table. Under our proposal, we have mandatory arbitration where the doctor and the patient will submit the case to an arbitration panel. If either side turns down the recommendation of the panel, they can go to court. But then the loser pay rule kicks in.

I think that will do more to weed out frivolous lawsuits than arbitrarily capping what the case may be worth in the eyes of a jury. I think it really does create a financial incentive not to bring frivolous lawsuits that does not exist today.

If there is a $500,000 damage cap, most of the people I know would say: I will take the $500,000. That is not much of a deterrent. But if we told someone they can bring this suit if the arbitration didn't go their way, but if they go into court after arbitration they risk some of their financial assets, people will think twice. I think that is why this is a good idea. The National Chamber of Commerce has endorsed it, and I am proud of the fact that they have endorsed it.

I would rather not go down this road, but if we are going to nationalize health care we also need to do something about the legal system that is going to be affected by the nationalization of health care.

A final comment I would like to make about what we are doing is that it is probably worrisome to people at home that we are about to change one-sixth of the economy and cannot find one Republican vote to help. I guess there are two ways to look at that: It is the problem of the Republican Party or maybe the bill is structured in a way that is so extreme there is no middle to it. I would argue that what we have done is abandon the middle for the extreme. It is pretty extreme, in my view, to take a program that is $38 trillion underfunded, cut it, and take the money to create a new program rather than saving the one that is in trouble. It is pretty extreme, in my view, to take a country that is so far in debt you cannot see the future and add $2.5 trillion of more debt onto a nation that is already debt laden in the name of reforming health care.

When you look at the second 10-year window of this bill, it adds $2.5 trillion to the national debt. Is that necessary to reform health care? Do we need any more money spent on health care or should we just take what we spend and spend it more wisely? The first 10 years is a complete gimmick. What we do in the first 10 years of this bill is collect the $½ trillion in taxes for the 10-year period, and we don't pay any benefits until the first 4 years are gone. That is not fair. That is a gimmick. That catches up with you in the second 10-year period.

So the reason we do not have any bipartisan support is because we have come up with a concept that has no middle to it. This is a power grab by the Federal Government. This is a chance to set in motion a single-payer health care plan that the most liberal Members of the House and the Senate have been dreaming of. This is a liberal bill written by and for liberals, and it is not going to get any moderate support on the Republican side—and there is some over here to be had—and they are going to have a hard time convincing those red State Democrats that this is good public policy. That is where we find ourselves, trying to change one-sixth of the economy in a way that you don't have any hope of bringing people together.

I would argue we should stop and start over.

I thank my good friend from Georgia for trying to find a way to change lawsuit abuse in a more reasoned fashion.

Mr. CHAMBLISS. I thank my colleague from South Carolina, Senator GRAHAM, for his thoughtful process that we went through in thinking through the loser pays bill and the amendment we have filed. Just like you, having practiced law for 26 years before I was elected to the House, the same year you were, and then we were elected over here, I tried plaintiffs cases as well as defendants cases. I never represented a defendant in a malpractice case. I was always on the other side.

I have great sympathy for individuals who are wronged by a physician who is negligent. You and I agree that anybody who is the victim of negligent action ought to have their day in court. That is what we provide for under our bill. There is absolutely no question about the fact that anybody who is subject to negligent acts on the part of a physician, they can have their day in court, and they should have their day in court if that is what they decide they want to do.

But under a loser pays provision like we have designed, we can eliminate, hopefully, the frivolous lawsuits that add significantly to the cost of health care delivery in this country. In 2003, direct tort litigation costs in America accounted for 2.2 percent of our GDP. That is double the percentage of Canada, Great Britain, Germany, France, and Australia—all of which have loser pays systems.

The State of Alaska has had a loser pays system since 1884 and tort claims in the State of Alaska constitute a smaller percentage of total litigation than the national average.

Florida, which applied a loser pays rule to medical malpractice suits from 1981 to 1985, saw 54 percent of their plaintiffs drop their suits voluntarily.

It does make a difference on frivolous suits. In the State of Florida during that same period of time, the jury awards for plaintiffs rose significantly. Just as in our situation, anybody who had a legitimate case in Florida during that period of time had the right to have their case adjudicated by a jury. Those who made the decision to do so received more significant awards. That is the way the system ought to work.

This is a win-win situation for the cost of health care delivery. It is a benefit to the physicians—sure, because they eliminate part of their significant cost of delivering health care services. But it also is a huge benefit to those individuals in America who are subject to negligent acts on the part of physicians.

I ask unanimous consent that a letter to Senator GRAHAM and myself from Bruce Josten at the U.S. Chamber of Commerce, dated November 3, 2009, be printed in the RECORD, and I yield the floor.

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

NOVEMBER 3, 2009.

Hon. LINDSEY GRAHAM,
U.S. Senate,
Washington, DC.
Hon. SAXBY CHAMBLISS,
U.S. Senate,
Washington, DC.

DEAR SENATORS GRAHAM AND CHAMBLISS: The U.S. Chamber of Commerce, the world's largest business federation representing more than three million businesses and organizations of every size, sector, and region, thanks you for introducing S. 2662, the ''Fair Resolution of Medical Liability Disputes Act of 2009.''

This legislation represents a positive and significant step toward providing a more reliable justice system for the victims of medical malpractice. Your bill encourages the states to establish alternative methods for resolving medical liability claims and provides them with the latitude to develop unique approaches that fit the needs of their diverse populations. The Chamber commends you for making this important and thoughtful effort to bring needed reforms to America's medical liability systems.

The issue of medical liability reform is central to any serious effort to overhaul America's healthcare system. The Congressional Budget Office recently determined that medical liability reform would reduce total national healthcare spending by $11 billion in 2009 and reduce the federal budget deficit by $54 billion over 10 years. The Chamber believes these estimates of healthcare savings may be too conservative. Yet nonetheless, the $54 billion in deficit reduction is significant, representing over 10 percent of the net cost of the insurance coverage provisions agreed to in the Finance Committee's ''America's Healthy Future Act of 2009.'' We are confident that you will be a forceful and effective advocate for medical liability improvements that will expand access to justice for injured patients and lower the cost of healthcare.

There is bipartisan agreement that for healthcare reform to be successful, it must ''bend the growth curve,'' making healthcare delivery more efficient and slowing healthcare inflation. Medical liability reform should play a critical role in any such effort. The Chamber appreciates your work on this legislation and looks forward to working with you and the Senate in the coming weeks and months to refine your legislation and advance commonsense changes to our system of resolving medical liability claims.

Sincerely,

R. BRUCE JOSTEN.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Could the Chair inform me how much time was used on the Republican side during the last group of speakers?

The PRESIDING OFFICER. That was 42 minutes 14 seconds.

Mr. DURBIN. I thank the Chair. I am going to proceed to speak in the same manner and yield to the Senator from Vermont. Our time will be less than that in total.

I see the Senator from Louisiana is here. We are going to be speaking less than 42 minutes. We guarantee him that much. We will follow the same process, if there is no objection, that was just followed with three Republican speakers who spoke in that 42-minute period of time.

I ask unanimous consent that Senator SANDERS be recognized after me to speak and that our total time be no more than 42 minutes.

Mr. VITTER. I object.

The PRESIDING OFFICER. Is there objection? Objection is heard.

Mr. DURBIN. Mr. President, I just offered that to the Republican side, and they asked me for permission and I gave permission, unanimous consent.

We will speak as long as we like. We will enter into a colloquy. I hope the Senator from Louisiana will reconsider.

Let me try to address a few of the issues that have been raised on the Senate floor. First, on the issue of medical malpractice, this is an issue often brought up on the other side of the aisle.

The first thing I would like to say is this is the bill we are debating. It is 2,074 pages, and one extra page makes it 2075 pages. It has taken us a year to put this together. There have been a series of committee hearings that have led to the creation of this legislation. It has been posted on the Web site for anyone interested. If they go to Google, for example, and put in ''Senate Democrats,'' they will be led to a Web site which will let them read every word of this bill. It has now been out there for 12 days at least, and it will continue to be there for review by anyone interested.

If you then Google ''Senate Republicans'' and go to their Web site on health care and look for the Senate Republican health care reform bill, you will find—this bill, the Democratic bill, because there is no Senate Republican health care bill. For a year, and with an enormous number of speeches, they have come to the floor and talked about health care but have never sat down and prepared a bill to deal with the health care system, which leads us to several conclusions.

This is hard work and they have not engaged in that hard work. It is easier to be critical of this work product. They have chosen that route. That is their right to do. This is the Senate. We are the majority party. We are trying to move through a bill. But all of the ideas they have talked about tonight and other evenings have not resulted in a bill.

Second, it may be that they do not want to see a change in the current system; they are happy with the health care system as it exists today. That is possible. In fact, I think it drives some of them to the point where they criticize our bill but do not want to change the system because they like it.

I guess there are some things to like about it. There are good hospitals and doctors in America. Some people are doing very well with the current system. But we also know there are some big problems. We know the current system is not affordable. We know the cost of health insurance has gone up 131 percent in the last 10 years; that 10 years ago a family of four paid about $6,000 a year for health insurance. Now that is up to $12,000 a year. We anticipate in 8 years or so it will be up to $24,000 a year. Roughly 40 percent or more of a person's gross income will be paid in health insurance.

That is absolutely unsustainable. So businesses are unable to offer health insurance as well as individuals are unable to buy health insurance. The Republicans have not proposed anything, nothing that will make health insurance more affordable. This bill addresses that issue. They have nothing.

Second, we know there are about 50 million Americans without health insurance. These are people who work for businesses that cannot afford to offer a benefits package. They are people who are recently unemployed, and they are people in such low-income categories they cannot afford to buy their own health insurance, and their children—50 million. This bill we have before us will give coverage to 94 percent of the people in America, the largest percentage of people insured in the history of our country.

The Republicans have failed to produce a bill that expands coverage for anyone in America. Under the Republican approach, nothing would be done to help the 50 million uninsured.

The third issue is one about health insurance companies. Everybody has an experience there. It is, unfortunately, not good for most, because when you pay premiums all your life and then need the health insurance, many times it is not there. What we do is give consumers bargaining power and a fighting chance with health insurance. That, to me, is a reasonable approach. It eliminates discrimination against people because of a preexisting condition and putting caps on the

amount of money that is being paid. We extend the coverage for children under family health plans from age 24 to age 26. We do things that give people peace of mind that when they need health insurance for themselves and their family it will be there.

The Republicans fail to offer anything that deals with health insurance reform. That is a fact. They have said a lot about Medicare.

I would like to tell you that tomorrow, or soon, I will be cosponsoring and Senator BENNET of Colorado will be offering an amendment which could not be clearer on the issue of this bill and the Medicare Program. The amendment is so short and brief and direct and understandable, I want to read a couple of highlights:

> Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed benefits under title XVIII of the Social Security Act.

That is Medicare. What Senator BENNET is saying is that people will have their Medicare benefits guaranteed. Nothing in this bill will infringe on their Medicare benefits, despite everything that has been said.

The Bennet amendment goes on to say:

> Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

All of the speeches made in the last 3 days about how this bill threatens Medicare—it does not—will be completely cleared up by the Bennet amendment. I hope some Republicans who have a newfound love of the Medicare Program, which was started many years ago, will join us in voting for this amendment. It would be great to see if their speeches to save Medicare will result in their votes for the Bennet amendment. This is a critically important amendment. I commend him for being so straightforward and showing real leadership on an issue of this magnitude.

I know the Senator from Vermont is interested in speaking. I am prepared to yield for comments and questions. Before I do, I wish to say by way of introduction that we heard one of our Republican colleagues say this is a single-payer bill, that at the end of the day we will have created a single-payer system. I think the Senator from Vermont is familiar with the concept of single payer, and I would invite his comments or questions through the Chair to me about his feelings on this issue.

Mr. SANDERS. I thank my friend from Illinois for asking that question because, coincidentally, we have just introduced and brought to the desk legislation for a single-payer national health care program. I suggest to my friend from Illinois and my Republican friends that it is a very different bill than the legislation we are now looking at. In no way, shape, or form is the legislation being debated now a single-payer national health care program. As my friend from Illinois understands—and I ask his views on this—I have heard some of our Republican friends talk about how strong this current health care system is that we have right now. I ask my friend from Illinois, do you think we can do better than being the only major country in the industrialized world that does not guarantee health care to all of its people? Can we do better than that?

Mr. DURBIN. In response to the Senator from Vermont, we must do better. This is the only civilized, developed, industrialized country in the world where a person can literally die because they don't have health insurance. Forty-five thousand people a year die because they don't have health insurance. What does that mean? One illustration: If you had a $5,000 copay on your health insurance policy—and people face that—and you go to the doctor and the doctor says: Durbin, we think you need a colonoscopy, and I realize I have to pay the first $5,000 and the colonoscopy is going to cost $3,000, and I say I am going to skip it—which people do, and bad things happen—I develop colon cancer and die, my insurance has failed me. Basic preventive care is not there. We are the only civilized, developed country where that is a fact.

Mr. SANDERS. I ask my friend from Illinois, has he talked to physicians who have, on that issue, told him that they have lost patients who walked into their office and they say: Why didn't you come in here 6 months ago or a year ago? And that patient says: I didn't have any money, and I thought maybe the pain in my stomach or my chest would get better.

I have had that conversation with physicians in Vermont. I wonder if the Senator has talked to physicians who have said the same thing.

Mr. DURBIN. A lady I met 2 weeks ago in southern Illinois, 60 years old, a hostess at a hotel who serves breakfast in the morning—they are there as we travel around our States—has never had health insurance in her life, is diabetic, and told me that her income is so low, $12,000 a year, she could not afford to go to a physician to check out some lumps she had discovered. That is the reality of the current health care system in the wealthiest, greatest Nation on Earth.

Mr. SANDERS. We have heard discussions of death panels. I think the Senator might agree with me that when we talk about death panels, we are talking in reality about 45,000 people who die every single year because they don't get to a doctor on time. That seems to me to be what a death panel is.

In the midst of all this, with 46 million uninsured, with 45,000 people dying every year because they don't get to a doctor when they should, when premiums have doubled in the last 9 years, when we have almost 1 million Americans going bankrupt because of medically related bills, I ask my friend from Illinois, isn't it time for a change? Isn't it time this country now moves forward and provides health care for all of our people in a comprehensive and cost-effective way?

Mr. DURBIN. Mr. President, I certainly agree with the Senator from Vermont. I would add one more statistic. Of the nearly 1 million people filing for bankruptcy in America each year because of health care costs, medical bills they can't pay, three-fourths of them have health insurance. Three-fourths of them were paying premiums. These were the people turned down when they needed coverage. These were the people who ran into caps on coverage on their policies. These are folks who had to battle it out and lost the battle with the insurance companies to try to get lifesaving drugs. That is the reality of the current system.

The fact is, the Republican side of the aisle has not produced an alternative. We have. We have worked long and hard to do it. They have not.

Mr. SANDERS. I ask my friend from Illinois if we are not only dealing with the personal health care issue of 46 million uninsured and people dying, but are we not dealing with a major economic issue? How are businesses going to compete with the rest of the world when every single year they are seeing huge increases in their health insurance premiums, and rather than investing in the business that they are supposed to be in, they are having to spend enormous sums of money as health care costs soar? I know small businesses in Vermont tell me that in some cases not only can they not provide health insurance to their workers, they cannot even provide it for themselves. I have to believe there is a similar situation in Illinois.

Mr. DURBIN. It is. We are sent many books and some of them I have a chance to glance at. This is the recent one I received, entitled ''Bend the Health Care Trend.'' They have here information which says: American health care spending reached $2.4 trillion in 2008 and will exceed $4 trillion by 2018. We expect a doubling of basic health insurance premiums in 8 to 10 years, and we know what you just described is reality. Even businesses owned by a couple, a husband and wife, are finding themselves not only unable to provide health insurance for their employees, because of its cost, they can't cover themselves.

I had a friend of mine, one of my boyhood friends, I grew up with him and his wife. His small business had one of their employees under the health insurance plan, and his wife had a baby with a serious illness. As a result, their premiums went through the roof. He had to cancel his group health insurance. He had to cancel the insurance he gave to his employees. He gave his employees the $300 a month, whatever it

was they were paying, and said: We are all on our own now. We have to go in the private market. The couple with the sick baby couldn't find any health insurance. My friend, who was in his 60s, and his wife are in a pitched battle every year about how much they have to pay for health insurance and the company, the only one that will cover them, each year excludes whatever they turned a claim in for last year. So that is the reality of health insurance for small businesses.

I also want to tell my friend from Vermont, about one-third of all realtors in America are uninsured, have no health insurance. They are independent contractors, and they have no health insurance, one out of three.

Mr. SANDERS. While we are talking about the economics of health care, I wonder if my friend from Illinois has had the same experience I have had in Vermont where people tell me they are staying on the job, not because they want to stay on their job but because the job is providing decent health insurance. They can't go where they want to go because the new job may not provide insurance or they are afraid about the interval when they may not have any health insurance at all. I wonder if my friend from Illinois happened to see the piece in the paper, unbelievable, where a middle-aged fellow joined the U.S. military because his wife was suffering from cancer, and he couldn't find a way to get health care for her so he joined the military. Does the Senator think this is what should be going on in the greatest country in the world?

Mr. DURBIN. We can do better. I would say to those who call our plan a single-payer plan, what we are trying to do is to get fair treatment from private health insurance companies for consumers and families across America and to give them choices. The Senator from Vermont, I assume, is part of the Federal Employees Health Benefits Program. So am I. Most Members of Congress belong to the program. Eight million Federal employees and Members of Congress are part of this program. It may be the best health insurance in America. And we can shop. I just got a notice in the mail that says open enrollment is coming. If you don't like the way you were treated by your health insurance plan last year, you can change. You can pick a new one. If it is a generous plan, more money will be taken out of your check. If it is not, less money will be taken out. We can shop. What we do on the insurance exchanges in this bill is say to these Americans who wouldn't otherwise have options, go shopping. Find the best health insurance plan for your family. Exercise your choice.

I would say to Senator HARRY REID, who drafted this bill, I thank him for his hard work. He includes a public option, a not-for-profit health insurance plan with lower costs that people can choose, if they care to. Giving people that choice, giving them an option to go shopping for the most affordable, best health insurance plan is what we enjoy as Members of Congress and what every American family should.

Mr. SANDERS. I ask my friend from Illinois, does he think some of our Republican friends feel so threatened and so upset by giving the American people the option to choose a public Medicare-type plan as opposed to a private insurance plan? Do you think that maybe, just maybe, some of our friends are more interested in representing the interests of the big private insurance companies rather than the needs of the American people?

Mr. DURBIN. I say to my colleague from Vermont, I am waiting for the first Republican Senator to offer an amendment to this bill to abolish Medicare. If they really believe that government health insurance is such a bad idea, they ought to step right up and show it.

Mr. SANDERS. I would say to my friend from Illinois that that is an interesting proposal and, in fact, I was almost thinking of offering an amendment at one point. We have a lot of people in this country who stand up and say: Get the government out of health care. Well, I think some of my Republican friends have kind of echoed that message. I do think that the Senator from Illinois is right. We may bring forth an amendment to allow our Republican friends to say: Let's abolish the Veterans' Administration. Because, as you know, that is a government-run program which most veterans in my State and I think around the country are very proud of. They think it is a good program. From what the statistics tell us, it is a very cost-effective way to provide quality health care to all of our veterans. Maybe we should bring forward an amendment to those who say get the government out of health care. If you want to abolish the Veterans' Administration, go for it. And what about TRICARE. Maybe you want to abolish TRICARE. Go for it. Maybe you want to abolish SCHIP which is providing high quality health insurance for millions of kids. Maybe we might work together and bring forth an amendment.

Let our Republican friends who say get the government out of health care, let them abolish the Veterans' Administration, Medicare, SCHIP, Medicaid, let them do that. We will see how many votes they might get.

Mr. DURBIN. There is another way that Senators who loathe the idea of government-run health insurance plans can show personally their commitment to that idea, by coming to the floor and publicly announcing they will not participate in the Federal Employees Health Benefit Program which provides health insurance for Members of Congress. I have yet to hear the first Member, critical of government health plans, come forward and say: So in a show of unity and personal commitment, I am going to opt out.

Mr. SANDERS. I suggest to my friend from Illinois that we could take it a step further. I go to the Capitol physician's office. That is where I go. We pay extra money for it. I have Blue Cross/Blue Shield, but I go there. Do you know who runs the Capitol physician's office, which I suspect the vast majority of the Members of Congress go to and get very fine primary health care?

Well, it is that terrible government agency, the U.S. Navy. So maybe some of our friends who are busy denouncing government health care might want to say they do not want to take advantage of that very fine, high quality health care, and that speaks for the whole military as well. While we are at it, maybe you should abolish health care for the U.S. military, which is all government run and, by the way, generally regarded as pretty good quality health care.

I would ask my friend his views on that.

Mr. DURBIN. I do not think you will hear that. I think you will hear a lot of speeches about socialized medicine, socialism, and the big reach of government.

When it comes right down to it, there is not a single Member from the other side who stepped up and said: Therefore, I will offer an amendment to abolish it. They will have their chance in this bill, and if they want to, they can. I do not think the people who have this coverage today would like to see it gone.

Mr. SANDERS. It might be an interesting amendment, I would say to my friend. There is another area where it is a semigovernment nonprofit, which I know the Senator from Illinois feels very strongly about, and that is the Federally Qualified Community Health Centers begun by Senator Kennedy over 40 years ago, where we now have over 1,200 community health centers all over this country. In fact, I know this is widely supported in a bipartisan or tripartisan way, because the Federally Qualified Community Health Centers provide quality health care and dental care and low-cost prescription drugs and mental health counseling.

I might say to my friend from Illinois, one of the provisions in that 2,000-page bill he is holding up is legislation he and I and others have worked hard on, which is to substantially expand the Community Health Center Program into every underserved area in America. We talk about 46 million people being uninsured in this country. We have 60 million people who do not have access to a doctor on a regular basis.

If we expand the Community Health Center Program, if we expand to a significant degree the National Health Service Corps so we can help young people become primary health care physicians by paying off their very substantial medical debts, would my friend agree with me that this would be a major step forward in improving primary health care in America?

Mr. DURBIN. The Senator from Vermont has been a leader on this

issue. I can recall when President Obama came forward with his stimulus bill, the recovery and reinvestment bill, that the Senator from Vermont was one of the leaders to put additional funds in the bill to build clinics all across America—in rural areas we represent, in the towns and cities we represent as well—for the very reason the Senator mentioned: Because for a lot of people who I represent in downstate, southern Illinois, in some of the rural regions, it is a long drive to a doctors clinic for primary care. So these community health clinics, FHQA clinics, are going to offer people primary care.

I think as a result of this bill, when we enact it—and I feel very good about the enactment of this because I think we sense this is a moment in history we should not miss—we are going to see this network grow across America. And it has proven itself to be so good.

In the city of Chicago, I have visited these community health clinics. I will bet the Senator does in Vermont. What I find there—many times I will walk in the door. The administrator will be there. We will start talking. I will meet the doctors. I will meet the nurses. When I finally get a chance to drink a cup of coffee and talk to them for a few minutes, I say—and I mean it—if I were sick, I would feel confident walking into the front door of this clinic, that I would be in the best of hands—better than the most expensive clinic in my State.

Mr. SANDERS. My friend from Illinois makes the point. And I have visited virtually all of them in the State of Vermont. We have gone from 2 to 8, with 40 satellites. We have over 100,000 people in the State of Vermont who now use these Federally Qualified Health Centers.

I know my friend from Illinois is also aware that when you talk about health care, you have to talk about dental care.

Mr. DURBIN. Yes.

Mr. SANDERS. Because what is true in Vermont is true in Illinois. You have a whole lot of people who do not have access to a dentist, which these Federally Qualified Health Centers now provide, and mental health counseling, and low-cost prescription drugs.

So I thank my friend from Illinois. I am sure the Senator and I are going to work together to make sure we, in fact, are successful in keeping people out of the emergency room, keeping them out of the hospital, by enabling them to get the medical care they need when they need it. I look forward to working with my friend on that.

Mr. DURBIN. I might say, the Senator from Vermont has also raised an important issue. We know we are going to need more primary care physicians, so there are provisions in this bill to encourage young people to pursue primary care—internists, family practitioners—because those are the frontline people who are needed more frequently for preventive care and basic checkups, so people have a chance to see a good doctor before they get sick or become seriously ill and it is much more expensive.

Mr. SANDERS. Right.

Mr. DURBIN. So we are pushing forward for more and more health care professionals. Again, the Republican critics of this legislation have offered nothing—nothing—when it comes to encouraging the growth in the number of our health care workers in America. This ought to be something that is nonpartisan. I would think that at some point they would agree that many things in here are essential for the future of our country. I think that is one of them.

Mr. SANDERS. Would my friend from Illinois agree, it does not make a whole lot of sense for people who do not have health insurance today to go into an emergency room and run up a huge cost or to get terribly ill because they do not go to a doctor when they should and end up in the hospital? Wouldn't it make a lot more sense, both for the personal health of the individual and saving money for the system, to provide health care to people when they need it?

Mr. DURBIN. I agree with the Senator from Vermont. I would say we have some of the best health care in America but also the most expensive health care in America. We spend more per person than any other nation on Earth, and a lot of it has to do with money not being well spent. People who do not have access to a medical home, which we establish in this bill, people who do not have access to a community health care clinic, in desperation, will take a baby with a high fever in to an emergency room.

Mr. SANDERS. Right.

Mr. DURBIN. They will wait for hours to finally see a doctor. Once there, they will have the most expensive care they could ever face, when they could have gone for a doctor's appointment.

Mr. SANDERS. Exactly.

Mr. DURBIN. And taken care of it for a fraction of the cost. That is not good for the hospitals because many of them are giving charity care they do not get compensated for, and they pass that cost along to other patients, and it certainly is not good for the families involved.

Mr. SANDERS. At this point, let me thank my friend from Illinois for allowing me to engage in this colloquy with him. I am going to yield back the floor to him and thank him for his very good work.

Mr. DURBIN. I thank the Senator from Vermont.

I say, at this point in time, we have three or four amendments before the Senate on health care reform. We started the debate on Monday. We are now wrapping up Wednesday. We are about to go into the 4th day of the debate on one of the most important bills in the history of the U.S. Senate, and we have yet to reach an agreement with the Republican side of the aisle to have the amendments voted on.

If we are only doing four amendments or three amendments in 4 days, this is not going to be the kind of debate the American people expected. They expected us to bring issues before the floor here, debate them, with a reasonable period of time, and then vote and move to another issue. Certainly, there are a lot of things to talk about.

So I hope the Republican side of the aisle will have a change of heart and will start to join us in this dialog, will offer their amendments in a timely fashion—we will give them their opportunity to debate them—and then bring them to a vote. But the fact is, we have not had a single vote this week on health care reform amendments because of objections from the other side. That is not in the interest of moving forward this important legislation and giving Members an opportunity to present their amendments and have them voted on in a timely fashion.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, I ask unanimous consent that after any leader time on Thursday, December 3, and the Senate resumes consideration of H.R. 3590, it be in order for any of the majority or Republican bill managers to be recognized for a total period of time not to extend beyond 10 minutes, equally divided and controlled; that the time until 11:45 a.m. be for debate with respect to the Mikulski amendment No. 2791 and the McCain motion to commit; and during this time it be in order for Senator MURKOWSKI to call up her amendment with respect to mammography, a copy of which is at the desk; and that it also be in order for Senator BENNET of Colorado to call up amendment No. 2826, a side-by-side amendment with respect to the McCain motion to commit; that no other amendments or motions to commit be in order during the pendency of these amendments and motion; that at 11:45 a.m., the Senate proceed to vote in relation to the Mikulski amendment No. 2791; that upon disposition of the Mikulski amendment, the Senate then proceed to vote in relation to the Murkowski amendment; that upon disposition of these two amendments, the Senate continue to debate until 2:45 p.m. the Bennet of Colorado amendment No. 2826 and the McCain motion to commit, with the time equally divided and controlled between Senators BAUCUS and MCCAIN or their designees; that at 2:45 p.m., the Senate proceed to vote in relation to the Bennet of Colorado amendment No. 2826; that upon disposition of that amendment, the Senate then proceed to vote in relation to the McCain motion to commit; that prior to the second vote in each sequence, there be 2 minutes of debate, equally divided and controlled in the

usual form; that each of the above referenced amendments or motion be subject to an affirmative 60-vote threshold, and that if the amendments or motion do not achieve that threshold, then they be withdrawn; further, that if any of the above listed achieve the 60-vote threshold, then the amendment or motion be agreed to, and the motion to reconsider be laid upon the table; further, that it be in order if there is a request for the yeas and nays to be ordered with respect to that amendment or motion, regardless of achieving the 60-vote threshold, that if the yeas and nays are ordered, the vote would occur immediately with no further debate in order with respect to this particular consent.

The PRESIDING OFFICER. Is there objection?

Mr. VITTER. Mr. President, reserving my right to object.

The PRESIDING OFFICER. The Republican leader.

Mr. MCCONNELL. Mr. President, reserving the right to object, and I will not object, I would just like to point out we have had some difficulty actually on both sides getting to the two votes that are designated in this consent agreement.

Our side of the aisle, the Republican side of the aisle, was prepared to vote on both of those amendments tonight. Then a problem developed on the other side, which I understand because we had had a problem on our side earlier. But I do just want to make it clear that Republicans were prepared and fully ready and willing to vote on the two amendments in the consent agreement tonight.

Mr. President, I do not object.

Mr. VITTER. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. VITTER. Thank you, Mr. President.

Mr. President, I certainly concur with the distinguished majority whip's goal of more amendments and more votes.

With regard to this very important screening and mammography issue, my goal has been a very focused one. I have a filed second-degree amendment that has a very simple, focused objective, which I believe is extremely noncontroversial. I believe it would be supported by everyone in this body, and that is simply to ensure that there is no legal force and effect to the recent recommendations issued in November of 2009 by the U.S. Preventative Services Task Force with regard to breast cancer screening, use of mammography, and self-examination.

As everyone knows, those new recommendations were shocking in that they took a giant step back from the previous recommendations and took a giant step back in terms of recommended screening, which virtually every expert I know of strongly disagrees with.

So this filed, simple second-degree amendment simply says that those new recommendations of November of this year have no force and effect. I will read the amendment. It is very short. To be clear, it does nothing more than that.

> [F]or the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

So we are simply ensuring that those new recommendations—which I strongly disagree with, experts strongly disagree with, I believe all of my colleagues do—have no legal force and effect. So I would simply ask that the unanimous consent proposed be modified so that the Mikulski amendment incorporates this language. I would propose that as an alternative unanimous consent request.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Mr. DURBIN. I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request from the Senator from Illinois?

Mr. VITTER. Yes, I continue to reserve my right to object. I am very disappointed about objecting to this important and what should be noncontroversial provision. I would suggest another solution, which is to take the unanimous consent request on the floor and modify it so there is simply a vote on this second-degree amendment, amendment No. 2808, immediately before the vote on the Mikulski amendment.

The PRESIDING OFFICER. Is there objection to the request, as modified?

Mr. DURBIN. Mr. President, reserving the right to object.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I am not sure I would support or oppose the amendment offered by the Senator from Louisiana, but this matter has been on the floor now for 3 days. I say to the Senator, there is a pending amendment here on your side of the aisle from Senator MURKOWSKI on this issue, and I would hope that the Senator has approached her to incorporate his language. I do not know if the Senator approached Senator MIKULSKI. But at this point we think we have some effort being made at fairness on both sides, that there will be Democratic amendments and Republican amendments both offered—Mikulski and Murkowski and McCain and Bennet—and so I would object because I believe we have the basis for a fair agreement at this point.

The PRESIDING OFFICER. Objection is heard. Is there objection to the original request of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving my right to object, again, I am very disappointed to hear that. I have approached both sides. Senator MURKOWSKI has incorporated similar language, and I was hoping we could come together, 100 to nothing, to actually pass this on to the bill, whichever alternative tomorrow is voted up—and maybe they both will be—but whichever is voted up or whichever is voted down, I think it is very important to come together and state that we don't want these new task force recommendations to have any force and effect.

So let me propose a third and final alternative unanimous consent request: that at any point after these votes, but before cloture is filed on the pending matter, this amendment No. 2808 receive a vote on the Senate floor as a first-degree amendment to the underlying bill.

Mr. DURBIN. Mr. President, reserving the right to object, may I suggest to my friend from Louisiana, would you consider approaching Senators MIKULSKI and/or MURKOWSKI the first thing tomorrow and see if they are prepared to work with you on this? This Mikulski amendment has been pending for 3 days.

Mr. VITTER. Mr. President, if I could——

Mr. DURBIN. Well, then, I object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original request?

Mr. VITTER. Mr. President, reserving my right to object, just so I can respond directly, I didn't mean to cut the Senator off. If he has any further statement, I will be happy to listen to it. But just so I can respond directly, the first thing today, I approached both those Members and everyone involved in this debate about this language and certainly the majority side has had this language for at least 7½ hours. The equivalent of this language has been incorporated into the Murkowski amendment, but my hope is that the same thing be accepted in the Mikulski amendment because it is not clear which is going to be adopted. I don't see the great controversy here. So that was my hope. And that is why I approached those two Senators and the majority side 7½ hours ago about it with specific language.

So I renew my last unanimous consent request I made in that spirit.

Mr. DURBIN. Reserving the right to object, the staff advises me that they are reaching out to Senator MIKULSKI at this moment. I don't know if we can be in contact with her this evening, but I would ask the Senator from Louisiana if he would consider allowing us to go forward with this unanimous consent request and hope we can still modify it tomorrow, if there is an agreement with Senator MIKULSKI at that point. I don't think that jeopardizes the right of the Senator from Louisiana to offer this at a later time during the course of this debate.

Based on that, I would continue to object.

The PRESIDING OFFICER. Objection is heard.

Is there objection to the original unanimous consent of the Senator from Illinois?

Mr. VITTER. Mr. President, reserving the right to object, merely to respond through the Chair, I would say I have been working in that spirit. I have given the language to the majority side. I have been working both at the staff level and Member level with many folks. This should be noncontroversial. I don't know of any Senator who disagrees with this. So I will accept that offer. I will not object to this pending unanimous consent, but I truly hope the offer is made in good faith because I believe, when anyone reads this language, they will agree with it.

Again, it simply says these latest recommendations by the U.S. Preventive Services Task Force, made 2 weeks ago, will not have any legal force and effect. I believe all of us—certainly, it is my impression and, I guess, we will find out tomorrow morning—I believe all of us want to stop them from having force and effect because it is a great step backward in terms of breast cancer screening and mammography and even education about self-examination.

So I certainly take that offer and look forward to the majority side rereading this language and hopefully accepting it tomorrow morning because I can't imagine, on substantive grounds, objecting to the language.

Thank you. With that, I will not object.

The PRESIDING OFFICER. Without objection, the request from the Senator from Illinois is agreed to.

Mr. DURBIN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

AMENDMENT NO. 2808 TO AMENDMENT NO. 2791

Mr. DURBIN. Mr. President, I ask unanimous consent that the previous order with respect to H.R. 3590 be modified to provide that the Vitter amendment No. 2808 to the Mikulski amendment No. 2791 be agreed to and the motion to reconsider be laid upon the table; that the order be further modified to provide that the vote with respect to the Mikulski amendment should now reflect the Mikulski amendment, as amended.

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

The amendment (No. 2808) was agreed to, as follows:

(Purpose: To prevent the United States Preventive Service Task Force recommendations from restricting mammograms for women)

On page 2 of the amendment, after line 15 insert the following:

''(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Fore regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.''

MORNING BUSINESS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

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

REMEMBERING MARY JOSEPHINE OBERST

Mr. McCONNELL. Mr. President, today I rise to honor the life of a Kentucky heroine, Ms. Mary Josephine Oberst of Owensboro. Ms. Oberst passed away on November 13, 2009, at the age of 95. A native Kentuckian, she proudly served her country as a member of the Army Nurse Corps beginning in 1937. In July 1941, Ms. Oberst was sent to the Philippines, and in early May the following year, when Bataan and Corregidor fell to the Japanese during the Battle of the Philippines, more than 60 nurses, including Ms. Oberst, were taken as prisoners of war, POWs, by the Japanese. These nurses, later christened the ''Angels of Bataan,'' were held as POWs for 33 months. During this time, Ms. Oberst continued her duties as a nurse, caring for fellow prisoners, even though she herself suffered from malaria and significant weight loss. In early February 1945, the 44th Tank Battalion rescued the POWs who were later brought back to the United States.

After overcoming the medical conditions which resulted from her imprisonment, Ms. Oberst was appointed captain and continued to serve as a member of the Army Nurse Corps. She worked in hospitals in Louisville, KY; Fort Knox, KY; and Ashford, WV, until her retirement from the Corps in 1947. Ms. Oberst was honored for her duty with several military service awards, including the Bronze Star Medal. Mary Josephine Oberst was a woman of high character, who faithfully served our country. Today, I wish to honor her life and her service, as well as give my condolences to her family for their loss.

AMINATOU HAIDAR

Mr. LEAHY. Mr. President, I want to bring to the attention of Senators who may not already be aware, a situation that has been unfolding in Morocco and the Canary Islands.

Last year, I had the privilege of meeting Ms. Aminatou Haidar, called by some the ''Saharawi Gandhi,'' who received the 2008 human rights award from the Robert F. Kennedy Center for Justice and Human Rights. Ms. Haidar is a focus of attention again today because she is on a hunger strike in the Canary Islands after being summarily deported by the Moroccan Government on her way home to Western Sahara from the United States, where, coincidently, she had been to receive the ''Civil Courage Prize'' from the Train Foundation.

Ms. Haidar is no newcomer to difficulties with the Moroccan authorities. She was first imprisoned in 1987 when she was a 20-year-old college student, after calling for a vote on independence for Western Sahara. When she was released after 4 years, during which she was badly mistreated, she continued her advocacy for the right of the Saharawi people to choose their own future.

Arrested again in 2005 and separated from her two daughters, she led a group of 37 other Saharawi prisoners on a 51-day hunger strike for better prison conditions, investigations into allegations of torture, and the release of political prisoners.

Since her 2006 release, she has continued her nonviolent struggle, which has brought widespread attention to the cause of the Saharawi people. The United Nations Security Council has repeatedly endorsed a referendum on self-determination for the people of Western Sahara.

On November 13, when Ms. Haidar arrived at the airport in El-Ayoun, she was detained by Moroccan authorities. She was told that by insisting on writing her place of residence as ''Western Sahara'' on her immigration form, she was in effect waiving her Moroccan citizenship. Her passport was taken, and she was forcibly put on a plane without travel documents to the Canary Islands, a Spanish archipelago located 60 miles west of the disputed border between Morocco and Western Sahara.

She remains there at the airport, separated from her daughters, in the 17th day of a hunger strike, and her health is reportedly rapidly deteriorating. She has refused an offer of a Spanish passport, insisting that she will not be a ''foreigner in her own country,'' and the Moroccan Government refuses to reinstate her passport. She is, in effect, a stateless person.

This is unacceptable. Article 12 of the International Covenant on Civil and Political Rights, which Morocco has ratified, states in part, ''Everyone shall be free to leave any country, including his own. . . . No one shall be arbitrarily deprived of the right to enter his own country.''

The situation in Western Sahara is a difficult one for the Saharawi people and the Moroccan Government. It is a protracted dispute in which the international community has invested a great deal to try to help resolve, without success. I recall the time and energy former Secretary of State James Baker devoted to it. The solution he proposed was rejected by the Moroccan Government.

Morocco and the United States are friends and allies, and I have commended the Moroccan Government for

positive steps it has taken in the past to improve respect for human rights and civil liberties. On a recent trip to North Africa, Secretary Clinton was complimentary of Morocco's efforts to reach a peaceful solution in Western Sahara. But the Saharawi people, including Aminatou Haidar, have passionately advocated for the right to self-determination, and the international community, including the U.N., has long supported a referendum on self-determination, which has thus far been blocked by the Moroccan Government.

I have no opinion on what the political status of Western Sahara should be, but I am disappointed that the Moroccan authorities have acted in this way because it only adds to the mistrust and further exacerbates a conflict that has proven hard enough to resolve. Nothing positive will be achieved by denying the basic rights of someone of Ms. Haidar's character and reputation, or restricting the right to travel of other residents of Western Sahara, as the Moroccan authorities have increasingly done in the last 2 months.

In the past, the United States has opposed proposals to extend the U.N.'s mandate in Western Sahara, currently limited to peacekeeping, to human rights monitoring. The recent crackdown on Ms. Haidar and other Saharawis who continue to insist on a referendum on self-determination suggests that human rights monitoring is needed and should be seriously considered when the U.N. mission comes up for renewal in April. I encourage the Department of State to review this question and to consult with the Congress about it.

I am confident that our relations with Morocco, already strong, will continue to deepen in the future. We share many important interests. But the United States was also instrumental in the creation of the Universal Declaration of Human Rights, and while we sometimes fall short ourselves, we will continue to strive to defend those whose fundamental rights are denied, wherever it occurs.

I appreciate the efforts the Department of State has made to try to help resolve this situation. I urge the Moroccan Government to reconsider its decision to deport Ms. Haidar, which will not advance its interests in the conflict over Western Sahara. It should return her passport, readmit her, and let her return to her home and family.

60TH ANNIVERSARY OF THE VOICE OF AMERICA'S UKRAINIAN SERVICE

Mr. CARDIN. Mr. President, for six decades the Voice of America's, VOA, Ukrainian-language service has been providing an invaluable service through its consistent broadcasting of factual and comprehensive news and information to the people of Ukraine.

During the first four decades of its existence, the Ukrainian service reached a Ukrainian population starving for information under an extremely strictly controlled, propagandistic Soviet media environment. Ukrainians went to great lengths and some risks to overcome Soviet censorship, which included the jamming of VOA and other shortwave international broadcasting.

During the Cold War VOA Ukrainian provided its listeners with uncensored news about such monumental events as the Hungarian Revolution, the Prague Spring, rise of Solidarity, and the fall of the Berlin Wall. A variety of shows worked to open the outside world to Ukrainian listeners, including a Popular Music Show, a Youth Show, and the long running series Democracy in Action, which was about how democracy works in the United States.

The Ukrainian service also focused on developments within Ukraine itself. VOA broadcasts about Soviet human rights violations in Ukraine, including its coverage of activities of the Helsinki process and the Helsinki Commission, gave sustenance to Helsinki Monitors and other Ukrainian human rights activists, especially those languishing in the gulag for daring to call upon the Soviet government to live up to its Helsinki Final Act obligations. They knew that they were not forgotten. Furthermore, the Ukrainian service also provided objective information about the Chornobyl nuclear disaster and the development of Ukraine's movement for democracy and independence, culminating in the December 1, 1991, referendum in Ukraine in which an overwhelming majority of Ukrainians voted for the restoration of their nation's independence.

For nearly two decades since, VOA's Ukrainian service has continued to fill an important role in Ukraine's evolving democracy. VOA reported on the challenges that Ukraine faced and on the U.S.'s considerable support and assistance for Ukraine, including in the dismantling of the nuclear arsenal it inherited from the Soviet Union. During the Orange Revolution, VOA Ukrainian helped to reassure millions of Ukrainians that the international community would not sanction electoral fraud.

As Ukraine has evolved, so has the Ukrainian Service. While no longer broadcasting on radio as it did for most of its 60 years, it reaches more Ukrainians than ever with daily broadcasts over Ukrainian television—something unthinkable during Soviet rule—and reporting on its website. It continues to report on what is happening in Ukraine, but also it continues to cover every aspect of American life and society. As Chairman of the Helsinki Commission, I commend the ongoing role of VOA's Ukrainian service in helping Ukraine fulfill its aspirations in becoming a more fully democratic, independent, and secure.

WORLD AIDS DAY

Mr. CARDIN. Mr. President, I rise today in recognition of World AIDS Day, an international commemoration held each year on December 1 to raise awareness of HIV and AIDS around the world. The theme for this year's World AIDS Day is ''universal access and human rights.''

Around the world, 33 million people were living with HIV in 2007, including 2.7 million new infections. In the U.S., more than 1.2 million people are infected with HIV. According to the Joint United Nations Program on HIV/AIDS, or UNAIDS, global reports indicated that 2 million people died from AIDS-related causes in 2007.

Globally, sub-Saharan Africa is the hardest-hit region when it comes to HIV infection, accounting for two-thirds of all people living with HIV and for three-quarters of AIDS deaths in 2007. Sadly, 75 percent of young people worldwide who are diagnosed with HIV are girls living in sub-Saharan Africa.

According to the results of a global youth survey conducted in 99 countries, 50 percent of young people have a dangerously low knowledge of how the disease is contracted and can be prevented. Another report by UNAIDS collected data from 64 countries and found that fewer than 40 percent of young people have basic information about HIV. This knowledge gap is particularly disturbing when taking into account a UNICEF report that indicates that 4.9 million young people, ages 15–24, are living with HIV worldwide.

Despite these statistics, recent advances in prevention and treatment of HIV give hope for the future. Globally, approximately 38 percent of the 730,000 children under 15 who needed antiretroviral drugs to treat HIV in 2008 were receiving the necessary therapy, according to UNAIDS. This is a huge increase from just a little over 10 percent in 2005.

The percentage of pregnant women living with HIV who received antiretroviral treatment to prevent mother-to-child transmission has increased from 9 percent in 2004 to 33 percent in 2007.

Despite recent improvements in treatment coverage and declining mother-to-child transmission of HIV, problems remain in preventing and treating the disease. In addition, the number of new HIV infections continues to outpace the advances made in treatment numbers for every two people put on antiretroviral drugs, another five become newly infected with the disease. Clearly, prevention measures are essential to continue the fight against HIV/AIDS.

No State in the U.S. is immune from the effects of HIV/AIDS, and the epidemic is deeply felt among Marylanders as well. At the end of 2007, Maryland had 28,270 people living with HIV and AIDS. That same year, Maryland ranked fourth in the U.S. for the number of AIDS cases per 100,000 people.

The Maryland Department of Health and Mental Hygiene has estimated that

there are between 6,000 and 9,000 Marylanders who are unaware that they are infected with HIV. Of the 1.2 million people in the United States who are estimated to be infected with HIV, as many as 21 percent are unaware that they have the virus.

To address this problem, it is crucial that HIV screening be readily available and accessible to everyone at little or no cost. This will increase the rate of diagnosis in individuals that have HIV and will accelerate their treatment.

The Patient Protection and Affordable Care Act will address this need and will help achieve the goals outlined by the theme of this year's World AIDS Day campaign of ''universal access and human rights.''

First and foremost, the bill eliminates discrimination based on pre-existing conditions. Individuals with HIV will no longer be rejected from insurance coverage because of their disease.

The bill also encourages outreach to enroll vulnerable and underserved populations in Medicare and CHIP, including adults and children with HIV/AIDS. It provides personal responsibility education grants to States to create HIV/AIDS education programs for adolescents.

The bill will also cover preventive services recommended by the U.S. Preventive Services Task Force, including HIV testing for all pregnant women. This testing will be provided at no individual cost, making it universally accessible to all women in the U.S. Testing pregnant women for HIV is vital for prevention efforts, allowing women who test positive to begin antiretroviral drugs to prevent transmission to their baby.

Furthermore, the Mikulski amendment, which I have cosponsored, would allow coverage for HIV testing for all women, regardless of risk, based on expert recommendations from the Health Resources and Services Administration.

The Patient Protection and Affordable Care Act also provides grants to encourage training health care workers to treat individuals with HIV/AIDS and other vulnerable populations.

Because of the numerous provisions in the bill that will help the prevention and treatment of HIV/AIDS, several groups have expressed their support for the Patient Protection and Affordable Care Act. Among the groups that I have heard from is the HIV Medicine Association, an organization representing 3,600 physicians, scientists, and health care professionals who work on the frontlines of the HIV/AIDS epidemic in communities across the country.

We must continue to fight HIV/AIDS, and I urge my colleagues to support the measures outlined in the Patient Protection and Affordable Care Act that will further our efforts to combat this disease.

RECOGNIZING REAL SALT LAKE SOCCER TEAM

Mr. HATCH. Mr. President, I rise and offer my congratulations to the Real Salt Lake soccer team, the newly crowned champions of Major League Soccer. While Utah has a number of sports teams with proud traditions—both collegiate and professional—Real Salt Lake has brought to my home State its first major professional championship since 1971, when the Utah Stars won the ABA title. Fans throughout Utah are thrilled.

Real Salt Lake came to Utah in 2004 and faced difficulties during its first three seasons. In just its fourth season, however, Real Salt Lake made an improbable run to the Western Conference Finals, despite only sneaking into the playoffs on the last day of the regular season. They eventually lost that game by a score of 1–0, but with their first playoff appearance, and opening their new world class soccer-specific stadium, their future was filled with promising signs.

In 2009 Real Salt Lake delivered on that promise. Once again, it was the last team to qualify for the playoffs and was the lowest overall seed. Despite barely squeaking into the playoffs, this team of overachievers sure made some noise once they got there. They quickly reeled off a string of consecutive upsets against glitzier opponents with established stars, dispatching top-seeded and defending MLS champion Columbus and then powerhouse Chicago and its star Cuauhtemoc Blanco.

On November 22, the title game in Seattle pitted the little-known upstarts of Real Salt Lake against the Western Conference champions, the Los Angeles Galaxy and its mega-stars Landon Donovan and David Beckham. After 90 minutes of regulation play and 30 minutes of overtime, the game remained tied at 1–1. In the penalty kick shootout, Real Salt Lake emerged victorious 5–4 as Donovan's potential game-tying spot kick sailed harmlessly over the crossbar. Real Salt Lake had delivered the first championship of its kind in Utah in nearly four decades—and it couldn't have come in a more exciting fashion or to a more deserving group of athletes.

In the end, it wasn't the Galaxy of stars that prevailed; it was Real Salt Lake with its philosophy that mirrors the words emblazoned on the sign in its home locker room: ''THE TEAM IS THE STAR.'' That teamwork was certainly on display in the title tilt against Los Angeles. It was reflected in Real Salt Lake Robbie Findley's breakout 64th-minute strike that knotted the score at 1–1 and made the team's overtime and penalty kick heroics possible. It was reflected in the play of Salt Lake goalkeeper and Cup final MVP Nick Rimando, who turned away penalties from L.A.'s Jovan Kirovski and Edson Buddle before besting Donovan. Finally, RSL's determination to overcome the odds also mirrors that of its owner, Dave Checketts, coach Jason Kreis and general manager Garth Lagerwey—all of whom turned the team into a champion despite the naysayers who said it couldn't be done.

No, Real Salt Lake's roster did not have the league's biggest stars. But in the words of midfielder Clint Mathis, better known as Cletus, RSL was ''the better team in every game.'' As much as anything else, that explains why champion Real Salt Lake is now the brightest light in MSL's firmament.

Once again, I congratulate Real Salt Lake on this accomplishment. Senator BENNETT and I have introduced a resolution expressing the Senate's congratulations for Real Salt Lake and I urge my colleagues to offer their support.

Mr. BENNETT. Mr. President, I wish to commend and congratulate Real Salt Lake for winning the 2009 Major League Soccer Cup. I am delighted to do so, and feel it is a privilege to honor the MLS Cup champions on the Senate floor. The story of Real Salt Lake is more than just a story about a soccer team capturing the MLS title; it is a story about banding together to overcome obstacles and defying the odds after being counted out and dismissed by ''the experts.'' In many ways, the story of Real Salt Lake is part and parcel of the American experience.

On November 22, 2009, in Seattle, WA, Real Salt Lake, or RSL, faced off against the better-known and widely acclaimed L.A. Galaxy. Just to give a sense of what RSL was up against, listed on the roster for the Galaxy were U.S. National Team star Landon Donovan, and the internationally acclaimed, indeed iconic, David Beckham. The RSL roster, on the other hand, didn't include what's known as a ''designated player,'' or in other words, a recognized superstar. If that wasn't enough, the Galaxy entered the postseason riding high, having finished at the top of the Western Conference in the regular season with a 12–6–12 record, and were expected by most to perform well if not to win the championship. RSL had a far different experience during their regular season, finishing with an 11–12–7 record. Indeed, they barely managed to make it into the eight team playoff that would determine the MLS Cup Champion.

Considering these facts, it would have been easy for RSL to give up. But that wasn't their attitude. When asked about not having a star player, instead of bemoaning that fact, the team's captain, Kyle Beckerman, said, ''We've really bought into the 'star is the team' here in Salt Lake. When we work as a team and [are] doing well it's because everybody's playing well. It pays off.'' This team unity had initially paid off in the postseason for RSL as they defeated the defending champion Columbus Crew, and beat the Chicago Fire in the Eastern Conference finals. Despite this, many doubted whether they could win against the Galaxy in the championship game. When asked

about their chances, head coach Jason Kreis sarcastically replied, ''Wow, it sounds like we better not even go. We don't even have a chance, do we?'' He knew RSL possessed something special.

Even in the final match, such outspoken optimism would be tested. By halftime, RSL was trailing 1–0. Two of their key players were unable to continue playing, sidelined by injury and illness. If ever there was a time to give up, it seemed that this was it. But that wasn't their attitude. Coach Kreis made a pair of substitutions, and encouraged his players to ''be confident,'' and play aggressive. And, well you can see where this is going. After 90 minutes of play, 30 minutes of overtime, and seven rounds of penalty kicks that included two blocked shots by RSL goalkeeper Nick Rimando, defender Robbie Russell converted the final penalty kick to seal the victory, establishing RSL as the champions of Major League Soccer.

Now I wish to place this victory into some context. This was significant for Utah in that it was the first professional sports crown to go to the State of Utah since the Utah Stars basketball team won the American Basketball Association title back in 1971. RSL's victory was notable not only because Jason Kreis, at the age of 36, became the youngest manager in MLS history to lead his team to the title, but also because RSL became the first franchise in professional sports history to win a championship after finishing the regular season without a winning record. Think about that for a minute—if there is ever a reason to dismiss a team, a losing record in the regular season should be it. But that wasn't RSL's attitude. Rather than dwelling in self-pity and regret, RSL fought on, determined to prove their detractors wrong. They believed they could beat the entire league, and they went out and did just that. Their story exemplifies the American values of hard work, resilience, and overcoming the odds.

Once again, I congratulate RSL for their victory; I join with their fans in celebration of this championship; and I hope that this is one of many more championships to come for Utah.

ADDITIONAL STATEMENTS

COACHED FOR LIFE

• Mr. BAUCUS. Mr. President, today I wish to speak about the life lessons we learn from participating in athletic activities and from the coaches who teach our young athletes. Michael T. Powers, author of many inspirational books once said, ''High school sports: where lessons of life are still being learned, and where athletes still compete for the love of the game and their teammates.'' High school sports are a way of life across Montana and they create an important sense of community in small towns and cities all over Big Sky country. In many areas across the state, small high schools will pool their resources to field football teams each fall; many play six or eight man games.

This year Ed Flaherty, a native Montanan co-authored the book ''Coached for Life'' about the experience he and his teammates had on the State champion Great Falls Central High School football team in 1962. I was inspired by the stories of these young men and how the lessons learned on the field from their coaches shaped who they became as people and their experiences later in life.

The young men that made up Great Falls Central's 1962 Championship squad truly embody the best of Montana ideals and values, like hard work and taking responsibility. They labored tirelessly both on and off the field and achieved not only athletic glory, but also learned the value of a good education and how to be role models and ambassadors for their school. Great Falls has always been a working class town and many families made significant financial sacrifices to allow their children to attend Great Falls Central, a private Catholic school. Coaches Bill Mehrens and John ''Poncho'' McMahon, reminded the players each day that playing football at Central was a privilege and that they had a responsibility to their teammates, their school, and the community to give it their all on each and every snap on the practice field, in the game, and in the classroom. No doubt the coaches pushed these young men each and every day, they did it to instill discipline and to make them the best they could be.

The 1962 season was a special one for Great Falls Central. The goal of the team was to win the State championship. A year earlier, the coaches drove some of their players north 115 miles to Havre to watch the State championship game, not only to scout two of the best teams in the State but also to witness a championship win. The Central players took it all in and knew they wanted to be the ones holding up the trophy the following season. The Mustangs achieved that goal, making it through the 1962 season undefeated and beating their rival, the defending State champions, Havre High 34–6 in the Montana Class A State championship game in front of more than 5,000 elated fans on their home field.

Having gone through this experience, the men later in life were able to rise up against the many challenges that were thrown their way. At a team reunion in 2002, 40 years after their championship run, the players and coaches got together to reflect and share their life stories. Some have gone on to be teachers and coaches, passing on the life lessons they learned from Mehrens and McMahon. Some, like Ed Flaherty, have achieved successful careers in business and in turn gave back to their communities. Some served their country heroically in the military. All have taken the lessons they learned from the fall of 1962 and have helped their communities and become leaders. Ed Flaherty has compiled these stories in his book and brings to life that amazing season and what it truly means to be coached for life.•

TRIBUTE TO HARRY R. BADER

• Mr. BEGICH. Mr. President, I wish congratulate Fairbanks, AK, resident Mr. Harry R. Bader for being the first Civilian Response Corps-Active Officer in the United States Agency for International Development, USAID, to be trained and ready for world-wide deployment.

Mr. Bader's specialized training, which will allow him to work in high threat environments, was recognized by the Administrator of USAID in a November 23, 2009, ceremony in Washington, DC. Currently, Mr. Bader is the USAID Deputy Environmental Officer for the Democracy, Conflict and Humanitarian Assistance Bureau.

USAID's Civilian Response Corps is a commendable program. The Corps plays an integral part in U.S. national security strategy. One of their missions is to bring coordination to military and civilian efforts in order to stabilize fragile states and to improve the effectiveness of counter-insurgency operations.

As an active officer, Mr. Bader's environmental security specialty will be brought to bear in those areas of the developing world where scarcity or degradation of natural resource contribute to conflict. His task will be to find ways to reduce the means and motivations for violence.

Mr. Bader's diverse educational and professional backgrounds make him well suited to excel as a Civilian Response Corps-Active Officer. He has a law degree from Harvard and B.A. from Washington State University. His career has been one of distinction and variety as a professor, author, researcher, lecturer, natural resource manager and consultant.

He taught at the University of Alaska Fairbanks as an associate professor of resources policy at the School of Natural Resources Management. During his tenure, he served on the Alaska Sea Grant Legal Research Team, which was created in response to the Exxon Valdez Oil Spill to help strengthen oversight of hazardous materials.

At the Alaska Department of Natural Resources, Mr. Bader was the northern region land manager in Fairbanks, where he was responsible for the stewardship of 40 million acres of public land in the arctic and boreal regions of Alaska. He often collaborated with industry and academia in developing land use policy.

Until recently, Mr. Bader was active with the Betula group, a consulting firm he founded which specializes in resource management issues in challenging social and physical environments. He travelled to Tajikistan, Iraq,

and Ukraine lending his expertise in the development of democracy and governance. Mr. Bader is also perusing a midcareer doctorate at the Yale School of Forestry and Environmental Studies.

I applaud Harry on this appointment and am confident he will make contributions to security and environmental improvement wherever he is assigned by the Corps.●

TRIBUTE TO DONALD DOWD

● Mr. KERRY. Mr. President, I congratulate Don Dowd for his longtime public service to New England and to the Commonwealth of Massachusetts. For more than half a century Mr. Dowd has been a fixture in the culture, civic life, and politics of our region of the United States. I also congratulate one of the many organizations with which Mr. Dowd has been associated—Special Olympics Massachusetts, part of the international Special Olympics organized by Eunice Shriver in 1968.

Special Olympics Massachusetts has just moved into a new state-of-the-art office and training center in Marlborough. The Yawkey Sports Training Center has training rooms, a gymnasium and outdoor soccer fields, all right in the heart of Massachusetts, less than a 90-minute drive from 90 percent of the population of the Commonwealth.

Mr. Dowd has been one of the biggest and most active supporters of Special Olympics, a global force for understanding and change, involving 2.5 million athletes representing more than 140 countries. Special Olympics Massachusetts currently serves more than 10,000 athletes and involves 11,000 volunteers and 1,600 coaches. With its new training center, which opened this fall, Special Olympics Massachusetts hopes to expand the program to 20,000 athletes by 2010. Mr. Dowd began his public service career as the Assistant Regional Director of the U.S. Postal Service for the six New England States during the Presidency of John F. Kennedy. He was political adviser to Robert F. Kennedy's Presidential campaign in 1968. And he was an aide and close friend to Senator Edward M. Kennedy throughout Ted's entire 47-year career in the Senate. Mr. Dowd coordinated the 1979 opening of the John F. Kennedy Presidential Library and has served as a member of the John F. Kennedy Library Foundation Board since its inception. Mr. Dowd continues to do consulting work since his retirement from his regional executive position with the Coca-Cola Company.

He is a lifelong resident of Springfield, MA, and as such once played a little known role in getting Ted Kennedy to make a cameo appearance in a video production. Twentieth Century Fox had invited every town named Springfield to enter videos to make the case that their town should be the Springfield in ''The Simpsons'' animated movie and television program, and it was no secret that the mayor in the Simpsons cartoon was a spoof on Ted.

Mr. President, I thank Mr. Dowd for his service and dedication to our region and our country. And I congratulate Special Olympics Massachusetts on their new facilities and express my appreciation for all it contributes to the physical, social, and psychological development of people with intellectual disabilities.●

RECOGNIZING SHAW AND TENNEY

● Ms. SNOWE. Mr. President, today I wish to honor a Maine small business with a long standing reputation for producing elegant and practical instruments used by the maritime industry. Founded in 1858, Shaw and Tenney of Orono, ME, has been producing renown, specialty handcrafted wooden oars and paddles for over a century and a half. Indeed, Shaw and Tenney is the oldest continuing producer of solid wooden paddles and oars in America, as well as the third oldest manufacturer of marine products in the country.

This historic company got its start on the banks of the Stillwater River near Orono where its founder, Frank Tenney, first launched his signature oars and paddles as part of the Orono Manufacturing Company. During the 19th century, Maine rivers and coastal waters served as a critical highway network for transporting people and goods throughout the State. Small boats such as skiffs, peapods, and canoes were several of the major vessels employed in promoting greater commerce, and Mr. Tenney's quality oars and paddles served as an indispensible tool in helping to propel major industries to new heights across the State. In the 1890s, Mr. Tenney merged his small manufacturing company with the Boston-based George Shaw Company, which produced similar goods. Together they formed what is now formally known as Shaw and Tenney.

The newly merged business soon moved to downtown Orono's Main Street and remained there until nearly 1950, when it relocated again to the company's current location at 20 Water Street. The Tenney family retained ownership until about 1970 when the company underwent three short-lived transitions to new owners. The current proprietors, Steve and Nancy Holt, share the privilege of carrying forward the legacy of this unique novelty company. Since the Holts came aboard, they have expanded the company's product line to include other specialty products such as masts, spars, boat hooks, and flagpoles. At the same time, the Holts take pride in producing the same quality product that's earned Shaw and Tenney its stellar reputation for dependable marine instruments.

More than just ordinary oars and paddles, the Shaw and Tenney product line is composed of individual pieces of art specially handcrafted to be both practical and refined. Much of the company's well-earned success lies in the quality of the raw material used to construct its distinguished oars and paddles. To make its flat- and spoon-bladed oars, Shaw and Tenney mostly utilizes clear, solid, eastern red spruce supplied by two mills located within a 50-mile radius of the company's facility. In fact, clear red spruce has the highest strength-to-weight ratio of any North American softwood, providing the finished products with a noticeable lightweight durability. Each piece of lumber is carefully critiqued before generating the exceptional, distinct oar or paddle.

Shaw and Tenney's artifacts are showcased across the country and, indeed, the world. Its traditional rowing oars can be found at places as diverse as California's Disneyland and the Royal Saudi Naval Force's whale boats. Domestic travelers will also notice Shaw and Tenney oars in Las Vegas as gondoliers ferry visitors around the city's reproduction of Venice's Grand Canal. Furthermore, many U.S. Marines give the company's paddles as a gift when an officer leaves the ranks and it is not uncommon for customers to request fancy oars to use as balusters or stair rails in their homes.

Shaw and Tenney has truly crafted a legendary product that highlights the ingenuity and craftsmanship of Mainers. Since its start on the banks of a small Maine river, this impressive small business has blossomed into a trusted and worldwide leader in its specialized industry. Congratulations to everyone at Shaw and Tenney for over 150 years of their extraordinary handiwork, and I offer my best wishes for their continued success in the future.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 12:53 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 3029. An act to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle and simple cycle power generation systems.

H.R. 3598. An act to ensure consideration of water intensity in the Department of Energy's energy research, development, and demonstration programs to help guarantee efficient, reliable, and sustainable delivery of energy and water resources.

H.R. 3667. An act to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida, as the ''Clyde L. Hillhouse Post Office Building''.

ENROLLED BILLS SIGNED

At 2:54 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the Speaker has signed the following enrolled bills:

S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1860. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

The enrolled bills were subsequently signed by the President pro tempore (Mr. BYRD).

At 3:12 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bill, without amendment:

S. 1422. An act to amend the Family and Medical Leave Act of 1993 to clarify the eligibility requirements with respect to airline flight crews.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 3029. An act to establish a research, development, and technology demonstration program to improve the efficiency of gas turbines used in combined cycle power generation systems; to the Committee on Energy and Natural Resources.

H.R. 3598. An act to ensure consideration of water intensity in the Department of Energy's energy research, development, and demonstration programs to help guarantee efficient, reliable, and sustainable delivery of energy and water resources; to the Committee on Energy and Natural Resources.

H.R. 3667. An act to designate the facility of the United States Postal Service located at 16555 Springs Street in White Springs, Florida as the ''Clyde L. Hillhouse Post Office Building''; to the Committee on Homeland Security and Governmental Affairs.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, December 2, 2009, she had presented to the President of the United States the following enrolled bills:

S. 1599. An act to amend title 36, United States Code, to include in the Federal charter of the Reserve Officers Association leadership positions newly added in its constitution and bylaws.

S. 1860. An act to permit each current member of the Board of Directors of the Office of Compliance to serve for 3 terms.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3779. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Pistachios Grown in California; Changes to Handling Regulations'' (Docket No. AMS–FV–09–0031; FV09–983–1 FR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3780. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Walnuts Grown in California; Increased Assessment Rate and Changes to Regulations Governing Reporting and Recordkeeping'' (Docket No. AMS–FV–09–0020; FV09–984–3 FR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3781. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Tomatoes Grown in Florida; Decreased Assessment Rate'' (Docket No. AMS–FV–09–0063; FV09–966–2 IFR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3782. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Domestic Dates Produced or Packed in Riverside County, CA; Increased Assessment Rate'' (Docket No. AMS–FV–09–0045; FV09–987–2 FR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3783. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Onions Grown in South Texas; Decreased Assessment Rate'' (Docket No. AMS–FV–09–0044; FV09–959–2 FIR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3784. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Pistachios Grown in California; Order Amending Marketing Order No. 983'' (Docket No. AO–FV–08–0147; Docket No. AMS–FV–08–0051; FV08–983–1) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3785. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Apricots Grown in Designated Counties in Washington; Decreased Assessment Rate'' (Docket No. AMS–FV–09–0038; FV09–922–1 FIR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3786. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Applications for Food and Drug Administration Approval to Market a New Drug; Postmarketing Reports; Reporting Information About Authorized Generic Drugs'' (Docket No. FDA–2008–N–0341) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3787. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Listing of Color Additives Exempt From Certification; Paracoccus Pigment'' (Docket No. FDA–2007–C–0456) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3788. A communication from the Director of Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled ''Defense Federal Acquisition Regulation Supplement; Whistleblower Protections for Contractor Employees'' (DFARS Case 2008–D012) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Armed Services.

EC–3789. A communication from the Assistant Secretary, Bureau of Political-Military Affairs, Department of State, transmitting, pursuant to law, an addendum to a certification, transmittal number: DDTC 128–09, of the proposed sale or export of defense articles, including technical data, and defense services to a Middle East country regarding any possible effects such a sale might have relating to Israel's Qualitative Military Edge over military threats to Israel; to the Committee on Armed Services.

EC–3790. A communication from the Secretary of Defense, transmitting a report on the approved retirement of Lieutenant General Maurice L. McFann, Jr., United States Air Force, and his advancement to the grade of lieutenant general on the retired list; to the Committee on Armed Services.

EC–3791. A communication from the Assistant Secretary (Legislative Affairs) Department of Defense, transmitting, pursuant to law, a report relative to the certification of protected documents; to the Committee on Armed Services.

EC–3792. A communication from the Under Secretary of Defense (Personnel and Readiness), transmitting, pursuant to law, a report relative to the quarterly reporting of withdrawals or diversions of equipment from Reserve component units; to the Committee on Armed Services.

EC–3793. A communication from the Secretary, Division of Trading and Markets, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled ''Amendments to Rules for Nationally Recognized Statistical Rating Organizations'' (RIN3235–AK14) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3794. A communication from the Associate Director, Office of Foreign Assets Control, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Sudanese Sanctions Regulations; Iranian Transactions Regulations'' (31 CFR Parts 538 and 560) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3795. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled ''Electronic Fund Transfers'' (Regulation E; Docket No. R–1343) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3796. A communication from the Secretary of the Treasury, transmitting, pursuant to law, a six-month periodic report on the national emergency with respect to Burma that was declared in Executive Order 13047 of May 20, 1997; to the Committee on Banking, Housing, and Urban Affairs.

EC–3797. A communication from the Secretary of the Treasury, transmitting, pursuant to law, a six-month periodic report on the national emergency with respect to stabilization of Iraq that was declared in Executive Order 13303 of May 22, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–3798. A communication from the Administrator and Chief Executive Officer, Bonneville Power Administration, Department of Energy, transmitting, pursuant to law, the Administration's Annual Report for fiscal year 2009; to the Committee on Energy and Natural Resources.

EC–3799. A communication from the Departmental Freedom of Information Officer, Office of the Secretary, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Amendment to the Freedom of Information Act Regulations'' (RIN1090–AA61) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Environment and Public Works.

EC–3800. A communication from the Deputy Assistant Administrator for Regulatory Programs, Office of Protected Resources, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Endangered and Threatened Wildlife; Sea Turtle Conservation'' (RIN0648–AX20) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Environment and Public Works.

EC–3801. A communication from the Chief of the Trade and Commercial Regulations Branch, Customs and Border Protection, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''Electronic Payment and Refund of Quarterly Harbor Maintenance Fees'' (RIN1505–AB97) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Finance.

EC–3802. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Applicable Federal Rates—December 2009'' (Rev. Rul. 2009–38) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Finance.

EC–3803. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Coordinated Issue: Margins and Other Unsubstantiated Additions to Insurance Company Reserves for Unpaid Losses and Claims'' (LMSB4–1109–041) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Finance.

EC–3804. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Temporary Closing of the Determination Letter Program for Adopters of Pre-Approved Defined Benefit Plans'' (Announcement 2009–85) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3805. A communication from the Acting Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''2010 Limitations Adjusted As Provided in Section 415(d), etc.'' (Notice 2009–94) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3806. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Agreements for Payment of Tax Liabilities in Installments'' ((RIN1545–AU97)(TD 9473)) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3807. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Notice: Tier 2 Tax Rates for 2010'', received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3808. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Notice Requirements for Certain Pension Plan Amendments Significantly Reducing the Rate of Future Benefit Accrual'' ((RIN1545–BG48)(TD 9472)) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3809. A communication from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting, pursuant to the Case—Zablocki Act, 1 U.S.C. 112b, as amended, the report of the texts and background statements of international agreements, other than treaties (List 2009–0201–2009–0212); to the Committee on Foreign Relations.

EC–3810. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, an annual report relative to the Benjamin A. Gilman International Scholarship Program for 2009; to the Committee on Foreign Relations.

EC–3811. A communication from the Assistant Secretary, Office of Legislative Affairs, Department of State, transmitting, pursuant to law, a report relative to U.S. military personnel and U.S. civilian contractors involved in the anti-narcotics campaign in Colombia; to the Committee on Foreign Relations.

EC–3812. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the manufacture of significant military equipment abroad relative to the manufacture of Propellant Actuated Devices (PAD) used on the Crew Escape System on the F–2 aircraft for end-use by Japan; to the Committee on Foreign Relations.

EC–3813. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed permanent export license for the export of defense articles, to include technical data, related to firearms relative to the sale of 4,000 Colt Defense LLC M4 Carbine Model R0977017, 5.6mm, 14.5'' barrel, Safe/Semi/Full Auto Rifles for end use by the Government of Kuwait's National Guard in the amount of $1,000,000 or more; to the Committee on Foreign Relations.

EC–3814. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed permanent export license for the export of defense articles, to include technical data, related to firearms relative to the sale of 252 sets of M60E4/Mk43 Mod 1 Machine Guns and basic accessories for end use by the Mexican Federal Police in the amount of $1,000,000 or more; to the Committee on Foreign Relations.

EC–3815. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed transfer of major defense equipment with an original acquisition value of more than $14,000,000 for Chile; to the Committee on Foreign Relations.

EC–3816. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed transfer of major defense equipment with an original acquisition value of more than $25,000,000 for the Kingdom of Jordan; to the Committee on Foreign Relations.

EC–3817. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed technical assistance agreement for the export of defense articles, including, technical data, and defense services to the United Arab Emirates relative to sale of the Sensor Fuzed Weapon in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3818. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed technical assistance agreement for the export of defense articles, including, technical data, and defense services to Canada relative to the design, manufacture, and delivery of the Telstar 14R Commercial Communication Satellite in the amount of $50,000,000 or more; to the Committee on Foreign Relations.

EC–3819. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed license for the export of defense articles that are controlled under Category VIII of the United States Munitions List relative to the transfer of 55–L–714A Engines and Tailpipe Kits for the CH–47 to support the United Kingdom in the amount of $100,000,000 or more; to the Committee on Foreign Relations.

EC–3820. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed manufacturing license agreement for the export of defense articles, including, technical data, and defense services relative to the design and manufacture of Troop Door Air Deflectors and Ramp Attached Torque Boxes for the C–17 Globemaster III for end use by the U.S. Air Force in the amount of $100,000,000 or more; to the Committee on Foreign Relations.

EC–3821. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the certification of a proposed amendment to a technical assistance agreement for the export of defense articles, including, technical data, and defense services to Canada relative to the sale of fifteen CH–47F Chinook Helicopters; to the Committee on Foreign Relations.

EC–3822. A communication from the Deputy Director, Office of Human Services Legislation, Department of Health and Human Services, transmitting, pursuant to law, a report entitled ''Report to Congress on the Provision of Services to Head Start Children with Disabilities''; to the Committee on Health, Education, Labor, and Pensions.

EC–3823. A communication from the Deputy Assistant Secretary for Program Operation, Employee Benefits Security Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled ''Investment Advice—Participants and Beneficiaries—Withdrawal of Final Rule'' (RIN1210—AB13) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3824. A communication from the Chief Human Capital Officer, Corporation for National and Community Service, transmitting, pursuant to law, the report of a vacancy in the position of Chief Executive Officer of the Corporation for National and Community Service and a nomination for the position; to the Committee on Health, Education, Labor, and Pensions.

EC–3825. A communication from the Assistant General Counsel for Regulatory Services, Office of Elementary and Secondary Education, Department of Education, transmitting, pursuant to law, the report of a rule entitled ''Race to the Top Fund—Final Priorities, Definitions, and Selection Criteria'' (RIN1810–AB07) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3826. A communication from the Assistant Secretary, Employment and Training Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled ''Operating Instructions for Implementing the Amendments to the Trade Act of 1974 Enacted by the Trade and Globalization Adjustment Assistance Act of 2009'' (TEGL No. 22–08) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–3827. A communication from the Secretary of the Interior, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report to Congress for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3828. A communication from the Acting Chief Financial Officer, Department of Homeland Security, transmitting, pursuant to law, the Department's Annual Financial Report for Fiscal Year 2009.; to the Committee on Homeland Security and Governmental Affairs.

EC–3829. A communication from the Chair, U.S. Election Assistance Commission, transmitting, pursuant to law, the Commission's Fiscal Year 2009 Annual Financial Report; to the Committee on Homeland Security and Governmental Affairs.

EC–3830. A communication from the Director, National Science Foundation, transmitting, pursuant to law, the URL address for the Agency's Financial Report, Annual Performance Report, and Performance Highlight Report; to the Committee on Homeland Security and Governmental Affairs.

EC–3831. A communication from the President, Federal Financing Bank, transmitting, pursuant to law, the Bank's Annual Report for Fiscal Year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3832. A communication from the Chairman, Merit System Protection Board, transmitting, pursuant to law, a report entitled ''As Supervisors Retire: An Opportunity to Reshape Organizations''; to the Committee on Homeland Security and Governmental Affairs.

EC–3833. A communication from the Chairman, Federal Communications Commission, transmitting, pursuant to law, the Commission's Fiscal Year 2009 Agency Financial Report; to the Committee on Homeland Security and Governmental Affairs.

EC–3834. A communication from the Board Members, Railroad Retirement Board, transmitting, pursuant to law, a report entitled ''Railroad Retirement Board's Performance and Accountability Report for Fiscal Year 2009''; to the Committee on Homeland Security and Governmental Affairs.

EC–3835. A communication from the Secretary of Veterans Affairs, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3836. A communication from the Chairman, Railroad Retirement Board, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3837. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the Department of Health and Human Services Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3838. A communication from the Administrator, General Services Administration, transmitting, pursuant to law, the Agency's Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3839. A communication from the Acting Chief Executive Officer, Corporation for National and Community Service, transmitting, pursuant to law, the Corporation's Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3840. A communication from the Secretary of Labor, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3841. A communication from the General Counsel, National Labor Relations Board, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3842. A communication from the Chairman, Federal Trade Commission, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3843. A communication from the Deputy General Counsel, National Aeronautics and Space Administration, transmitting, pursuant to law, the report of a rule entitled ''Patents and Other Intellectual Property Rights'' (RIN2700—AD45) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3844. A communication from the Chairman of the National Transportation Safety Board, transmitting, pursuant to law, a report relative to the actions taken to ensure that audits are conducted of its programs and operations for fiscal year 2009; to the Committee on Commerce, Science, and Transportation.

EC–3845. A communication from the Assistant Secretary of the Employment and Training Administration, Department of Labor, transmitting, pursuant to law, the report of a rule entitled ''Temporary Agricultural Employment of H–2A Aliens in the United States'' (RIN1205–AB55) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on the Judiciary.

EC–3846. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1882); to the Committee on the Judiciary.

EC–3847. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1964); to the Committee on the Judiciary.

EC–3848. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1962); to the Committee on the Judiciary.

EC–3849. A communication from the Department of State, transmitting, pursuant to law, a report relative to the transfer of detainees (OSS Control No. 2009–1963); to the Committee on the Judiciary.

EC–3850. A communication from the Chairman of the Federal Election Commission, transmitting, pursuant to law, the report of a rule entitled ''Final Rule and Explanation and Justification for Campaign Travel'' (Notice 2009–27) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Rules and Administration.

EC–3851. A communication from the Deputy General Counsel, Office of Policy and Strategic Planning, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled ''The American Recovery and Reinvestment Act of 2009; Secondary Market First Lien Position 504 Loan Pool Guarantee'' (RIN3245–AF90) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Small Business and Entrepreneurship.

EC–3852. A communication from the Deputy General Counsel, Office of Surety Guarantees, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled ''American Recovery and Reinvestment Act: Surety Bond Guarantees; Size Standards'' (RIN3245–AF94) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Small Business and Entrepreneurship.

EC–3853. A communication from the Deputy General Counsel, HUBZone Program Office, Small Business Administration, transmitting, pursuant to law, the report of a rule entitled ''HUBZone and Government Contracting'' (RIN3245–AF44) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Small Business and Entrepreneurship.

EC–3854. A communication from the Director of Regulations Management, Veterans Benefits Administration, Department of Veterans Affairs, transmitting, pursuant to law, the report of a rule entitled ''Servicemembers' Group Life Insurance — Dependent Coverage'' (RIN2900–AN39) received in the Office of the President of the Senate on November 19, 2009; to the Committee on Veterans' Affairs.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. LEVIN for the Committee on Armed Services.

*Terry A. Yonkers, of Maryland, to be an Assistant Secretary of the Air Force.

*Clifford L. Stanley, of Pennsylvania, to be Under Secretary of Defense for Personnel and Readiness.

*Lawrence G. Romo, of Texas, to be Director of the Selective Service.

*Frank Kendall III, of Virginia, to be Principal Deputy Under Secretary of Defense for Acquisition, Technology, and Logistics.

*Erin C. Conaton, of the District of Columbia, to be Under Secretary of the Air Force.

Air Force nomination of Maj. Gen. Kurt A. Cichowski, to be Lieutenant General.

Air Force nomination of Maj. Gen. Janet C. Wolfenbarger, to be Lieutenant General.

Air Force nomination of Col. Frank J. Sullivan, to be Brigadier General.

Army nomination of Maj. Gen. Guy C. Swan III, to be Lieutenant General.

Army nomination of Brig. Gen. William N. Phillips, to be Lieutenant General.

Army nomination of Maj. Gen. Richard P. Formica, to be Lieutenant General.

Army nomination of Maj. Gen. Michael L. Oates, to be Lieutenant General.

Army nomination of Brig. Gen. Charles J. Barr, to be Major General.

Navy nomination of Capt. Sean R. Filipowski, to be Rear Admiral (lower half).

Navy nomination of Rear Adm. John T. Blake, to be Vice Admiral.

Navy nomination of Vice Adm. Bernard J. McCullough III, to be Vice Admiral.

Navy nomination of Rear Adm. Michael A. LeFever, to be Vice Admiral.

Navy nomination of Rear Adm. William R. Burke, to be Vice Admiral.

Mr. LEVIN. Mr. President, for the Committee on Armed Services I report favorably the following nomination lists which were printed in the RECORDs on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

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

Air Force nominations beginning with Jeffrey K. Atkisson and ending with Roger L. Willis, Jr., which nominations were received by the Senate and appeared in the Congressional Record on September 21, 2009.

Air Force nominations beginning with Christopher C. Abate and ending with Christopher J. Zuhlke, which nominations were received by the Senate and appeared in the Congressional Record on September 21, 2009.

Air Force nomination of Elisha T. Powell IV, to be Colonel.

Army nomination of James C. Lewis, to be Major.

Army nominations beginning with Anuli L. Anyachebelu and ending with John M. Stang, which nominations were received by the Senate and appeared in the Congressional Record on October 28, 2009.

Army nominations beginning with Anthony C. Bostick and ending with Joseph G. Williamson, which nominations were received by the Senate and appeared in the Congressional Record on October 28, 2009.

Army nominations beginning with Risa D. Bator and ending with Thomas R. Yarber, which nominations were received by the Senate and appeared in the Congressional Record on October 28, 2009.

Army nominations beginning with James R. Andrews and ending with Shanda M. Zugner, which nominations were received by the Senate and appeared in the Congressional Record on October 28, 2009.

Army nomination of Edwin S. Fuller, to be Major.

Army nomination of Robert J. Schultz, to be Lieutenant Colonel.

Army nominations beginning with Clement D. Ketchum and ending with John Lopez, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009.

Army nominations beginning with Carey L. Mitchell and ending with Melissa F. Tucker, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009.

Army nominations beginning with Craig R. Bottoni and ending with Akash S. Taggarse, which nominations were received by the Senate and appeared in the Congressional Record on November 4, 2009.

Army nomination of Leon L. Robert, to be Colonel.

Army nomination of Michael C. Metcalf, to be Colonel.

Army nominations beginning with Todd E. Farmer and ending with Steven R. Watt, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nominations beginning with Mark D. Crowley and ending with Michael J. Stevenson, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nominations beginning with Nathanael L. Allen and ending with X001320, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nominations beginning with Scott C. Armstrong and ending with D004309, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nominations beginning with Michael W. Anastasia and ending with D003756, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

Army nomination of Scott E. McNeil, to be Colonel.

Army nomination of Scott E. Zipprich, to be Colonel.

Army nomination of Mary B. McQuary, to be Colonel.

Army nominations beginning with Marvin R. Manibusan and ending with Francisco J. Neuman, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009.

Army nominations beginning with Patrick S. Callender and ending with Steven L. Shugart, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009.

Army nominations beginning with Michael A. Bennett and ending with Kevin M. Walker, which nominations were received by the Senate and appeared in the Congressional Record on November 17, 2009.

Navy nominations beginning with Timothy M. Sherry and ending with Robert N. Mills, which nominations were received by the Senate and appeared in the Congressional Record on October 22, 2009.

Navy nomination of Matthew P. Luff, to be Lieutenant Commander.

Navy nomination of Everett F. Magann, to be Captain.

Navy nomination of William V. Dolan, to be Captain.

Navy nominations beginning with Brian D. Barth and ending with Stacy M. Wuthier, which nominations were received by the Senate and appeared in the Congressional Record on November 16, 2009.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. MENENDEZ:

S. 2823. A bill to amend chapter 417 of title 49, United States Code, to require air carriers and ticket agents to notify consumers of all taxes and fees applicable to airline tickets in a timely manner, to prohibit the imposition of fuel surcharges that do not correlate to the fuel costs incurred by air carriers, and for other purposes: to the Committee on Commerce, Science, and Transportation.

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

S. 2824. A bill to establish a small dollar loan-loss guarantee fund, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mrs. MURRAY (for herself and Ms. CANTWELL):

S. Res. 366. A resolution extending condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; considered and agreed to.

ADDITIONAL COSPONSORS

S. 435

At the request of Mr. CASEY, the name of the Senator from Vermont (Mr. SANDERS) was added as a cosponsor of S. 435, a bill to provide for evidence-based and promising practices related to juvenile delinquency and criminal street gang activity prevention and intervention to help build individual, family, and community strength and resiliency to ensure that youth lead productive, safe, health, gang-free, and law-abiding lives.

S. 491

At the request of Mr. WEBB, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 491, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 497

At the request of Mr. DURBIN, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 497, a bill to amend the Public Health Service Act to authorize capitation grants to increase the number of nursing faculty and students, and for other purposes.

S. 777

At the request of Mr. BROWN, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 777, a bill to promote industry growth and competitiveness and to improve worker training, retention, and advancement, and for other purposes.

S. 850

At the request of Mr. KERRY, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 850, a bill to amend the High Seas Driftnet Fishing Moratorium Protection Act and the Magnuson-Stevens Fishery Conservation and Management Act to improve the conservation of sharks.

S. 1019

At the request of Mr. HARKIN, the name of the Senator from Michigan (Ms. STABENOW) 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. 1052

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

S. 1304

At the request of Mr. GRASSLEY, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 1304, a bill to restore the economic rights of automobile dealers, and for other purposes.

S. 1353

At the request of Mr. LEAHY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1353, a bill to amend title 1 of the Omnibus Crime Control and Safe Streets Act of 1986 to include nonprofit and volunteer ground and air ambulance crew members and first responders for certain benefits.

S. 1374

At the request of Mr. BROWN, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1374, a bill to amend the Worker Adjustment and Retraining Notification Act to minimize the adverse effects of employment dislocation, and for other purposes.

S. 1638

At the request of Mr. WICKER, the name of the Senator from Montana (Mr. TESTER) was added as a cosponsor of S. 1638, a bill to permit Amtrak passengers to safely transport firearms and ammunition in their checked baggage.

S. 1744

At the request of Mr. SCHUMER, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 1744, a bill to require the Administrator of the Federal Aviation Administration to prescribe regulations to ensure that all crewmembers on air carriers have proper qualifications and experience, and for other purposes.

S. 1822

At the request of Mr. MERKLEY, the names of the Senator from Arkansas (Mr. PRYOR) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. 1822, a bill to amend the Emergency Economic Stabilization Act of 2008, with respect to considerations of the Secretary of the Treasury in providing assistance under that Act, and for other purposes.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 2097

At the request of Mr. THUNE, the names of the Senator from Oklahoma (Mr. INHOFE) and the Senator from West Virginia (Mr. BYRD) were added as cosponsors of S. 2097, a bill to authorize the rededication of the District of Columbia War Memorial as a National and District of Columbia World War I Memorial to honor the sacrifices made by American veterans of World War I.

S. 2128

At the request of Mr. LEMIEUX, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 2128, a bill to provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

S. 2727

At the request of Mr. LUGAR, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 2727, a bill to provide for continued application of arrangements under the Protocol on Inspections and Continuous Monitoring Activities Relating to the Treaty Between the United States of America and the Union of Soviet Socialist Republics on the Reduction and Limitation of Strategic Offensive Arms in the period following the Protocol's termination on December 5, 2009.

S. 2730

At the request of Mr. BROWN, the names of the Senator from Illinois (Mr. DURBIN), the Senator from Vermont (Mr. SANDERS), the Senator from Michigan (Mr. LEVIN) and the Senator from New Jersey (Mr. LAUTENBERG) were added as cosponsors of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2781

At the request of Ms. MIKULSKI, the name of the Senator from Nebraska (Mr. JOHANNS) was added as a cosponsor of S. 2781, a bill to change references in Federal law to mental retardation to references to an intellectual disability, and to change references to a mentally retarded individual to references to an individual with an intellectual disability.

S. 2794

At the request of Mr. SCHUMER, the name of the Senator from Nebraska (Mr. NELSON) was added as a cosponsor of S. 2794, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat.

S. 2812

At the request of Mr. BINGAMAN, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 2812, a bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out programs to develop and demonstrate 2 small modular nuclear reactor designs, and for other purposes.

S. CON. RES. 39

At the request of Mr. MENENDEZ, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. Con. Res. 39, a concurrent resolution expressing the sense of the Congress that stable and affordable housing is an essential component of an effective strategy for the prevention, treatment, and care of human immunodeficiency virus, and that the United States should make a commitment to providing adequate funding for the development of housing as a response to the acquired immunodeficiency syndrome pandemic.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2791

At the request of Ms. MIKULSKI, the name of the Senator from Pennsylvania (Mr. SPECTER) was added as a cosponsor of amendment No. 2791 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2793

At the request of Mr. DORGAN, the names of the Senator from Vermont (Mr. SANDERS) and the Senator from Minnesota (Mr. FRANKEN) were added as cosponsors of amendment No. 2793 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2795

At the request of Mr. LEAHY, the names of the Senator from Illinois (Mr.

DURBIN) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of amendment No. 2795 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first—time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

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

S. 2824. A bill to establish a small dollar loan-loss guarantee fund, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. KOHL. Mr. President, I rise to introduce the Safe Affordable Loan Act. This legislation will increase the access for low and moderate income Americans to mainstream financial institutions while reducing the relevance of pay day lenders. Additionally, the bill will encourage community banks and credit unions to provide small dollar loan amounts to families across their communities.

There are approximately 30 million Americans operating on the fringe of the financial system. They are known as the ''unbanked.'' The average income for these individuals is approximately $26,390, with little to no savings. Additionally, these consumers rely on check cashing services or payday lenders as a way to access credit. Most of these operations charge excessive fees and interest rates that leave consumers financially devastated. Without access to mainstream financial services, consumers can be trapped in a cycle of debt with little hope of escape.

In 2008, the FDIC launched a Small Dollar Loan program which offers volunteer participants CRA credit to provide consumers with affordable small dollar loans. I am proud that two banks from Wisconsin, Mitchell Bank in Milwaukee and Benton State Bank in Benton are participating in this valuable program. While this program has been beneficial to communities across the country, only 31 banks have chosen to participate. That is a drop in the bucket compared to the 23,000 payday lender operations. Without other incentives, banks will shy away from lending consumers small amounts, leaving them to rely on payday lenders and other loan alternatives.

The legislation I am proposing would create a loan-loss reserve fund that financial institutions could access in order to mitigate some of the risk associated with offering small dollar loans. Financial institutions will be able to access the reserve fund and could potentially recover 60 percent of a lost loan, provided that their loans meet certain affordability requirements. The institutions must offer loans that have no prepayment penalties, have a repayment period longer than 60 days and has an interest rate of 36 percent APR or lower. Additionally, the loan size cannot exceed $2,500. In order to protect the government from excessive risk taking by the financial institutions, the fund administrator will take into consideration the overall default rate of the loan program that the institution offers to determine the reimbursement rate. Furthermore, the financial institutions would be required to report payment history to the credit reporting bureaus which will help consumers build credit or repair bad credit.

As we consider changes to our financial system, we should include reforms that will help increase access to many of those who are left out. I look forward to working with my colleagues on this important issue in the Banking Committee to move it towards passage.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 366—EXTENDING CONDOLENCES TO THE FAMILIES OF SERGEANT MARK RENNINGER, OFFICER TINA GRISWOLD, OFFICER RONALD OWENS, AND OFFICER GREG RICHARDS

Mrs. MURRAY (for herself and Ms. CANTWELL) submitted the following resolution; which was considered and agreed to:

S. RES. 366

Whereas on the morning of November 29, 2009, 4 members of the Lakewood Police Department were slain by gunfire in a senseless act of violence while preparing for their shift in Lakewood, Washington;

Whereas the 4 officers have been members of the Lakewood Police Department since its founding 5 years ago, were valuable members of the community, and were deeply respected for their service;

Whereas Sergeant Mark Renninger, who served 13 years in law enforcement, first with the Tukwila Police Department and most recently with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas Officer Tina Griswold, who served 14 years in law enforcement, first with the Lacey Police Department and most recently with the Lakewood Police Department, is survived by her husband and 2 children;

Whereas Officer Ronald Owens, who served 12 years in law enforcement, first with the Washington State Patrol and most recently with the Lakewood Police Department, is survived by his daughter;

Whereas Officer Greg Richards, who served 8 years in law enforcement, first with the Kent Police Department and most recently with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas the senseless violence against and murder of law enforcement officers, who are sworn to serve, protect, and preserve the peace of the communities, is a particularly heinous crime; and

Whereas in the face of this senseless tragedy, the people of the City of Lakewood, the surrounding communities, and the State of Washington have come together in support of the law enforcement community and the families of the victims: Now, therefore, be it

Resolved, That the Senate—

(1) extends its condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; and

(2) stands with the people of Lakewood, Washington, the men and women of the Lakewood Police Department, and members of the law enforcement community as they celebrate the lives and mourn the loss of these 4 dedicated public servants and law enforcement heroes.

AMENDMENTS SUBMITTED & PROPOSED

SA 2798. Mr. INOUYE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2799. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2800. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2801. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2802. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2803. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2804. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2805. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2806. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2807. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2808. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2791 proposed by Ms. MIKULSKI (for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN) to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2809. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2810. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2811. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2812. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2813. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2814. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2815. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2816. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2817. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2818. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2819. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2820. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2821. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2822. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2823. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2824. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2825. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2826. Mr. BENNET (for himself, Mr. HARKIN, Mr. DODD, Mr. BROWN, Mr. DURBIN, Mrs. LINCOLN, Mr. WYDEN, Mr. BEGICH, Mr. BAYH, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2827. Mr. TESTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2828. Mr. WHITEHOUSE (for himself, Mr. KERRY, Mr. FEINGOLD, and Mr. FRANKEN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2829. Mr. GRAHAM (for himself and Mr. CHAMBLISS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2830. Mr. BROWNBACK (for himself and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2831. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2832. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2833. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2834. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2835. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2836. Ms. MURKOWSKI (for herself, Mrs. HUTCHISON, and Mr. JOHANNS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2837. Mr. SANDERS (for himself, Mr. BURRIS, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2838. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2839. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2840. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2841. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2842. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2843. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2844. Mr. SANDERS (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2845. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2846. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2847. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2848. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2849. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2850. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2851. Mr. SANDERS submitted an amendment intended to be proposed to

amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2852. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2853. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2854. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2855. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2856. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2857. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2858. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2859. Ms. SNOWE (for herself, Ms. LANDRIEU, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2798. Mr. INOUYE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title V, add the following:

SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.

(a) ESTABLISHMENT OF PROGRAM.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a training demonstration program for family nurse practitioners (referred to in this section as the ''program'') to employ and provide intensive, one-year training for nurse practitioners who have graduated from a nurse practitioner program not more than 18 months prior to commencing such training, for careers as primary care providers in Federally qualified health centers (referred to in this section as ''FQHCs'') and nurse-managed health clinics, in order to increase access to primary care in impoverished, urban, and rural underserved communities.

(b) PURPOSE.—The purpose of the program is to enable each grant recipient to—

(1) provide new nurse practitioners with a depth, breadth, volume, and intensity of clinical training necessary to serve as primary care providers in the complex settings of FQHCs and nurse-managed health clinics;

(2) train new nurse practitioners to work under a model of primary care, including the use of electronic health records, planned care and chronic care models, and interdisciplinary team-based care, that is consistent with—

(A) the principles of health care set forth by the Institute of Medicine; and

(B) the needs of vulnerable populations;

(3) create a model of FQHC- and nurse-managed health clinic-based training for nurse practitioners that may be replicated nationwide; and

(4) provide additional intensive learning experiences with high-volume, high-risk, or high-burden problems commonly encountered in FQHCs and nurse-managed health clinics, such as HIV/AIDS, prenatal care, orthopedics, geriatrics, diabetes, asthma, and obesity prevention.

(c) GRANTS.—The Secretary shall award grants to eligible entities that meet the eligibility requirements established by the Secretary, for the purpose of operating the nurse practitioner primary care programs described in subsection (a) in such entities.

(d) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

(1)(A) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)); or

(B) be a nurse-managed health clinic, as defined in section 330A-1 of the Public Health Service Act (as added by section 5208 of this Act); and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(e) PRIORITY IN AWARDING GRANTS.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners per year and the half-time employment of a qualified program coordinator;

(2) will provide that each such program will entail 12-full months of full-time, paid employment for each awardee, and will offer each awardee benefits consistent with the benefits offered to other full-time employees of such entity;

(3) will assign not less than 1 staff nurse practitioner or physician to each of 4 precepted clinics, in which the awardee is the primary provider for the patient, per week, and during such clinics, ensure that the assigned staff nurse practitioner or physician shall be available exclusively to the awardees and have no other assigned clinical or administrative duties;

(4) will provide to each awardee specialty rotations consisting of 3 sessions per week, either within or outside of the FQHC or nurse-managed health clinic, based upon the capability of the FQHC or nurse-managed health clinic to provide specialty training in prenatal care and women's health, adult and child psychiatry, orthopedics, geriatrics, and at least 3 other high-volume, high-burden specialty areas, such as HIV/AIDS, dermatology, cardiology, diabetes, asthma, urgent care (minor trauma), and pain management;

(5) enable awardees to practice alongside other primary care providers so that the awardees may consult with such primary care providers as necessary;

(6) provide educational and didactic sessions on high-volume, high-risk health problems;

(7) have implemented (or will complete, not later than the beginning of the program, implementation of) health information technology, and will make use of an electronic training evaluation system;

(8) provide continuous training to a FQHC standard of a high performance health system that includes access to health care, continuity, planned care, team-based, prevention-focused care that includes the use of electronic health records and other health information technology;

(9) have a record of recruiting, training, caring for, and otherwise demonstrating competency in advancing the primary care of individuals who are from underrepresented minority groups or from a poor urban or rural, or otherwise disadvantaged background;

(10) have a record of training health care professionals in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities; and

(11) have a record of collaboration with other safety net providers, schools, colleges, and universities that provide health professions training, establish formal relationships, and submit joint applications with rural health clinics, area health education centers, and community health centers located in underserved areas, or that serve underserved populations.

(f) ELIGIBILITY OF AWARDEES.—

(1) IN GENERAL.—To be eligible for acceptance to a nurse practitioner training program funded through a grant awarded under this section, an individual shall—

(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a nurse-managed health clinic.

(2) PREFERENCE.—In selecting awardees under the program, each recipient of a grant under this section shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

(3) DEFERRAL OF CERTAIN SERVICE.—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until the date that is 90 days after the completion of the program.

(4) AWARDEE DEFINED.—In this section, the term ''awardee'' means an individual who has been accepted into a nurse practitioner training program funded through a grant awarded under this section.

(g) DURATION OF AWARDS.—Each grant awarded under this section shall be for a period of 3 years. A grant recipient may carry over funds from one fiscal year to another without obtaining approval from the Secretary.

(h) GRANT AMOUNT.—Each grant awarded under this section shall be in an amount not to exceed $600,000 per year, as determined by the Secretary, taking into account—

(1) the financial need of the FQHC or nurse-managed health clinic, considering, Federal, State, local, and other operational

funding provided to the FQHC or nurse-managed health clinic; and

(2) other factors, as the Secretary determines appropriate.

(i) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to FQHCs and nurse-managed health clinics that plan to establish, or that have established, a nurse practitioner residency training program. The Secretary shall award a technical assistance grant to 1 FQHC that has expertise in establishing a nurse practitioner residency program, for the purpose of providing technical assistance to other recipients of grants under this section.

(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.

SA 2799. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. ENTITLEMENT REFORM.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce the Federal budgetary commitment to health care by January 1, 2019, as compared to Federal budgetary commitment to health care by January 1, 2019 that would have resulted if such Act (and amendments) is not implemented.

SA 2800. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. LOWERING COSTS FOR FAMILIES.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce annual health insurance premiums by $2,500 for the average American family.

SA 2801. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 354, after line 2, insert the following:

''(D) STATE ELECTION.—

''(i) IN GENERAL.—At the election of a State, with respect to any calendar year, if such State determines that such an election will promote job creation or increase wages in such State, subparagraphs (A) and (B) may be applied to months in such calendar year by substituting '499' for '50' each place it appears.

''(ii) TIMING AND MANNER OF ELECTION.—Such election with respect to any calendar year shall apply to all months in such calendar year and shall be made at such time and in such manner as the Secretary may provide.

SA 2802. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 97, line 19, insert ''or after'' after ''enrolled on''.

SA 2803. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. MEMBERS OF CONGRESS REQUIRED TO HAVE COVERAGE UNDER MEDICAID INSTEAD OF THROUGH FEHBP.

(a) IN GENERAL.—Notwithstanding chapter 89 of title 5, United States Code, title XIX of the Social Security Act, or any provision of this Act, effective January 1, 2010—

(1) each Member of Congress shall be eligible for medical assistance under the Medicaid plan of the State in which the Member resides; and

(2) any employer contribution under chapter 89 of title 5 of such Code on behalf of the Member may be paid only to the State agency responsible for administering the Medicaid plan in which the Member enrolls and not to the offeror of a plan offered through the Federal employees health benefit program under such chapter.

(b) PAYMENTS BY FEDERAL GOVERNMENT.—The Secretary of Health and Human Services, in consultation with the Director of the Office of Personnel Management, shall establish procedures under which the employer contributions that would otherwise be made on behalf of a Member of Congress if the Member were enrolled in a plan offered through the Federal employees health benefit program may be made directly to the State agencies described in subsection (a).

(c) INELIGIBLE FOR FEHBP.—Effective January 1, 2010, no Member of Congress shall be eligible to obtain health insurance coverage under the program chapter 89 of title 5, United States Code.

(d) DEFINITION.—In this section, the term ''Member of Congress'' means any member of the House of Representatives or the Senate.

SA 2804. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. NONAPPLICATION OF MEDICAID ELIGIBILITY EXPANSIONS UNTIL REDUCTION IN MEDICAID FRAUD RATE.

Notwithstanding any other provision of this Act, any provision of this Act or an amendment made by this Act that imposes federally-mandated expansions of eligibility for Medicaid shall not apply to any State before the date on which the Secretary of Health and Human Services certifies that the average payment error rate measurement (commonly referred to as ''PERM'') for all State Medicaid programs does not exceed 3.9 percent.

SA 2805. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. 1___. REQUIREMENT OF ELIMINATION OF THE FEDERAL DEFICIT.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no Federal outlays authorized under this Act (or such an amendment) may take effect until the Office of Management and Budget certifies that the Federal budget deficit has been eliminated.

SA 2806. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ___. ENSURING LOWER HEALTH CARE COSTS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act (and amendments), other than this section, shall not take effect until such

time as the Office of the Actuary for the Centers for Medicare & Medicaid Services certifies to Congress that the implementation of this Act (and amendments) would reduce projected National Health Expenditures by January 1, 2019, as compared to the projected National Health Expenditures by January 1, 2019 that would have resulted if such Act (and amendments) is not implemented.

SA 2807. Mr. CORNYN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1000, strike line 19 and all that follows through line 2 on page 1053.

SA 2808. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2791 proposed by Ms. MIKULSKI (for herself, Mr. HARKIN, Mrs. BOXER, and Mr. FRANKEN) to the amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2 of the amendment, after line 15 insert the following:

''(5) for the purposes of this Act, and for the purposes of any other provisions of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.''

SA 2809. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with epilepsy.

SA 2810. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 723, strike line 3 and all that follows through page 739, line 17.

SA 2811. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with childhood cancer.

SA 2812. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 842, strike line 3 and all that follows through page 846, line 10.

SA 2813. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 923, between lines 7 and 8, insert the following:

SEC. 3211. PROTECTING CHOICE AND COMPETITION FOR MEDICARE BENEFICIARIES.

No provisions of, or amendments made by, this Act that change the Medicare Advantage program under part C of title XVIII of the Social Security Act in a manner that would result in decreased choice and competition for Medicare beneficiaries shall take effect and are repealed.

SA 2814. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with juvenile diabetes.

SA 2815. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with autism.

SA 2816. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with cancer.

SA 2817. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 828, strike line 5 and all that follows through page 836, line 22.

SA 2818. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers which would have the effect of restricting access to treatment for individuals with chronic obstructive pulmonary disease (COPD).

SA 2819. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 974, strike line 12 and all that follows through page 999, line 16.

SA 2820. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by providers of services or suppliers located in rural areas.

SA 2821. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 869, strike line 17 and all that follows through page 903, line 15.

SA 2822. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1000, strike line 19 and all that follows through page 1053, line 2.

SA 2823. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2006.

SA 2824. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2953.

SA 2825. Mr. COBURN submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. __. BUREAUCRAT LIMITATION.

For each new bureaucrat added to any department or agency of the Federal Government for the purpose of implementing the provisions of this Act (or any amendment made by this Act), the head of such department or agency shall ensure that the addition of such new bureaucrat is offset by a reduction of 1 existing bureaucrat at such department or agency.

SA 2826. Mr. BENNET (for himself, Mr. HARKIN, Mr. DODD, Mr. BROWN, Mr. DURBIN, Mrs. LINCOLN, Mr. WYDEN, Mr. BEGICH, Mr. BAYH, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1134, between lines 3 and 4, insert the following:

Subtitle G—Protecting and Improving Guaranteed Medicare Benefits

SEC. 3601. PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS.

(a) PROTECTING GUARANTEED MEDICARE BENEFITS.—Nothing in the provisions of, or amendments made by, this Act shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act.

(b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

SA 2827. Mr. TESTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1203, strike line 19 and all that follows through page 1209, line 20 and insert the following:

SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming, with not less than 20 percent of such grants being made to State or local government agencies and community-based organizations located in or serving, or both, rural areas.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency;

(B) a local governmental agency;

(C) a national network of community-based organizations;

(D) a State or local non-profit organization; or

(E) an Indian tribe; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(c) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—

(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan may focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban, rural, and frontier areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) ACTIVITIES.—An eligible entity shall implement activities detailed in the community transformation plan under paragraph (2).

(C) IN-KIND SUPPORT.—An eligible entity may provide in-kind resources such as staff, equipment, or office space in carrying out activities under this section.

(4) EVALUATION.—

(A) IN GENERAL.—An eligible entity shall use amounts provided under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities

(B) TYPES OF MEASURES.—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;

(ii) changes in proper nutrition;

(iii) changes in physical activity;

(iv) changes in tobacco use prevalence;

(v) changes in emotional well-being and overall mental health;

(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and

(vii) other factors as determined by the Secretary, including differential susceptibility, mortality, or morbidity due to chronic diseases such as cancer, diabetes, and cardiovascular disease.

(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) DISSEMINATION.—A grantee under this section shall—

(A) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities carried out under the grant; and

(B) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) TRAINING.—

(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans

(3) EVALUATION.—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(e) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 4201A. REDUCTION OF HEALTH DISPARITIES IN RURAL AREAS.

(a) AUTHORIZATION OF INITIATIVE.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in collaboration or conjunction with the Director of the National Center for Health Disparities and Deputy Assistant Secretary for Minority Health, shall establish an initiative—

(A) that is specifically directed toward addressing the issue of health disparities attributable to chronic diseases in rural and frontier areas by creating and promoting educational, screening, and outreach programs that reduce the prevalence, morbidity, and mortality of chronic diseases or susceptibility to such diseases; and

(B) whose goal is to significantly improve access to, and utilization of, beneficial chronic disease interventions in rural communities experiencing health disparities in order to reduce such disparities.

(2) HEALTH DISPARITY POPULATION.—

(A) IN GENERAL.—For purposes of carrying out the initiative described in paragraph (1), a population shall be considered a health disparity population if there is a significant disparity in the overall rate of chronic disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.

(B) CHRONIC DISEASES.—In this paragraph, the term ''chronic disease'' includes hypertension, diabetes, cancer, and heart disease.

(b) COMMON ADMINISTRATIVE STRUCTURE.—The initiative described in subsection (a) shall—

(1) utilize a common administrative structure to ensure coordinated implementation, oversight, and accountability;

(2) be amenable to regional organization in order to meet the specific needs of rural communities throughout the United States; and

(3) involve elements located in rural communities and areas.

(c) DESIGN.—The initiative described in subsection (a) shall be designed to reach rural communities and populations that experience a disproportionate share of chronic disease burden, including African Americans, American Indians or Alaska Natives, Hawaiian Natives and other Pacific Islanders, Asians, Hispanics or Latinos, and other underserved rural populations.

(d) ESTABLISHMENT OF INITIATIVE AND GRANTS.—In carrying out the initiative described in subsection (a), the Secretary of Health and Human Services shall, from funds appropriated to carry out this section—

(1) use 50 percent for the establishment of such initiative; and

(2) use 50 percent to award competitive grants or contracts to organizations, universities, or similar entities to carry out the initiative, with preference given to entities having a demonstrable track record of service to rural communities, including tribally-affiliated colleges or universities.

SA 2828. Mr. WHITEHOUSE (for himself, Mr. KERRY, Mr. FEINGOLD, and Mr. FRANKEN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—MEDICAL BANKRUPTCIES

SECTION ____1. SHORT TITLE.

This title may be cited as the ''Medical Bankruptcy Fairness Act of 2009''.

SEC. ____2. DEFINITIONS.

Section 101 of title 11, the United States Code, is amended by inserting after paragraph (39A) the following:

''(39B) The term 'medical debt' means any debt incurred directly or indirectly as a result of the diagnosis, cure, mitigation, treatment, or prevention of injury, deformity, or disease, or for the purpose of affecting any structure or function of the body.

''(39C) The term 'medically distressed debtor' means a debtor who, during any 12-month period during the 3 years before the date of the filing of the petition—

''(A) incurred or paid medical debts for the debtor or a dependent of the debtor, or a nondependent member of the immediate family of the debtor (including any parent, grandparent, sibling, child, grandchild, or spouse of the debtor), that were not paid by any third party payor and were in excess of 25 percent of the debtor's annual adjusted gross income (as such term is defined under section 62 of the Internal Revenue Code of 1986), set forth in the most recent Federal income tax return filed by the debtor, or by the debtor and the debtor's spouse, prior to the commencement of the case;

''(B) was a member of a household in which 1 or more members (including the debtor) lost all or substantially all of the member's domestic support obligation income, taking into consideration any disability insurance payments, for 4 or more weeks, due to a medical problem of a person obligated to pay such domestic support; or

''(C) experienced a downgrade in employment status that correlates to a reduction in wages or work hours or results in unemployment, to care for an ill, injured, or disabled dependent of the debtor, or an ill, injured, or disabled nondependent member of the immediate family of the debtor (including any parent, grandparent, sibling, child, grandchild, or spouse of the debtor), for not less than 30 days.''.

SEC. ____3. EXEMPTIONS.

(a) EXEMPT PROPERTY.—Section 522 of title 11, the United States Code, is amended by adding at the end the following:

''(r) For a debtor who is a medically distressed debtor, if the debtor elects to exempt property—

''(1) listed in subsection (b)(2), then in lieu of the exemption provided under subsection (d)(1), the debtor may elect to exempt the debtor's aggregate interest, not to exceed $250,000 in value, in real property or personal property that the debtor or a dependent of the debtor uses as a residence, in a cooperative that owns property that the debtor or a dependent of the debtor uses as a residence, or in a burial plot for the debtor or a dependent of the debtor; or

''(2) listed in subsection (b)(3), then if the exemption provided under applicable law specifically for property of the kind described in paragraph (1) is for less than $250,000 in value, the debtor may elect in lieu of such exemption to exempt the debtor's aggregate interest, not to exceed $250,000 in value, in any such real or personal property, cooperative, or burial plot.''.

(b) CONFORMING AMENDMENTS.—Sections 104(b)(1) and 104(b)(2) of title 11, the United States Code, are each amended by inserting ''522(r),'' after ''522(q),''.

SEC. ____4. DISMISSAL OF A CASE OR CONVERSION TO A CASE UNDER CHAPTER 11 OR 13.

Section 707(b) of title 11, the United States Code, is amended by adding at the end the following:

''(8) No judge, United States trustee (or bankruptcy administrator, if any), trustee, or other party in interest may file a motion under paragraph (2) if the debtor is a medically distressed debtor.''.

SEC. ___5. CREDIT COUNSELING.

Section 109(h)(4) of title 11 United States Code, is amended by inserting ''a medically distressed debtor or'' after ''with respect to''.

SEC. ___6. NONDISCHARGEABILITY OF CERTAIN ATTORNEYS FEES.

Section 523(a) of title 11, United States Code, is amended—

(1) in paragraph (18), by striking ''or'' at the end;

(2) in paragraph (19), by striking the period at the end and inserting ''; or''; and

(3) by inserting after paragraph (19) the following:

''(20) in a case arising under chapter 7 of this title, owed to an attorney as reasonable compensation for representing the debtor in connection with the case.''.

SEC. ___7. EFFECTIVE DATE; APPLICATION OF AMENDMENTS.

(a) EFFECTIVE DATE.—Except as provided in subsection (b), this title and the amendments made by this title shall take effect on the date of enactment of this Act.

(b) APPLICATION OF AMENDMENTS.—The amendments made by this title shall apply only with respect to cases commenced under title 11, United States Code, on or after the date of enactment of this Act.

SEC. ___8. ATTESTATION BY DEBTOR.

Any debtor who seeks relief as a medically distressed debtor in accordance with the amendments made by this title shall attest in writing and under penalty of perjury that the medical expenses of the debtor were genuine, and were not specifically incurred to bring the debtor within the coverage of the medical bankruptcy provisions, as provided in this title and the amendments made by this title.

SA 2829. Mr. GRAHAM (for himself and Mr. CHAMBLISS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—MEDICAL LIABILITY REFORM

SEC. __01. SHORT TITLE.

This title may be cited as the ''Fair Resolution of Medical Liability Disputes Act of 2009''.

SEC. __02. FINDINGS.

Congress finds that—

(1) the health care and insurance industries are industries affecting interstate commerce, and the health care malpractice litigation systems throughout the United States affect interstate commerce by contributing to the high cost of health care and premiums for malpractice insurance purchased by health care providers; and

(2) the Federal Government, as a direct provider of health care and as a source of payment for health care, has a major interest in health care and a demonstrated interest in assessing the quality of care, access to care, and the costs of care through the evaluative activities of several Federal agencies.

SEC. __03. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under this title that provides for the resolution of covered health care malpractice claims in a manner other than through a civil action in Federal or State court.

(2) COVERED HEALTH CARE MALPRACTICE ACTION.—The term ''covered health care malpractice action'' means a civil action in which a covered health care malpractice claim is made against a health care provider or health care professional.

(3) COVERED HEALTH CARE MALPRACTICE CLAIM.—The term ''covered health care malpractice claim'' means a malpractice claim (excluding product liability claims) relating to the provision of, or the failure to provide, health care services involving a defendant covered health care professional or provider.

(4) COVERED HEALTH CARE PROFESSIONAL.—The term ''covered health care professional'' means an individual, including a physician, nurse, chiropractor, nurse midwife, physical therapist, social worker, or physician assistant—

(A) who provides health care services in a State;

(B) for whom individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits under part B of such Act (42 U.S.C. 1395j et seq.) comprise not less than 25 percent of the total patients of such professional, as determined by the Secretary; and

(C) who is required by State law or regulation to be licensed or certified by a State a condition for providing such services in the State.

(5) COVERED HEALTH CARE PROVIDER.—The term ''covered health care provider'' means an organization or institution—

(A) that is engaged in the delivery of health care services in a State;

(B) for which individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits under part B of such Act (42 U.S.C. 1395j et seq.) comprise not less than 25 percent of the total patients of such organization or institution, as determined by the Secretary; and

(C) that is required by State law or regulation to be licensed or certified by the State as a condition for engaging in the delivery of such services in the State.

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

(7) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. __04. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A covered health care malpractice action may not be brought in any State court during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Attorney General under section __06(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section __06(b).

(2) FEDERAL DIVERSITY ACTIONS.—A covered health care malpractice action may not be brought in a Federal court under section 1332 of title 28, United States Code, during a calendar year unless the covered health care malpractice claim that is the subject of the action has been initially resolved under the alternative dispute resolution system described in paragraph (1) that applied in the State whose law applies in such action.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is ''initially resolved'' under an alternative dispute resolution system if—

(1) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(2) if the ADR determines that the defendant is liable, the ADR reaches a decision regarding the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—

(A) IN GENERAL.—Not later than 60 days after a decision is issued with respect to a covered health care malpractice claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction, selected by the arbitrator, indicating whether the party intends to contest the decision.

(B) SEALED STATEMENTS.—Each sealed statement submitted to a court under subparagraph (A) shall remain sealed until the earlier of—

(i) the date on which all affected parties have submitted such statement; or

(ii) the submission deadline described in subparagraph (A).

(2) REQUIREMENTS FOR FILING ACTION.—A covered health care malpractice action may not be brought by a party unless—

(A) such party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the covered health care malpractice claim that is the subject of the action is issued under the applicable alternative dispute resolution system; and

(B) any party has filed the notice of intent required by paragraph (1).

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—A decision reached under an alternative dispute resolution system that is not contested under subsection (c) shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a covered health care malpractice action adjudicated in a State or Federal trial court.

(e) STANDARD OF JUDICIAL REVIEW.—The standard of judicial review of a claim filed under subsection (c) shall be de novo.

(f) AWARD OF COSTS AND ATTORNEYS' FEES AFTER INITIAL ADR RESOLUTION.—

(1) IN GENERAL.—In the case of a covered health care malpractice action brought in any State or Federal court after ADR, if the final judgment or order issued (exclusive of costs, expenses, and attorneys' fees incurred after judgment or trial) in the action is not more favorable to a party contesting the ADR decision than the ADR decision, the opposing party may file with the court, not later than 10 days after the final judgment or order is issued, a petition for payment of costs and expenses, including attorneys' fees, incurred with respect to the claim or claims after the date of the ADR decision.

(2) AWARD OF COSTS AND EXPENSES.—If the court finds, under a petition filed under paragraph (1), with respect to a claim or claims, that the judgment or order finally obtained is not more favorable to the party

contesting the ADR decision with respect to the claim or claims than the ADR decision, the court shall order the contesting party to pay the costs and expenses of the opposing party, including attorneys' fees, incurred with respect to the claim or claims after the date of the ADR decision, unless the court finds that requiring the payment of such costs and expenses would be manifestly unjust.

(3) LIMITATION.—Attorneys' fees awarded under this subsection shall be in an amount reasonably attributable to the claim or claims involved, calculated on the basis of an hourly rate of the attorney, which may not exceed that which the court considers acceptable in the community in which the attorney practices law, taking into account the attorney's qualifications and experience and the complexity of the case. Attorneys' fees under this subsection may not exceed—

(A) the actual cost incurred by the party for attorneys' fees payable to an attorney for services in connection with the claim or claims; or

(B) if no such cost was incurred by the party due to a contingency fee agreement, a reasonable cost that would have been incurred by the party for noncontingent attorneys' fees payable to an attorney for services in connection with the claim or claims.

(g) APPLICABILITY.—The requirements of this section shall apply only to each covered health care malpractice claim arising out of an event (or events) occurring on or after the date that is 270 days after the date of enactment of this Act.

SEC. __05. BASIC REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

The alternative dispute resolution system of a State meets the requirements of this section if the system—

(1) applies to all covered health care malpractice claims under the jurisdiction of the courts of such State;

(2) requires that a written opinion resolving the dispute be issued not later than 180 days after the date on which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute; and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications as the State may require (in accordance with regulations of the Attorney General);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system; and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator of the Agency for Healthcare Research and Quality of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

SEC. __06. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than 270 days after the date of enactment of this Act and periodically thereafter, the Attorney General, in consultation with the Secretary, shall determine whether the alternative dispute resolution systems of each State meet the requirements of this title.

(2) BASIS FOR CERTIFICATION.—The Attorney General shall certify the alternative dispute resolution system of a State under this subsection for a calendar year if the Attorney General determines under paragraph (1) that such system meets the requirements of section __05.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than 270 days after the date of enactment of this Act, the Attorney General, in consultation with the Secretary, shall establish by rulemaking an alternative Federal ADR system for the resolution of covered health care malpractice claims during a calendar year, to be used for a calendar year in States that do not have an alternative dispute resolution system that is certified under subsection (a) for such year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section __05 shall apply to claims brought under such system;

(B) the claims brought under such system shall be heard and resolved by medical and legal experts appointed as arbitrators by the Attorney General, in consultation with the Secretary; and

(C) with respect to a State in which such system is in effect, the Attorney General may (at the request of such State) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of health care malpractice claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year such State shall reimburse the United States, at such time and in such manner as the Secretary may require, for the costs incurred by the United States during such year as a result of the application of the system with respect to the State.

SEC. __07. GAO STUDY OF PRIVATE LITIGATION INSURANCE.

The Comptroller General of the United States shall—

(1) undertake a study of the effectiveness of private litigation insurance markets, such as those in the United Kingdom and Germany, in providing affordable access to courts, evaluating the merit of prospective claims, and ensuring that prevailing parties in ''loser pays'' systems are reimbursed for attorneys' fees; and

(2) not later than 270 days after the date of enactment of this Act, submit to Congress a report describing the results of such study.

SA 2830. Mr. BROWNBACK (for himself and Mr. LAUTENBERG) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 143 of the amendment, after line 7, add the following:

SEC. 10011. CERTIFICATION.

(a) IN GENERAL.—This title (other than this section), and the amendments made by this title, shall become effective only if the Secretary of Health and Human Services certifies to Congress that the implementation of this title, and the amendments made by this title, will—

(1) pose no additional risk to the public's health and safety; and

(2) result in a significant reduction in the cost of covered products to the American consumer.

(b) EFFECTIVE DATE.—Notwithstanding any other provision of this title, or of any amendment made by this title—

(1) any reference in this title, or in such amendments, to the date of enactment of this title shall be deemed to be a reference to the date of the certification under subsection (a); and

(2) each reference to ''January 1, 2012'' in section 10006(c) shall be substituted with ''90 days after the effective date of this title''.

SA 2831. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. NONAPPLICATION OF ANY MEDICAID ELIGIBILITY EXPANSION UNTIL REDUCTION IN MEDICAID FRAUD RATE.

Notwithstanding any other provision of this Act, with respect to a State, any provision of this Act or an amendment made by this Act that imposes a federally-mandated expansion of eligibility for Medicaid shall not apply to the State before the date on which the State Medicaid Director certifies to the Secretary of Health and Human Services that the Medicaid payment error rate measurement (commonly referred to as ''PERM'') for the State does not exceed 5 percent.

SA 2832. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

SEC. _____. DISTRIBUTION OF REMAINING BALANCES IN FLEXIBLE SPENDING ARRANGEMENTS UPON TERMINATION FROM EMPLOYMENT.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and by inserting after subsection (h) the following new subsection:

''(i) DISTRIBUTION OF REMAINING BALANCES IN FLEXIBLE SPENDING ARRANGEMENTS UPON TERMINATION FROM EMPLOYMENT.—

''(1) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a health flexible spending arrangement or a dependent care flexible spending arrangement solely because under the plan or arrangement a participant is permitted access to any unused balance in the participant's accounts under such plan or arrangement in the manner provided under paragraph (2).

''(2) DISTRIBUTION UPON TERMINATION.—

''(A) IN GENERAL.—A plan or arrangement shall permit a participant (or any designated heir of the participant) to receive a cash payment equal to the aggregate unused account balances in the plan or arrangement as of the date the individual is separated (including by death or disability) from employment with the employer maintaining the plan or arrangement.

''(B) INCLUSION IN INCOME.—Any payment under subparagraph (A) shall be includible in gross income for the taxable year in which such payment is distributed to the employee.

''(3) TERMS RELATING TO FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section—

''(A) FLEXIBLE SPENDING ARRANGEMENTS.—A flexible spending arrangement is a benefit program which provides employees with coverage under which specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions).

''(B) HEALTH AND DEPENDENT CARE ARRANGEMENTS.—The terms 'health flexible spending arrangement' and 'dependent care flexible spending arrangement' means any flexible spending arrangement (or portion thereof) which provides payments for expenses incurred for medical care (as defined in section 213(d)) or dependent care (within the meaning of section 129), respectively.''.

(b) CONFORMING AMENDMENTS.—

(1) The heading for section 125 of the Internal Revenue Code of 1986 is amended by inserting ''**AND FLEXIBLE SPENDING ARRANGEMENTS**'' after ''**PLANS**''.

(2) The item relating to section 125 in the table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting ''and flexible spending arrangements'' after ''plans''.

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

SA 2833. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. NONAPPLICATION OF ANY MEDICAID ELIGIBILITY EXPANSION UNTIL ENROLLMENT OF AT LEAST 90 PERCENT OF CURRENTLY ELIGIBLE INDIVIDUALS.

Notwithstanding any other provision of this Act, with respect to a State, any provision of this Act or an amendment made by this Act that imposes a federally-mandated expansion of eligibility for Medicaid shall not apply to the State before the date on which the State Medicaid Director certifies to the Secretary of Health and Human Services that at least 90 percent of the individuals eligible for medical assistance under the State's Medicaid plan, including under any waiver of such plan, are enrolled in the plan or waiver.

SA 2834. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 340, between lines 21 and 22, insert the following:

(e) EXPEDITED JUDICIAL REVIEW.—If any action is brought to challenge the constitutionality of section 5000A of the Internal Revenue Code of 1986, as added by subsection (b), the following rules shall apply:

(1) The action shall be filed in the United States District Court for the District of Columbia and shall be heard by a 3-judge court convened pursuant to section 2284 of title 28, United States Code.

(2) A copy of the complaint shall be delivered promptly to the Clerk of the House of Representatives and the Secretary of the Senate.

(3) A final decision in the action shall be reviewable only by appeal directly to the Supreme Court of the United States. Such appeal shall be taken by the filing of a notice of appeal within 10 days, and the filing of a jurisdictional statement within 30 days, of the entry of the final decision.

(4) It shall be the duty of the United States District Court for the District of Columbia and the Supreme Court of the United States to advance on the docket and to expedite to the greatest possible extent the disposition of the action and appeal.

SA 2835. Mr. JOHANNS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1006, between lines 8 and 9, insert the following:

''(vii) The proposal shall not include any recommendation that would reduce payment rates for items and services furnished by a critical access hospital (as defined in section 1861(mm)(1)).

SA 2836. Ms. MURKOWSKI (for herself, Mrs. HUTCHISON, and Mr. JOHANNS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 17, strike lines 11 through 14.

On page 17, line 15, strike ''(2)'' and insert ''(1).''

On page 17, line 20, strike ''(3)'' and insert ''(2)''.

On page 17, between lines 24 and 25, insert the following:

''Notwithstanding any other provision of law, the Secretary shall not use any recommendation made by the United States Preventive Services Task Force to deny coverage of an item or service by a group health plan or health insurance issuer offering group or individual health insurance coverage or under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C.1320a–7b(f))) or private insurance.

''(b) DETERMINATIONS OF BENEFITS COVERAGE.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, in determining which preventive items and services to provide coverage for under the plan or coverage, consult the medical guidelines and recommendations of relevant professional medical organizations of relevant medical practice areas (such as the American Society of Clinical Oncology, the American College of Surgeons, the American College of Radiation Oncology, the American College of Obstetricians and Gynecologists, and other similar organizations), including guidelines and recommendations relating to the coverage of women's preventive services (such as mammograms and cervical cancer screenings). The plan or issuer shall disclose such guidelines and recommendations to enrollees as part of the summary of benefits and coverage explanation provided under section 2715.''.

On page 17, line 25, strike ''(b)'' and insert ''(c)''.

On page 18, lines 3 and 4, strike ''or (a)(2)''.

On page 18, line 4, strike ''(a)(3)'' and insert ''(a)(2)''

On page 18, line 11, strike ''(c)'' and insert ''(d)''.

On page 124, between lines 22 and 23, insert the following:

(d) RULE OF CONSTRUCTION WITH RESPECT TO PREVENTIVE SERVICES.—Nothing in this Act (or an amendment made by this Act) shall be construed to authorize the Secretary, or any other governmental or quasi-governmental entity, to define or classify abortion or abortion services as ''preventive care'' or as a ''preventive service''.

On page 1680, strike lines 10 through 12, and insert the following:

''(A) to permit the Secretary to use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), to deny coverage of an item or service under a Federal health care program (as defined in section 1128B(f)) or private insurance; or''.

SA 2837. Mr. SANDERS (for himself, Mr. BURRIS, and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue

Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1, strike line 6 and all the follows to the end and insert the following:

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

TITLE I—AMERICAN HEALTH SECURITY

Sec. 1000. Short title.

Subtitle A—Establishment of a State-Based American Health Security Program; Universal Entitlement; Enrollment

Sec. 1001. Establishment of a State-based American Health Security Program.
Sec. 1002. Universal entitlement.
Sec. 1003. Enrollment.
Sec. 1004. Portability of benefits.
Sec. 1005. Effective date of benefits.
Sec. 1006. Relationship to existing Federal health programs.

Subtitle B—Comprehensive Benefits, Including Preventive Benefits and Benefits for Long-Term Care

Sec. 1101. Comprehensive benefits.
Sec. 1102. Definitions relating to services.
Sec. 1103. Special rules for home and community-based long-term care services.
Sec. 1104. Exclusions and limitations.
Sec. 1105. Certification; quality review; plans of care.

Subtitle C—Provider Participation

Sec. 1201. Provider participation and standards.
Sec. 1202. Qualifications for providers.
Sec. 1203. Qualifications for comprehensive health service organizations.
Sec. 1204. Limitation on certain physician referrals.

Subtitle D—Administration

PART I—GENERAL ADMINISTRATIVE PROVISIONS

Sec. 1301. American Health Security Standards Board.
Sec. 1302. American Health Security Advisory Council.
Sec. 1303. Consultation with private entities.
Sec. 1304. State health security programs.
Sec. 1305. Complementary conduct of related health programs.

PART II—CONTROL OVER FRAUD AND ABUSE

Sec. 1310. Application of Federal sanctions to all fraud and abuse under American Health Security Program.
Sec. 1311. Requirements for operation of State health care fraud and abuse control units.

Subtitle E—Quality Assessment

Sec. 1401. American Health Security Quality Council.
Sec. 1402. Development of certain methodologies, guidelines, and standards.
Sec. 1403. State quality review programs.
Sec. 1404. Elimination of utilization review programs; transition.

Subtitle F—Health Security Budget; Payments; Cost Containment Measures

PART I—BUDGETING AND PAYMENTS TO STATES

Sec. 1501. National health security budget.
Sec. 1502. Computation of individual and State capitation amounts.
Sec. 1503. State health security budgets.
Sec. 1504. Federal payments to States.
Sec. 1505. Account for health professional education expenditures.

PART II—PAYMENTS BY STATES TO PROVIDERS

Sec. 1510. Payments to hospitals and other facility-based services for operating expenses on the basis of approved global budgets.
Sec. 1511. Payments to health care practitioners based on prospective fee schedule.
Sec. 1512. Payments to comprehensive health service organizations.
Sec. 1513. Payments for community-based primary health services.
Sec. 1514. Payments for prescription drugs.
Sec. 1515. Payments for approved devices and equipment.
Sec. 1516. Payments for other items and services.
Sec. 1517. Payment incentives for medically underserved areas.
Sec. 1518. Authority for alternative payment methodologies.

PART III—MANDATORY ASSIGNMENT AND ADMINISTRATIVE PROVISIONS

Sec. 1520. Mandatory assignment.
Sec. 1521. Procedures for reimbursement; appeals.

Subtitle G—Financing Provisions; American Health Security Trust Fund

Sec. 1530. Amendment of 1986 code; Section 15 not to apply.

PART I—AMERICAN HEALTH SECURITY TRUST FUND

Sec. 1531. American Health Security Trust Fund.

PART II—TAXES BASED ON INCOME AND WAGES

Sec. 1535. Payroll tax on employers.
Sec. 1536. Health care income tax.

Subtitle H—Conforming Amendments to the Employee Retirement Income Security Act of 1974

Sec. 1601. ERISA inapplicable to health coverage arrangements under State health security programs.
Sec. 1602. Exemption of State health security programs from ERISA preemption.
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TITLE I—AMERICAN HEALTH SECURITY

SEC. 1000. SHORT TITLE.

This title may be cited as the ''American Health Security Act of 2009''

Subtitle A—Establishment of a State-Based American Health Security Program; Universal Entitlement; Enrollment

SEC. 1001. ESTABLISHMENT OF A STATE-BASED AMERICAN HEALTH SECURITY PROGRAM.

(a) IN GENERAL.—There is hereby established in the United States a State-Based American Health Security Program to be administered by the individual States in accordance with Federal standards specified in, or established under, this title.

(b) STATE HEALTH SECURITY PROGRAMS.—In order for a State to be eligible to receive payment under section 1504, a State must establish a State health security program in accordance with this title.

(c) STATE DEFINED.—

(1) IN GENERAL.—In this title, subject to paragraph (2), the term ''State'' means each of the 50 States and the District of Columbia.

(2) ELECTION.—If the Governor of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands certifies to the President that the legislature of the Commonwealth or territory has enacted legislation desiring that the Commonwealth or territory be included as a State under the provisions of this title, such Commonwealth or territory shall be included as a ''State'' under this title beginning January 1 of the first year beginning 90 days after the President receives the notification.

SEC. 1002. UNIVERSAL ENTITLEMENT.

(a) IN GENERAL.—Every individual who is a resident of the United States and is a citizen or national of the United States or lawful resident alien (as defined in subsection (d)) is entitled to benefits for health care services under this title under the appropriate State health security program. In this section, the term ''appropriate State health security program'' means, with respect to an individual, the State health security program for the State in which the individual maintains a primary residence.

(b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

(1) IN GENERAL.—The American Health Security Standards Board (in this title referred to as the ''Board'') may make eligible for benefits for health care services under the appropriate State health security program under this title such classes of aliens admitted to the United States as nonimmigrants as the Board may provide.

(2) CONSIDERATION.—In providing for eligibility under paragraph (1), the Board shall consider reciprocity in health care services offered to United States citizens who are nonimmigrants in other foreign states, and such other factors as the Board determines to be appropriate.

(c) TREATMENT OF OTHER INDIVIDUALS.—

(1) BY BOARD.—The Board also may make eligible for benefits for health care services under the appropriate State health security program under this title other individuals not described in subsection (a) or (b), and regulate the nature of the eligibility of such individuals, in order—

(A) to preserve the public health of communities;

(B) to compensate States for the additional health care financing burdens created by such individuals; and

(C) to prevent adverse financial and medical consequences of uncompensated care,

while inhibiting travel and immigration to the United States for the sole purpose of obtaining health care services.

(2) BY STATES.—Any State health security program may make individuals described in paragraph (1) eligible for benefits at the expense of the State.

(d) LAWFUL RESIDENT ALIEN DEFINED.—For purposes of this section, the term ''lawful

resident alien'' means an alien lawfully admitted for permanent residence and any other alien lawfully residing permanently in the United States under color of law, including an alien with lawful temporary resident status under section 210, 210A, or 234A of the Immigration and Nationality Act (8 U.S.C. 1160, 1161, or 1255a).

SEC. 1003. ENROLLMENT.

(a) IN GENERAL.—Each State health security program shall provide a mechanism for the enrollment of individuals entitled or eligible for benefits under this title. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States and at the time of immigration into the United States or other acquisition of lawful resident status in the United States;

(2) provide for the enrollment, as of January 1, 2011, of all individuals who are eligible to be enrolled as of such date; and

(3) include a process for the enrollment of individuals made eligible for health care services under subsections (b) and (c) of section 1002.

(b) AVAILABILITY OF APPLICATIONS.—Each State health security program shall make applications for enrollment under the program available—

(1) at employment and payroll offices of employers located in the State;

(2) at local offices of the Social Security Administration;

(3) at social services locations;

(4) at out-reach sites (such as provider and practitioner locations); and

(5) at other locations (including post offices and schools) accessible to a broad cross-section of individuals eligible to enroll.

(c) ISSUANCE OF HEALTH SECURITY CARDS.—In conjunction with an individual's enrollment for benefits under this title, the State health security program shall provide for the issuance of a health security card that shall be used for purposes of identification and processing of claims for benefits under the program. The State health security program may provide for issuance of such cards by employers for purposes of carrying out enrollment pursuant to subsection (a)(2).

SEC. 1004. PORTABILITY OF BENEFITS.

(a) IN GENERAL.—To ensure continuous access to benefits for health care services covered under this title, each State health security program—

(1) shall not impose any minimum period of residence in the State, or waiting period, in excess of 3 months before residents of the State are entitled to, or eligible for, such benefits under the program;

(2) shall provide continuation of payment for covered health care services to individuals who have terminated their residence in the State and established their residence in another State, for the duration of any waiting period imposed in the State of new residency for establishing entitlement to, or eligibility for, such services; and

(3) shall provide for the payment for health care services covered under this title provided to individuals while temporarily absent from the State based on the following principles:

(A) Payment for such health care services is at the rate that is approved by the State health security program in the State in which the services are provided, unless the States concerned agree to apportion the cost between them in a different manner.

(B) Payment for such health care services provided outside the United States is made on the basis of the amount that would have been paid by the State health security program for similar services rendered in the State, with due regard, in the case of hospital services, to the size of the hospital, standards of service, and other relevant factors.

(b) CROSS-BORDER ARRANGEMENTS.—A State health security program for a State may negotiate with such a program in an adjacent State a reciprocal arrangement for the coverage under such other program of health care services to enrollees residing in the border region.

SEC. 1005. EFFECTIVE DATE OF BENEFITS.

Benefits shall first be available under this title for items and services furnished on or after January 1, 2011.

SEC. 1006. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

(a) MEDICARE, MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).—

(1) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraph (2)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any item or service furnished after December 31, 2010;

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished after such date;

(C) no individual is entitled to medical assistance under an SCHIP plan under title XXI of such Act for any item or service furnished after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before January 1, 2011, and which had not ended as of such date, for which benefits are provided under title XVIII, under a State plan under title XIX, or a State child health plan under title XXI, of the Social Security Act, the Secretary of Health and Human Services and each State plan, respectively, shall provide for continuation of benefits under such title or plan until the end of the period of stay.

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, for any part of a coverage period occurring after December 31, 2010.

(c) CHAMPUS.—No benefits shall be made available under sections 1079 and 1086 of title 10, United States Code, for items or services furnished after December 31, 2010.

(d) TREATMENT OF BENEFITS FOR VETERANS AND NATIVE AMERICANS.—Nothing in this title shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

Subtitle B—Comprehensive Benefits, Including Preventive Benefits and Benefits for Long-Term Care

SEC. 1101. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the succeeding provisions of this title, individuals enrolled for benefits under this title are entitled to have payment made under a State health security program for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) HOSPITAL SERVICES.—Inpatient and outpatient hospital care, including 24-hour-a-day emergency services.

(2) PROFESSIONAL SERVICES.—Professional services of health care practitioners authorized to provide health care services under State law, including patient education and training in self-management techniques.

(3) COMMUNITY-BASED PRIMARY HEALTH SERVICES.—Community-based primary health services (as defined in section 1102(a)).

(4) PREVENTIVE SERVICES.—Preventive services (as defined in section 1102(b)).

(5) LONG-TERM, ACUTE, AND CHRONIC CARE SERVICES.—

(A) Nursing facility services.

(B) Home health services.

(C) Home and community-based long-term care services (as defined in section 1102(c)) for individuals described in section 1103(a).

(D) Hospice care.

(E) Services in intermediate care facilities for individuals with mental retardation.

(6) PRESCRIPTION DRUGS, BIOLOGICALS, INSULIN, MEDICAL FOODS.—

(A) Outpatient prescription drugs and biologics, as specified by the Board consistent with section 1515.

(B) Insulin.

(C) Medical foods (as defined in section 1102(e)).

(7) DENTAL SERVICES.—Dental services (as defined in section 1102(h)).

(8) MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES.—Mental health and substance abuse treatment services (as defined in section 1102(f)).

(9) DIAGNOSTIC TESTS.—Diagnostic tests.

(10) OTHER ITEMS AND SERVICES.—

(A) OUTPATIENT THERAPY.—Outpatient physical therapy services, outpatient speech pathology services, and outpatient occupational therapy services in all settings.

(B) DURABLE MEDICAL EQUIPMENT.—Durable medical equipment.

(C) HOME DIALYSIS.—Home dialysis supplies and equipment.

(D) AMBULANCE.—Emergency ambulance service.

(E) PROSTHETIC DEVICES.—Prosthetic devices, including replacements of such devices.

(F) ADDITIONAL ITEMS AND SERVICES.—Such other medical or health care items or services as the Board may specify.

(b) PROHIBITION OF BALANCE BILLING.—No person may impose a charge for covered services for which benefits are provided under this title.

(c) NO DUPLICATE HEALTH INSURANCE.—Each State health security program shall prohibit the sale of health insurance in the State if payment under the insurance duplicates payment for any items or services for which payment may be made under such a program.

(d) STATE PROGRAM MAY PROVIDE ADDITIONAL BENEFITS.—Nothing in this title shall be construed as limiting the benefits that may be made available under a State health security program to residents of the State at the expense of the State.

(e) EMPLOYERS MAY PROVIDE ADDITIONAL BENEFITS.—Nothing in this title shall be construed as limiting the additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.

SEC. 1102. DEFINITIONS RELATING TO SERVICES.

(a) COMMUNITY-BASED PRIMARY HEALTH SERVICES.—In this title, the term ''community-based primary health services'' means ambulatory health services furnished—

(1) by a rural health clinic;

(2) by a federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act), and which, for purposes of this title, include services furnished by State and local health agencies;

(3) in a school-based setting;

(4) by public educational agencies and other providers of services to children entitled to assistance under the Individuals with

Disabilities Education Act for services furnished pursuant to a written Individualized Family Services Plan or Individual Education Plan under such Act; and

(5) public and private nonprofit entities receiving Federal assistance under the Public Health Service Act.

(b) PREVENTIVE SERVICES.—

(1) IN GENERAL.—In this title, the term ''preventive services'' means items and services—

(A) which—

(i) are specified in paragraph (2); or

(ii) the Board determines to be effective in the maintenance and promotion of health or minimizing the effect of illness, disease, or medical condition; and

(B) which are provided consistent with the periodicity schedule established under paragraph (3).

(2) SPECIFIED PREVENTIVE SERVICES.—The services specified in this paragraph are as follows:

(A) Basic immunizations.

(B) Prenatal and well-baby care (for infants under 1 year of age).

(C) Well-child care (including periodic physical examinations, hearing and vision screening, and developmental screening and examinations) for individuals under 18 years of age.

(D) Periodic screening mammography, Pap smears, and colorectal examinations and examinations for prostate cancer.

(E) Physical examinations.

(F) Family planning services.

(G) Routine eye examinations, eyeglasses, and contact lenses.

(H) Hearing aids, but only upon a determination of a certified audiologist or physician that a hearing problem exists and is caused by a condition that can be corrected by use of a hearing aid.

(3) SCHEDULE.—The Board shall establish, in consultation with experts in preventive medicine and public health and taking into consideration those preventive services recommended by the Preventive Services Task Force and published as the Guide to Clinical Preventive Services, a periodicity schedule for the coverage of preventive services under paragraph (1). Such schedule shall take into consideration the cost-effectiveness of appropriate preventive care and shall be revised not less frequently than once every 5 years, in consultation with experts in preventive medicine and public health.

(c) HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.—In this title, the term ''home and community-based long-term care services'' means the following services provided to an individual to enable the individual to remain in such individual's place of residence within the community:

(1) Home health aide services.

(2) Adult day health care, social day care or psychiatric day care.

(3) Medical social work services.

(4) Care coordination services, as defined in subsection (g)(1).

(5) Respite care, including training for informal caregivers.

(6) Personal assistance services, and homemaker services (including meals) incidental to the provision of personal assistance services.

(d) HOME HEALTH SERVICES.—

(1) IN GENERAL.—The term ''home health services'' means items and services described in section 1861(m) of the Social Security Act and includes home infusion services.

(2) HOME INFUSION SERVICES.—The term ''home infusion services'' includes the nursing, pharmacy, and related services that are necessary to conduct the home infusion of a drug regimen safely and effectively under a plan established and periodically reviewed by a physician and that are provided in compliance with quality assurance requirements established by the Secretary.

(e) MEDICAL FOODS.—In this title, the term ''medical foods'' means foods which are formulated to be consumed or administered enterally under the supervision of a physician and which are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

(f) MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES.—

(1) SERVICES DESCRIBED.—In this title, the term ''mental health and substance abuse treatment services'' means the following services related to the prevention, diagnosis, treatment, and rehabilitation of mental illness and promotion of mental health:

(A) INPATIENT HOSPITAL SERVICES.—Inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse for up to 60 days during a year, reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of inpatient residential services furnished to the individual under subparagraph (B) during the year after such services have been furnished to the individual for 120 days during the year (rounded to the nearest day), but only if (with respect to services furnished to an individual described in section 1104(b)(1)) such services are furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1104(b)(2).

(B) INTENSIVE RESIDENTIAL SERVICES.—Intensive residential services (as defined in paragraph (2)) furnished to an individual for up to 120 days during any calendar year, except that—

(i) such services may be furnished to the individual for additional days during the year if necessary for the individual to complete a course of treatment to the extent that the number of days of inpatient hospital services described in subparagraph (A) that may be furnished to the individual during the year (as reduced under such subparagraph) is not less than 15; and

(ii) reduced by a number of days determined by the Secretary so that the actuarial value of providing such number of days of services under this paragraph to the individual is equal to the actuarial value of the days of intensive community-based services furnished to the individual under subparagraph (D) during the year after such services have been furnished to the individual for 90 days (or, in the case of services described in subparagraph (D)(ii), for 180 days) during the year (rounded to the nearest day).

(C) OUTPATIENT SERVICES.—Outpatient treatment services of mental illness or substance abuse (other than intensive community-based services under subparagraph (D)) for an unlimited number of days during any calendar year furnished in accordance with standards established by the Secretary for the management of such services, and, in the case of services furnished to an individual described in section 1104(b)(1) who is not an inpatient of a hospital, in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1104(b)(2).

(D) INTENSIVE COMMUNITY-BASED SERVICES.—Intensive community-based services (as described in paragraph (3))—

(i) for an unlimited number of days during any calendar year, in the case of services described in section 1861(ff)(2)(E) that are furnished to an individual who is a seriously mentally ill adult, a seriously emotionally disturbed child, or an adult or child with serious substance abuse disorder (as determined in accordance with criteria established by the Secretary);

(ii) in the case of services described in section 1861(ff)(2)(C), for up to 180 days during any calendar year, except that such services may be furnished to the individual for a number of additional days during the year equal to the difference between the total number of days of intensive residential services which the individual may receive during the year under part A (as determined under subparagraph (B)) and the number of days of such services which the individual has received during the year; or

(iii) in the case of any other such services, for up to 90 days during any calendar year, except that such services may be furnished to the individual for the number of additional days during the year described in clause (ii).

(2) INTENSIVE RESIDENTIAL SERVICES DEFINED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the term ''intensive residential services'' means inpatient services provided in any of the following facilities:

(i) Residential detoxification centers.

(ii) Crisis residential programs or mental illness residential treatment programs.

(iii) Therapeutic family or group treatment homes.

(iv) Residential centers for substance abuse treatment.

(B) REQUIREMENTS FOR FACILITIES.—No service may be treated as an intensive residential service under subparagraph (A) unless the facility at which the service is provided—

(i) is legally authorized to provide such service under the law of the State (or under a State regulatory mechanism provided by State law) in which the facility is located or is certified to provide such service by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

(ii) meets such other requirements as the Secretary may impose to assure the quality of the intensive residential services provided.

(C) SERVICES FURNISHED TO AT-RISK CHILDREN.—In the case of services furnished to an individual described in section 1104(b)(1), no service may be treated as an intensive residential service under this subsection unless the service is furnished in conformity with the plan of an organized system of care for mental health and substance abuse services in accordance with section 1104(b)(2).

(D) MANAGEMENT STANDARDS.—No service may be treated as an intensive residential service under subparagraph (A) unless the service is furnished in accordance with standards established by the Secretary for the management of such services.

(3) INTENSIVE COMMUNITY-BASED SERVICES DEFINED.—

(A) IN GENERAL.—The term ''intensive community-based services'' means the items and services described in subparagraph (B) prescribed by a physician (or, in the case of services furnished to an individual described in section 1104(b)(1), by an organized system of care for mental health and substance abuse services in accordance with such section) and provided under a program described in subparagraph (D) under the supervision of a physician (or, to the extent permitted under the law of the State in which the services are furnished, a non-physician mental health professional) pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program) which sets

forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan, but does not include any item or service that is not furnished in accordance with standards established by the Secretary for the management of such services.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are—

(i) partial hospitalization services consisting of the items and services described in subparagraph (C);

(ii) psychiatric rehabilitation services;

(iii) day treatment services for individuals under 19 years of age;

(iv) in-home services;

(v) case management services, including collateral services designated as such case management services by the Secretary;

(vi) ambulatory detoxification services; and

(vii) such other items and services as the Secretary may provide (but in no event to include meals and transportation),

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

(C) ITEMS AND SERVICES INCLUDED AS PARTIAL HOSPITALIZATION SERVICES.—For purposes of subparagraph (B)(i), partial hospitalization services consist of the following:

(i) Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law).

(ii) Occupational therapy requiring the skills of a qualified occupational therapist.

(iii) Services of social workers, trained psychiatric nurses, behavioral aides, and other staff trained to work with psychiatric patients (to the extent authorized under State law).

(iv) Drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered).

(v) Individualized activity therapies that are not primarily recreational or diversionary.

(vi) Family counseling (the primary purpose of which is treatment of the individual's condition).

(vii) Patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment).

(viii) Diagnostic services.

(D) PROGRAMS DESCRIBED.—A program described in this subparagraph is a program (whether facility-based or freestanding) which is furnished by an entity—

(i) legally authorized to furnish such a program under State law (or the State regulatory mechanism provided by State law) or certified to furnish such a program by an appropriate accreditation entity approved by the State in consultation with the Secretary; and

(ii) meeting such other requirements as the Secretary may impose to assure the quality of the intensive community-based services provided.

(g) CARE COORDINATION SERVICES.—

(1) IN GENERAL.—In this title, the term ''care coordination services'' means services provided by care coordinators (as defined in paragraph (2)) to individuals described in paragraph (3) for the coordination and monitoring of home and community-based long term care services to ensure appropriate, cost-effective utilization of such services in a comprehensive and continuous manner, and includes—

(A) transition management between inpatient facilities and community-based services, including assisting patients in identifying and gaining access to appropriate ancillary services; and

(B) evaluating and recommending appropriate treatment services, in cooperation with patients and other providers and in conjunction with any quality review program or plan of care under section 1105.

(2) CARE COORDINATOR.—

(A) IN GENERAL.—In this title, the term ''care coordinator'' means an individual or nonprofit or public agency or organization which the State health security program determines—

(i) is capable of performing directly, efficiently, and effectively the duties of a care coordinator described in paragraph (1); and

(ii) demonstrates capability in establishing and periodically reviewing and revising plans of care, and in arranging for and monitoring the provision and quality of services under any plan.

(B) INDEPENDENCE.—State health security programs shall establish safeguards to assure that care coordinators have no financial interest in treatment decisions or placements. Care coordination may not be provided through any structure or mechanism through which quality review is performed.

(3) ELIGIBLE INDIVIDUALS.—An individual described in this paragraph is an individual described in section 1103 (relating to individuals qualifying for long term and chronic care services).

(h) DENTAL SERVICES.—

(1) IN GENERAL.—In this title, subject to subsection (b), the term ''dental services'' means the following:

(A) Emergency dental treatment, including extractions, for bleeding, pain, acute infections, and injuries to the maxillofacial region.

(B) Prevention and diagnosis of dental disease, including examinations of the hard and soft tissues of the oral cavity and related structures, radiographs, dental sealants, fluorides, and dental prophylaxis.

(C) Treatment of dental disease, including non-cast fillings, periodontal maintenance services, and endodontic services.

(D) Space maintenance procedures to prevent orthodontic complications.

(E) Orthodontic treatment to prevent severe malocclusions.

(F) Full dentures.

(G) Medically necessary oral health care.

(H) Any items and services for special needs patients that are not described in subparagraphs (A) through (G) and that—

(i) are required to provide such patients the items and services described in subparagraphs (A) through (G);

(ii) are required to establish oral function (including general anesthesia for individuals with physical or emotional limitations that prevent the provision of dental care without such anesthesia);

(iii) consist of orthodontic care for severe dentofacial abnormalities; or

(iv) consist of prosthetic dental devices for genetic or birth defects or fitting for such devices.

(I) Any dental care for individuals with a seizure disorder that is not described in subparagraphs (A) through (H) and that is required because of an illness, injury, disorder, or other health condition that results from such seizure disorder.

(2) LIMITATIONS.—Dental services are subject to the following limitations:

(A) PREVENTION AND DIAGNOSIS.—

(i) EXAMINATIONS AND PROPHYLAXIS.—The examinations and prophylaxis described in paragraph (1)(B) are covered only consistent with a periodicity schedule established by the Board, which schedule may provide for special treatment of individuals less than 18 years of age and of special needs patients.

(ii) DENTAL SEALANTS.—The dental sealants described in such paragraph are not covered for individuals 18 years of age or older. Such sealants are covered for individuals less than 10 years of age for protection of the 1st permanent molars. Such sealants are covered for individuals 10 years of age or older for protection of the 2d permanent molars.

(B) TREATMENT OF DENTAL DISEASE.—Prior to January 1, 2016, the items and services described in paragraph (1)(C) are covered only for individuals less than 18 years of age and special needs patients. On or after such date, such items and services are covered for all individuals enrolled for benefits under this title, except that endodontic services are not covered for individuals 18 years of age or older.

(C) SPACE MAINTENANCE.—The items and services described in paragraph (1)(D) are covered only for individuals at least 3 years of age, but less than 13 years of age and—

(i) are limited to posterior teeth;

(ii) involve maintenance of a space or spaces for permanent posterior teeth that would otherwise be prevented from normal eruption if the space were not maintained; and

(iii) do not include a space maintainer that is placed within 6 months of the expected eruption of the permanent posterior tooth concerned.

(3) DEFINITIONS.—For purposes of this title:

(A) MEDICALLY NECESSARY ORAL HEALTH CARE.—The term ''medically necessary oral health care'' means oral health care that is required as a direct result of, or would have a direct impact on, an underlying medical condition. Such term includes oral health care directed toward control or elimination of pain, infection, or reestablishment of oral function.

(B) SPECIAL NEEDS PATIENT.—The term ''special needs patient'' includes an individual with a genetic or birth defect, a developmental disability, or an acquired medical disability.

(i) NURSING FACILITY; NURSING FACILITY SERVICES.—Except as may be provided by the Board, the terms ''nursing facility'' and ''nursing facility services'' have the meanings given such terms in sections 1919(a) and 1905(f), respectively, of the Social Security Act.

(j) SERVICES IN INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH MENTAL RETARDATION.—Except as may be provided by the Board—

(1) the term ''intermediate care facility for individuals with mental retardation'' has the meaning specified in section 1905(d) of the Social Security Act (as in effect before the enactment of this title); and

(2) the term ''services in intermediate care facilities for individuals with mental retardation'' means services described in section 1905(a)(15) of such Act (as so in effect) in an intermediate care facility for individuals with mental retardation to an individual determined to require such services in accordance with standards specified by the Board and comparable to the standards described in section 1902(a)(31)(A) of such Act (as so in effect).

(k) OTHER TERMS.—Except as may be provided by the Board, the definitions contained in section 1861 of the Social Security Act shall apply.

SEC. 1103. SPECIAL RULES FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.

(a) QUALIFYING INDIVIDUALS.—For purposes of section 1101(a)(5)(C), individuals described in this subsection are the following individuals:

(1) ADULTS.—Individuals 18 years of age or older determined (in a manner specified by the Board)—

(A) to be unable to perform, without the assistance of an individual, at least 2 of the following 5 activities of daily living (or who has a similar level of disability due to cognitive impairment)—

(i) bathing;

(ii) eating;

(iii) dressing;

(iv) toileting; and

(v) transferring in and out of a bed or in and out of a chair;

(B) due to cognitive or mental impairments, to require supervision because the individual behaves in a manner that poses health or safety hazards to himself or herself or others; or

(C) due to cognitive or mental impairments, to require queuing to perform activities of daily living.

(2) CHILDREN.—Individuals under 18 years of age determined (in a manner specified by the Board) to meet such alternative standard of disability for children as the Board develops. Such alternative standard shall be comparable to the standard for adults and appropriate for children.

(b) LIMIT ON SERVICES.—

(1) IN GENERAL.—The aggregate expenditures by a State health security program with respect to home and community-based long-term care services in a period (specified by the Board) may not exceed 65 percent (or such alternative ratio as the Board establishes under paragraph (2)) of the average of the amount of payment that would have been made under the program during the period if all the home-based long-term care beneficiaries had been residents of nursing facilities in the same area in which the services were provided.

(2) ALTERNATIVE RATIO.—The Board may establish for purposes of paragraph (1) an alternative ratio (of payments for home and community-based long term care services to payments for nursing facility services) as the Board determines to be more consistent with the goal of providing cost-effective long-term care in the most appropriate and least restrictive setting.

SEC. 1104. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Subject to section 1101(e), benefits for service are not available under this title unless the services meet the standards specified in section 1101(a).

(b) SPECIAL DELIVERY REQUIREMENTS FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES PROVIDED TO AT-RISK CHILDREN.—

(1) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—A State health security program shall ensure that mental health services and substance abuse treatment services are furnished through an organized system of care, as described in paragraph (2), if—

(A) the services are provided to an individual less than 22 years of age;

(B) the individual has a serious emotional disturbance or a substance abuse disorder; and

(C) the individual is, or is at imminent risk of being, subject to the authority of, or in need of the services of, at least 1 public agency that serves the needs of children, including an agency involved with child welfare, special education, juvenile justice, or criminal justice.

(2) REQUIREMENTS FOR SYSTEM OF CARE.—In this subsection, an ''organized system of care'' is a community-based service delivery network, which may consist of public and private providers, that meets the following requirements:

(A) The system has established linkages with existing mental health services and substance abuse treatment service delivery programs in the plan service area (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile justice, criminal justice, health care, mental health, and substance abuse prevention and treatment.

(C) The system provides for the involvement of the families of children to whom mental health services and substance abuse treatment services are provided in the planning of treatment and the delivery of services.

(D) The system provides for the development and implementation of individualized treatment plans by multidisciplinary and multiagency teams, which are recognized and followed by the applicable agencies and providers in the area.

(E) The system ensures the delivery and coordination of the range of mental health services and substance abuse treatment services required by individuals under 22 years of age who have a serious emotional disturbance or a substance abuse disorder.

(F) The system provides for the management of the individualized treatment plans described in subparagraph (D) and for a flexible response to changes in treatment needs over time.

(c) TREATMENT OF EXPERIMENTAL SERVICES.—In applying subsection (a), the Board shall make national coverage determinations with respect to those services that are experimental in nature. Such determinations shall be made consistent with a process that provides for input from representatives of health care professionals and patients and public comment.

(d) APPLICATION OF PRACTICE GUIDELINES.—In the case of services for which the American Health Security Quality Council (established under section 1401) has recognized a national practice guideline, the services are considered to meet the standards specified in section 1101(a) if they have been provided in accordance with such guideline or in accordance with such guidelines as are provided by the State health security program consistent with subtitle E. For purposes of this subsection, a service shall be considered to have been provided in accordance with a practice guideline if the health care provider providing the service exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline.

(e) SPECIFIC LIMITATIONS.—

(1) LIMITATIONS ON EYEGLASSES, CONTACT LENSES, HEARING AIDS, AND DURABLE MEDICAL EQUIPMENT.—Subject to section 1101(e), the Board may impose such limits relating to the costs and frequency of replacement of eyeglasses, contact lenses, hearing aids, and durable medical equipment to which individuals enrolled for benefits under this title are entitled to have payment made under a State health security program as the Board deems appropriate.

(2) OVERLAP WITH PREVENTIVE SERVICES.—The coverage of services described in section 1101(a) (other than paragraph (3)) which also are preventive services are required to be covered only to the extent that they are required to be covered as preventive services.

(3) MISCELLANEOUS EXCLUSIONS FROM COVERED SERVICES.—Covered services under this title do not include the following:

(A) Surgery and other procedures (such as orthodontia) performed solely for cosmetic purposes (as defined in regulations) and hospital or other services incident thereto, unless—

(i) required to correct a congenital anomaly;

(ii) required to restore or correct a part of the body which has been altered as a result of accidental injury, disease, or surgery; or

(iii) otherwise determined to be medically necessary and appropriate under section 1101(a).

(B) Personal comfort items or private rooms in inpatient facilities, unless determined to be medically necessary and appropriate under section 1101(a).

(C) The services of a professional practitioner if they are furnished in a hospital or other facility which is not a participating provider.

(f) NURSING FACILITY SERVICES AND HOME HEALTH SERVICES.—Nursing facility services and home health services (other than post-hospital services, as defined by the Board) furnished to an individual who is not described in section 1103(a) are not covered services unless the services are determined to meet the standards specified in section 1101(a) and, with respect to nursing facility services, to be provided in the least restrictive and most appropriate setting.

SEC. 1105. CERTIFICATION; QUALITY REVIEW; PLANS OF CARE.

(a) CERTIFICATIONS.—State health security programs may require, as a condition of payment for institutional health care services and other services of the type described in such sections 1814(a) and 1835(a) of the Social Security Act, periodic professional certifications of the kind described in such sections.

(b) QUALITY REVIEW.—For requirement that each State health security program establish a quality review program that meets the requirements for such a program under subtitle E, see section 1304(b)(1)(H).

(c) PLAN OF CARE REQUIREMENTS.—A State health security program may require, consistent with standards established by the Board, that payment for services exceeding specified levels or duration be provided only as consistent with a plan of care or treatment formulated by one or more providers of the services or other qualified professionals. Such a plan may include, consistent with subsection (b), case management at specified intervals as a further condition of payment for services.

Subtitle C—Provider Participation

SEC. 1201. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under a State health security program under this title is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the services under section 1202;

(2) has filed with the State health security program a participation agreement described in subsection (b); and

(3) meets such other qualifications and conditions as are established by the Board or the State health security program under this title.

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between a State health security program and a provider shall provide at least for the following:

(A) Services to eligible persons will be furnished by the provider without discrimination on the ground of race, national origin, income, religion, age, sex or sexual orientation, disability, handicapping condition, or (subject to the professional qualifications of the provider) illness. Nothing in this subparagraph shall be construed as requiring the provision of a type or class of services which services are outside the scope of the provider's normal practice.

(B) No charge will be made for any covered services other than for payment authorized by this title.

(C) The provider agrees to furnish such information as may be reasonably required by the Board or a State health security program, in accordance with uniform reporting standards established under section 1301(g)(1), for—

(i) quality review by designated entities;

(ii) the making of payments under this title (including the examination of records as may be necessary for the verification of information on which payments are based);

(iii) statistical or other studies required for the implementation of this title; and

(iv) such other purposes as the Board or State may specify.

(D) The provider agrees not to bill the program for any services for which benefits are not available because of section 1104(d).

(E) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider who or which has had a participation agreement under this subsection terminated for cause.

(F) In the case of a provider paid under a fee-for-service basis under section 1511, the provider agrees to submit bills and any required supporting documentation relating to the provision of covered services within 30 days (or such shorter period as a State health security program may require) after the date of providing such services.

(2) TERMINATION OF PARTICIPATION AGREEMENTS.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Board or a State health security program for failure to meet the requirements of this title; or

(ii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Board or a State health security program terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

SEC. 1202. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to provide covered services if the provider is licensed or certified and meets—

(1) all the requirements of State law to provide such services;

(2) applicable requirements of Federal law to provide such services; and

(3) any applicable standards established under subsection (b).

(b) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Board shall establish, evaluate, and update national minimum standards to assure the quality of services provided under this title and to monitor efforts by State health security programs to assure the quality of such services. A State health security program may also establish additional minimum standards which providers must meet.

(2) NATIONAL MINIMUM STANDARDS.—The national minimum standards under paragraph (1) shall be established for institutional providers of services, individual health care practitioners, and comprehensive health service organizations. Except as the Board may specify in order to carry out this title, a hospital, nursing facility, or other institutional provider of services shall meet standards for such a facility under the medicare program under title XVIII of the Social Security Act. Such standards also may include, where appropriate, elements relating to—

(A) adequacy and quality of facilities;

(B) training and competence of personnel (including continuing education requirements);

(C) comprehensiveness of service;

(D) continuity of service;

(E) patient satisfaction (including waiting time and access to services); and

(F) performance standards (including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation).

(3) TRANSITION IN APPLICATION.—If the Board provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) EXCHANGE OF INFORMATION.—The Board shall provide for an exchange, at least annually, among State health security programs of information with respect to quality assurance and cost containment.

SEC. 1203. QUALIFICATIONS FOR COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—For purposes of this title, a comprehensive health service organization (in this section referred to as a ''CHSO'') is a public or private organization which, in return for a capitated payment amount, undertakes to furnish, arrange for the provision of, or provide payment with respect to—

(1) a full range of health services (as identified by the Board), including at least hospital services and physicians services; and

(2) out-of-area coverage in the case of urgently needed services;

to an identified population which is living in or near a specified service area and which enrolls voluntarily in the organization.

(b) ENROLLMENT.—

(1) IN GENERAL.—All eligible persons living in or near the specified service area of a CHSO are eligible to enroll in the organization; except that the number of enrollees may be limited to avoid overtaxing the resources of the organization.

(2) MINIMUM ENROLLMENT PERIOD.—Subject to paragraph (3), the minimum period of enrollment with a CHSO shall be twelve months, unless the enrolled individual becomes ineligible to enroll with the organization.

(3) WITHDRAWAL FOR CAUSE.—Each CHSO shall permit an enrolled individual to disenroll from the organization for cause at any time.

(c) REQUIREMENTS FOR CHSOS.—

(1) ACCESSIBLE SERVICES.—Each CHSO, to the maximum extent feasible, shall make all services readily and promptly accessible to enrollees who live in the specified service area.

(2) CONTINUITY OF CARE.—Each CHSO shall furnish services in such manner as to provide continuity of care and (when services are furnished by different providers) shall provide ready referral of patients to such services and at such times as may be medically appropriate.

(3) BOARD OF DIRECTORS.—In the case of a CHSO that is a private organization—

(A) CONSUMER REPRESENTATION.—At least one-third of the members of the CHSO's board of directors must be consumer members with no direct or indirect, personal or family financial relationship to the organization.

(B) PROVIDER REPRESENTATION.—The CHSO's board of directors must include at least one member who represents health care providers.

(4) PATIENT GRIEVANCE PROGRAM.—Each CHSO must have in effect a patient grievance program and must conduct regularly surveys of the satisfaction of members with services provided by or through the organization.

(5) MEDICAL STANDARDS.—Each CHSO must provide that a committee or committees of health care practitioners associated with the organization will promulgate medical standards, oversee the professional aspects of the delivery of care, perform the functions of a pharmacy and drug therapeutics committee, and monitor and review the quality of all health services (including drugs, education, and preventive services).

(6) PREMIUMS.—Premiums or other charges by a CHSO for any services not paid for under this title must be reasonable.

(7) UTILIZATION AND BONUS INFORMATION.—Each CHSO must—

(A) comply with the requirements of section 1876(i)(8) of the Social Security Act (relating to prohibiting physician incentive plans that provide specific inducements to reduce or limit medically necessary services); and

(B) make available to its membership utilization information and data regarding financial performance, including bonus or incentive payment arrangements to practitioners.

(8) PROVISION OF SERVICES TO ENROLLEES AT INSTITUTIONS OPERATING UNDER GLOBAL BUDGETS.—The organization shall arrange to reimburse for hospital services and other facility-based services (as identified by the Board) for services provided to members of the organization in accordance with the global operating budget of the hospital or facility approved under section 1510.

(9) BROAD MARKETING.—Each CHSO must provide for the marketing of its services (including dissemination of marketing materials) to potential enrollees in a manner that is designed to enroll individuals representative of the different population groups and geographic areas included within its service area and meets such requirements as the Board or a State health security program may specify.

(10) ADDITIONAL REQUIREMENTS.—Each CHSO must meet—

(A) such requirements relating to minimum enrollment;

(B) such requirements relating to financial solvency;

(C) such requirements relating to quality and availability of care; and

(D) such other requirements,

as the Board or a State health security program may specify.

(d) PROVISION OF EMERGENCY SERVICES TO NONENROLLEES.—A CHSO may furnish emergency services to persons who are not enrolled in the organization. Payment for such services, if they are covered services to eligible persons, shall be made to the organization unless the organization requests that it be made to the individual provider who furnished the services.

SEC. 1204. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.

(a) APPLICATION TO AMERICAN HEALTH SECURITY PROGRAM.—Section 1877 of the Social Security Act, as amended by subsections (b) and (c), shall apply under this title in the same manner as it applies under title XVIII of the Social Security Act; except that in applying such section under this title any references in such section to the Secretary or

title XVIII of the Social Security Act are deemed references to the Board and the American Health Security Program under this title, respectively.

(b) EXPANSION OF PROHIBITION TO CERTAIN ADDITIONAL DESIGNATED SERVICES.—Section 1877(h)(6) of the Social Security Act (42 U.S.C. 1395nn(h)(6)) is amended by adding at the end the following:

''(M) Ambulance services.

''(N) Home infusion therapy services.''.

(c) CONFORMING AMENDMENTS.—Section 1877 of such Act is further amended—

(1) in subsection (a)(1)(A), by striking ''for which payment otherwise may be made under this title'' and inserting ''for which a charge is imposed'';

(2) in subsection (a)(1)(B), by striking ''under this title'';

(3) by amending paragraph (1) of subsection (g) to read as follows:

''(1) DENIAL OF PAYMENT.—No payment may be made under a State health security program for a designated health service for which a claim is presented in violation of subsection (a)(1)(B). No individual, third party payor, or other entity is liable for payment for designated health services for which a claim is presented in violation of such subsection.''; and

(4) in subsection (g)(3), by striking ''for which payment may not be made under paragraph (1)'' and inserting ''for which such a claim may not be presented under subsection (a)(1)''.

Subtitle D—Administration

PART I—GENERAL ADMINISTRATIVE PROVISIONS

SEC. 1301. AMERICAN HEALTH SECURITY STANDARDS BOARD.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Standards Board.

(b) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Board shall be composed of—

(A) the Secretary of Health and Human Services; and

(B) 6 other individuals (described in paragraph (2)) appointed by the President with the advice and consent of the Senate.

The President shall first nominate individuals under subparagraph (B) on a timely basis so as to provide for the operation of the Board by not later than January 1, 2010.

(2) SELECTION OF APPOINTED MEMBERS.—With respect to the individuals appointed under paragraph (1)(B):

(A) They shall be chosen on the basis of backgrounds in health policy, health economics, the healing professions, and the administration of health care institutions.

(B) They shall provide a balanced point of view with respect to the various health care interests and at least 2 of them shall represent the interests of individual consumers.

(C) Not more than 3 of them shall be from the same political party.

(D) To the greatest extent feasible, they shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS OF APPOINTED MEMBERS.—Individuals appointed under paragraph (1)(B) shall serve for a term of 6 years, except that the terms of 5 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, 4, and 5 years. During a term of membership on the Board, no member shall engage in any other business, vocation or employment.

(c) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Board in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Board.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint an appointed member of the Board for a second term in the same manner as the original appointment. A member who has served for 2 consecutive 6-year terms shall not be eligible for reappointment until 2 years after the member has ceased to serve.

(4) REMOVAL FOR CAUSE.—Upon confirmation, members of the Board may not be removed except by the President for cause.

(d) CHAIR.—The President shall designate 1 of the members of the Board, other than the Secretary, to serve at the will of the President as Chair of the Board.

(e) COMPENSATION.—Members of the Board (other than the Secretary) shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

(f) GENERAL DUTIES OF THE BOARD.—

(1) IN GENERAL.—The Board shall develop policies, procedures, guidelines, and requirements to carry out this title, including those related to—

(A) eligibility;

(B) enrollment;

(C) benefits;

(D) provider participation standards and qualifications, as defined in subtitle C;

(E) national and State funding levels;

(F) methods for determining amounts of payments to providers of covered services, consistent with part II of subtitle D;

(G) the determination of medical necessity and appropriateness with respect to coverage of certain services;

(H) assisting State health security programs with planning for capital expenditures and service delivery;

(I) planning for health professional education funding (as specified in subtitle E); and

(J) encouraging States to develop regional planning mechanisms (described in section 1304(a)(3)).

(2) REGULATIONS.—Regulations authorized by this title shall be issued by the Board in accordance with the provisions of section 553 of title 5, United States Code.

(g) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Board shall establish uniform reporting requirements and standards to ensure an adequate national data base regarding health services practitioners, services and finances of State health security programs, approved plans, providers, and the costs of facilities and practitioners providing services. Such standards shall include, to the maximum extent feasible, health outcome measures.

(B) REPORTS.—The Board shall analyze regularly information reported to it, and to State health security programs pursuant to such requirements and standards.

(2) ANNUAL REPORT.—Beginning January 1, of the second year beginning after the date of the enactment of this title, the Board shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this title.

(C) Benefits under this title.

(D) Expenditures and financing under this title.

(E) Cost-containment measures and achievements under this title.

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

(H) Long-range plans and goals for the delivery of health services.

(I) Differences in the health status of the populations of the different States, including income and racial characteristics.

(J) Necessary changes in the education of health personnel.

(K) Plans for improving service to medically underserved populations.

(L) Transition problems as a result of implementation of this title.

(M) Opportunities for improvements under this title.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Board may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, state, or local basis, of any aspect of the operation of this title, including studies of the effect of the Act upon the health of the people of the United States and the effect of comprehensive health services upon the health of persons receiving such services;

(B) develop and test methods of providing through payment for services or otherwise, additional incentives for adherence by providers to standards of adequacy, access, and quality; methods of consumer and peer review and peer control of the utilization of drugs, of laboratory services, and of other services; and methods of consumer and peer review of the quality of services;

(C) develop and test, for use by the Board, records and information retrieval systems and budget systems for health services administration, and develop and test model systems for use by providers of services;

(D) develop and test, for use by providers of services, records and information retrieval systems useful in the furnishing of preventive or diagnostic services;

(E) develop, in collaboration with the pharmaceutical profession, and test, improved administrative practices or improved methods for the reimbursement of independent pharmacies for the cost of furnishing drugs as a covered service; and

(F) make such other studies as it may consider necessary or promising for the evaluation, or for the improvement, of the operation of this title.

(4) REPORT ON USE OF EXISTING FEDERAL HEALTH CARE FACILITIES.—Not later than 1 year after the date of the enactment of this title, the Board shall recommend to the Congress one or more proposals for the treatment of health care facilities of the Federal Government.

(h) EXECUTIVE DIRECTOR.—

(1) APPOINTMENT.—There is hereby established the position of Executive Director of the Board. The Director shall be appointed by the Board and shall serve as secretary to the Board and perform such duties in the administration of this subtitle as the Board may assign.

(2) DELEGATION.—The Board is authorized to delegate to the Director or to any other officer or employee of the Board or, with the approval of the Secretary of Health and Human Services (and subject to reimbursement of identifiable costs), to any other officer or employee of the Department of Health and Human Services, any of its functions or duties under this title other than—

(A) the issuance of regulations; or

(B) the determination of the availability of funds and their allocation to implement this title.

(3) COMPENSATION.—The Executive Director of the Board shall be entitled to compensation at a level equivalent to level III of the

Executive Schedule, in accordance with section 5314 of title 5, United States Code.

(i) INSPECTOR GENERAL.—The Inspector General Act of 1978 (5 U.S.C. App.) is amended—

(1) in section 12(1), by inserting after ''Corporation;'' the first place it appears the following: ''the Chair of the American Health Security Standards Board;'';

(2) in section 12(2), by inserting after ''Resolution Trust Corporation,'' the following: ''the American Health Security Standards Board,''; and

(3) by inserting before section 9 the following:

''SPECIAL PROVISIONS CONCERNING AMERICAN HEALTH SECURITY STANDARDS BOARD

''SEC. 8M. The Inspector General of the American Health Security Standards Board, in addition to the other authorities vested by this Act, shall have the same authority, with respect to the Board and the American Health Security Program under this Act, as the Inspector General for the Department of Health and Human Services has with respect to the Secretary of Health and Human Services and the medicare and medicaid programs, respectively.''.

(j) STAFF.—The Board shall employ such staff as the Board may deem necessary.

(k) ACCESS TO INFORMATION.—The Secretary of Health and Human Services shall make available to the Board all information available from sources within the Department or from other sources, pertaining to the duties of the Board.

SEC. 1302. AMERICAN HEALTH SECURITY ADVISORY COUNCIL.

(a) IN GENERAL.—The Board shall provide for an American Health Security Advisory Council (in this section referred to as the ''Council'') to advise the Board on its activities.

(b) MEMBERSHIP.—The Council shall be composed of—

(1) the Chair of the Board, who shall serve as Chair of the Council; and

(2) twenty members, not otherwise in the employ of the United States, appointed by the Board without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

The appointed members shall include, in accordance with subsection (e), individuals who are representative of State health security programs, public health professionals, providers of health services, and of individuals (who shall constitute a majority of the Council) who are representative of consumers of such services, including a balanced representation of employers, unions, consumer organizations, and population groups with special health care needs. To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(c) TERMS OF MEMBERS.—Each appointed member shall hold office for a term of 4 years, except that—

(1) any member appointed to fill a vacancy occurring during the term for which the member's predecessor was appointed shall be appointed for the remainder of that term; and

(2) the terms of the members first taking office shall expire, as designated by the Board at the time of appointment, 5 at the end of the first year, 5 at the end of the second year, 5 at the end of the third year, and 5 at the end of the fourth year after the date of enactment of this Act.

(d) VACANCIES.—

(1) IN GENERAL.—The Board shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The Board may reappoint an appointed member of the Council for a second term in the same manner as the original appointment.

(e) QUALIFICATIONS.—

(1) PUBLIC HEALTH REPRESENTATIVES.—Members of the Council who are representative of State health security programs and public health professionals shall be individuals who have extensive experience in the financing and delivery of care under public health programs.

(2) PROVIDERS.—Members of the Council who are representative of providers of health care shall be individuals who are outstanding in fields related to medical, hospital, or other health activities, or who are representative of organizations or associations of professional health practitioners.

(3) CONSUMERS.—Members who are representative of consumers of such care shall be individuals, not engaged in and having no financial interest in the furnishing of health services, who are familiar with the needs of various segments of the population for personal health services and are experienced in dealing with problems associated with the consumption of such services.

(f) DUTIES.—

(1) IN GENERAL.—It shall be the duty of the Council—

(A) to advise the Board on matters of general policy in the administration of this title, in the formulation of regulations, and in the performance of the Board's duties under section 1301; and

(B) to study the operation of this title and the utilization of health services under it, with a view to recommending any changes in the administration of the Act or in its provisions which may appear desirable.

(2) REPORT.—The Council shall make an annual report to the Board on the performance of its functions, including any recommendations it may have with respect thereto, and the Board shall promptly transmit the report to the Congress, together with a report by the Board on any recommendations of the Council that have not been followed.

(g) STAFF.—The Council, its members, and any committees of the Council shall be provided with such secretarial, clerical, or other assistance as may be authorized by the Board for carrying out their respective functions.

(h) MEETINGS.—The Council shall meet as frequently as the Board deems necessary, but not less than 4 times each year. Upon request by 7 or more members it shall be the duty of the Chair to call a meeting of the Council.

(i) COMPENSATION.—Members of the Council shall be reimbursed by the Board for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(j) FACA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to the Council.

SEC. 1303. CONSULTATION WITH PRIVATE ENTITIES.

The Secretary and the Board shall consult with private entities, such as professional societies, national associations, nationally recognized associations of experts, medical schools and academic health centers, consumer groups, and labor and business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to assure the broadest and most informed input in the administration of this title. Nothing in this title shall prevent the Secretary from adopting guidelines developed by such a private entity if, in the Secretary's and Board's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this title.

SEC. 1304. STATE HEALTH SECURITY PROGRAMS.

(a) SUBMISSION OF PLANS.—

(1) IN GENERAL.—Each State shall submit to the Board a plan for a State health security program for providing for health care services to the residents of the State in accordance with this title.

(2) REGIONAL PROGRAMS.—A State may join with 1 or more neighboring States to submit to the Board a plan for a regional health security program instead of separate State health security programs.

(3) REGIONAL PLANNING MECHANISMS.—The Board shall provide incentives for States to develop regional planning mechanisms to promote the rational distribution of, adequate access to, and efficient use of, tertiary care facilities, equipment, and services.

(b) REVIEW AND APPROVAL OF PLANS.—

(1) IN GENERAL.—The Board shall review plans submitted under subsection (a) and determine whether such plans meet the requirements for approval. The Board shall not approve such a plan unless it finds that the plan (or State law) provides, consistent with the provisions of this title, for the following:

(A) Payment for required health services for eligible individuals in the State in accordance with this title.

(B) Adequate administration, including the designation of a single State agency responsible for the administration (or supervision of the administration) of the program.

(C) The establishment of a State health security budget.

(D) Establishment of payment methodologies (consistent with part II of subtitle E).

(E) Assurances that individuals have the freedom to choose practitioners and other health care providers for services covered under this title.

(F) A procedure for carrying out long-term regional management and planning functions with respect to the delivery and distribution of health care services that—

(i) ensures participation of consumers of health services and providers of health services; and

(ii) gives priority to the most acute shortages and maldistributions of health personnel and facilities and the most serious deficiencies in the delivery of covered services and to the means for the speedy alleviation of these shortcomings.

(G) The licensure and regulation of all health providers and facilities to ensure compliance with Federal and State laws and to promote quality of care.

(H) Establishment of an independent ombudsman for consumers to register complaints about the organization and administration of the State health security program and to help resolve complaints and disputes between consumers and providers.

(I) Publication of an annual report on the operation of the State health security program, which report shall include information on cost, progress towards achieving full enrollment, public access to health services, quality review, health outcomes, health professional training, and the needs of medically underserved populations.

(J) Provision of a fraud and abuse prevention and control unit that the Inspector General determines meets the requirements of section 1309(a).

(K) Prohibit payment in cases of prohibited physician referrals under section 1204.

(2) CONSEQUENCES OF FAILURE TO COMPLY.—If the Board finds that a State plan submitted under paragraph (1) does not meet the

requirements for approval under this section or that a State health security program or specific portion of such program, the plan for which was previously approved, no longer meets such requirements, the Board shall provide notice to the State of such failure and that unless corrective action is taken within a period specified by the Board, the Board shall place the State health security program (or specific portions of such program) in receivership under the jurisdiction of the Board.

(c) STATE HEALTH SECURITY ADVISORY COUNCILS.—

(1) IN GENERAL.—For each State, the Governor shall provide for appointment of a State Health Security Advisory Council to advise and make recommendations to the Governor and State with respect to the implementation of the State health security program in the State.

(2) MEMBERSHIP.—Each State Health Security Advisory Council shall be composed of at least 11 individuals. The appointed members shall include individuals who are representative of the State health security program, public health professionals, providers of health services, and of individuals (who shall constitute a majority) who are representative of consumers of such services, including a balanced representation of employers, unions and consumer organizations. To the greatest extent feasible, the membership of each State Health Security Advisory Council shall represent the various geographic regions of the State and shall reflect the racial, ethnic, and gender composition of the population of the State.

(3) DUTIES.—

(A) IN GENERAL.—Each State Health Security Advisory Council shall review, and submit comments to the Governor concerning the implementation of the State health security program in the State.

(B) ASSISTANCE.—Each State Health Security Advisory Council shall provide assistance and technical support to community organizations and public and private non-profit agencies submitting applications for funding under appropriate State and Federal public health programs, with particular emphasis placed on assisting those applicants with broad consumer representation.

(d) STATE USE OF FISCAL AGENTS.—

(1) IN GENERAL.—Each State health security program, using competitive bidding procedures, may enter into such contracts with qualified entities, such as voluntary associations, as the State determines to be appropriate to process claims and to perform other related functions of fiscal agents under the State health security program.

(2) RESTRICTION.—Except as the Board may provide for good cause shown, in no case may more than 1 contract described in paragraph (1) be entered into under a State health security program.

SEC. 1305. COMPLEMENTARY CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary of Health and Human Services shall direct all activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this title.

PART II—CONTROL OVER FRAUD AND ABUSE

SEC. 1310. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER AMERICAN HEALTH SECURITY PROGRAM.

The following sections of the Social Security Act shall apply to State health security programs in the same manner as they apply to State medical assistance plans under title XIX of such Act (except that in applying such provisions any reference to the Secretary is deemed a reference to the Board):

(1) Section 1128 (relating to exclusion of individuals and entities).

(2) Section 1128A (civil monetary penalties).

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

SEC. 1311. REQUIREMENTS FOR OPERATION OF STATE HEALTH CARE FRAUD AND ABUSE CONTROL UNITS.

(a) REQUIREMENT.—In order to meet the requirement of section 1304(b)(1)(J), each State health security program must establish and maintain a health care fraud and abuse control unit (in this section referred to as a ''fraud unit'') that meets requirements of this section and other requirements of the Board. Such a unit may be a State medicaid fraud control unit (described in section 1903(q) of the Social Security Act).

(b) STRUCTURE OF UNIT.—The fraud unit must—

(1) be a single identifiable entity of the State government;

(2) be separate and distinct from the State agency with principal responsibility for the administration of the State health security program; and

(3) meet 1 of the following requirements:

(A) It must be a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations.

(B) If it is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Board, that—

(i) assure its referral of suspected criminal violations relating to the State health insurance plan to the appropriate authority or authorities in the States for prosecution; and

(ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions.

(C) It must have a formal working relationship with the office of the State Attorney General and have formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Board and which provide effective coordination of activities between the fraud unit and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the State health insurance plan.

(c) FUNCTIONS.—The fraud unit must—

(1) have the function of conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of health care services and activities of providers of such services under the State health security program;

(2) have procedures for reviewing complaints of the abuse and neglect of patients of providers and facilities that receive payments under the State health security program, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action; and

(3) provide for the collection, or referral for collection to a single State agency, of overpayments that are made under the State health security program to providers and that are discovered by the fraud unit in carrying out its activities.

(d) RESOURCES.—The fraud unit must—

(1) employ such auditors, attorneys, investigators, and other necessary personnel;

(2) be organized in such a manner; and

(3) provide sufficient resources (as specified by the Board),

as is necessary to promote the effective and efficient conduct of the unit's activities.

(e) COOPERATIVE AGREEMENTS.—The fraud unit must have cooperative agreements (as specified by the Board) with—

(1) similar fraud units in other States;

(2) the Inspector General; and

(3) the Attorney General of the United States.

(f) REPORTS.—The fraud unit must submit to the Inspector General an application and annual reports containing such information as the Inspector General determines to be necessary to determine whether the unit meets the previous requirements of this section.

Subtitle E—Quality Assessment

SEC. 1401. AMERICAN HEALTH SECURITY QUALITY COUNCIL.

(a) ESTABLISHMENT.—There is hereby established an American Health Security Quality Council (in this subtitle referred to as the ''Council'').

(b) DUTIES OF THE COUNCIL.—The Council shall perform the following duties:

(1) PRACTICE GUIDELINES.—The Council shall review and evaluate each practice guideline developed under part B of title IX of the Public Health Service Act. The Council shall determine whether the guideline should be recognized as a national practice guideline to be used under section 1104(d) for purposes of determining payments under a State health security program.

(2) STANDARDS OF QUALITY, PERFORMANCE MEASURES, AND MEDICAL REVIEW CRITERIA.—The Council shall review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act. The Council shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of services provided by State health security programs, health care institutions, or health care professionals.

(3) CRITERIA FOR ENTITIES CONDUCTING QUALITY REVIEWS.—The Council shall develop minimum criteria for competence for entities that can qualify to conduct ongoing and continuous external quality review for State quality review programs under section 1403. Such criteria shall require such an entity to be administratively independent of the individual or board that administers the State health security program and shall ensure that such entities do not provide financial incentives to reviewers to favor one pattern of practice over another. The Council shall ensure coordination and reporting by such entities to assure national consistency in quality standards.

(4) REPORTING.—The Council shall report to the Board annually on the conduct of activities under such title and shall report to the Board annually specifically on findings from outcomes research and development of practice guidelines that may affect the Board's determination of coverage of services under section 401(f)(1)(G).

(5) OTHER FUNCTIONS.—The Council shall perform the functions of the Council described in section 1402.

(c) APPOINTMENT AND TERMS OF MEMBERS.—

(1) IN GENERAL.—The Council shall be composed of 10 members appointed by the President. The President shall first appoint individuals on a timely basis so as to provide for the operation of the Council by not later than January 1, 2010.

(2) SELECTION OF MEMBERS.—Each member of the Council shall be a member of a health

profession. Five members of the Council shall be physicians. Individuals shall be appointed to the Council on the basis of national reputations for clinical and academic excellence. To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States and shall reflect the racial, ethnic, and gender composition of the population of the United States.

(3) TERMS OF MEMBERS.—Individuals appointed to the Council shall serve for a term of 5 years, except that the terms of 4 of the individuals initially appointed shall be, as designated by the President at the time of their appointment, for 1, 2, 3, and 4 years.

(d) VACANCIES.—

(1) IN GENERAL.—The President shall fill any vacancy in the membership of the Council in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Council.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The President may reappoint a member of the Council for a second term in the same manner as the original appointment. A member who has served for 2 consecutive 5-year terms shall not be eligible for reappointment until 2 years after the member has ceased to serve.

(e) CHAIR.—The President shall designate 1 of the members of the Council to serve at the will of the President as Chair of the Council.

(f) COMPENSATION.—Members of the Council who are not employees of the Federal Government shall be entitled to compensation at a level equivalent to level II of the Executive Schedule, in accordance with section 5313 of title 5, United States Code.

SEC. 1402. DEVELOPMENT OF CERTAIN METHODOLOGIES, GUIDELINES, AND STANDARDS.

(a) PROFILING OF PATTERNS OF PRACTICE; IDENTIFICATION OF OUTLIERS.—The Council shall adopt methodologies for profiling the patterns of practice of health care professionals and for identifying outliers (as defined in subsection (e)).

(b) CENTERS OF EXCELLENCE.—The Council shall develop guidelines for certain medical procedures designated by the Board to be performed only at tertiary care centers which can meet standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome. Reimbursement under this Act for such a designated procedure may only be provided if the procedure was performed at a center that meets such standards.

(c) REMEDIAL ACTIONS.—The Council shall develop standards for education and sanctions with respect to outliers so as to assure the quality of health care services provided under this Act. The Council shall develop criteria for referral of providers to the State licensing board if education proves ineffective in correcting provider practice behavior.

(d) DISSEMINATION.—The Council shall disseminate to the State—

(1) the methodologies adopted under subsection (a);

(2) the guidelines developed under subsection (b); and

(3) the standards developed under subsection (c);

for use by the States under section 1403.

(e) OUTLIER DEFINED.—In this title, the term ''outlier'' means a health care provider whose pattern of practice, relative to applicable practice guidelines, suggests deficiencies in the quality of health care services being provided.

SEC. 1403. STATE QUALITY REVIEW PROGRAMS.

(a) REQUIREMENT.—In order to meet the requirement of section 404(b)(1)(H), each State health security program shall establish 1 or more qualified entities to conduct quality reviews of persons providing covered services under the program, in accordance with standards established under subsection (b)(1) (except as provided in subsection (b)(2)) and subsection (d).

(b) FEDERAL STANDARDS.—

(1) IN GENERAL.—The Council shall establish standards with respect to—

(A) the adoption of practice guidelines (whether developed by the Federal Government or other entities);

(B) the identification of outliers (consistent with methodologies adopted under section 1402(a));

(C) the development of remedial programs and monitoring for outliers; and

(D) the application of sanctions (consistent with the standards developed under section 1402(c)).

(2) STATE DISCRETION.—A State may apply under subsection (a) standards other than those established under paragraph (1) so long as the State demonstrates to the satisfaction of the Council on an annual basis that the standards applied have been as efficacious in promoting and achieving improved quality of care as the application of the standards established under paragraph (1). Positive improvements in quality shall be documented by reductions in the variations of clinical care process and improvement in patient outcomes.

(c) QUALIFICATIONS.—An entity is not qualified to conduct quality reviews under subsection (a) unless the entity satisfies the criteria for competence for such entities developed by the Council under section 1401(b)(3).

(d) INTERNAL QUALITY REVIEW.—Nothing in this section shall preclude an institutional provider from establishing its own internal quality review and enhancement programs.

SEC. 1404. ELIMINATION OF UTILIZATION REVIEW PROGRAMS; TRANSITION.

(a) INTENT.—It is the intention of this title to replace by January 1, 2013, random utilization controls with a systematic review of patterns of practice that compromise the quality of care.

(b) SUPERSEDING CASE REVIEWS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the program of quality review provided under the previous sections of this title supersede all existing Federal requirements for utilization review programs, including requirements for random case-by-case reviews and programs requiring pre-certification of medical procedures on a case-by-case basis.

(2) TRANSITION.—Before January 1, 2013, the Board and the States may employ existing utilization review standards and mechanisms as may be necessary to effect the transition to pattern of practice-based reviews.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) as precluding the case-by-case review of the provision of care—

(i) in individual incidents where the quality of care has significantly deviated from acceptable standards of practice; and

(ii) with respect to a provider who has been determined to be an outlier; or

(B) as precluding the case management of catastrophic, mental health, or substance abuse cases or long-term care where such management is necessary to achieve appropriate, cost-effective, and beneficial comprehensive medical care, as provided for in section 1104.

Subtitle F—Health Security Budget; Payments; Cost Containment Measures

PART I—BUDGETING AND PAYMENTS TO STATES

SEC. 1501. NATIONAL HEALTH SECURITY BUDGET.

(a) NATIONAL HEALTH SECURITY BUDGET.—

(1) IN GENERAL.—By not later than September 1 before the beginning of each year (beginning with 2010), the Board shall establish a national health security budget, which—

(A) specifies the total expenditures (including expenditures for administrative costs) to be made by the Federal Government and the States for covered health care services under this title; and

(B) allocates those expenditures among the States consistent with section 1504.

Pursuant to subsection (b), such budget for a year shall not exceed the budget for the preceding year increased by the percentage increase in gross domestic product.

(2) DIVISION OF BUDGET INTO COMPONENTS.—The national health security budget shall consist of at least 4 components:

(A) A component for quality assessment activities (described in subtitle E).

(B) A component for health professional education expenditures.

(C) A component for administrative costs.

(D) A component (in this subtitle referred to as the ''operating component'') for operating and other expenditures not described in subparagraphs (A) through (C), consisting of amounts not included in the other components. A State may provide for the allocation of this component between capital expenditures and other expenditures.

(3) ALLOCATION AMONG COMPONENTS.—Taking into account the State health security budgets established and submitted under section 1503, the Board shall allocate the national health security budget among the components in a manner that—

(A) assures a fair allocation for quality assessment activities (consistent with the national health security spending growth limit); and

(B) assures that the health professional education expenditure component is sufficient to provide for the amount of health professional education expenditures sufficient to meet the need for covered health care services (consistent with the national health security spending growth limit under subsection (b)(2)).

(b) BASIS FOR TOTAL EXPENDITURES.—

(1) IN GENERAL.—The total expenditures specified in such budget shall be the sum of the capitation amounts computed under section 1502(a) and the amount of Federal administrative expenditures needed to carry out this title.

(2) NATIONAL HEALTH SECURITY SPENDING GROWTH LIMIT.—For purposes of this part, the national health security spending growth limit described in this paragraph for a year is (A) zero, or, if greater, (B) the average annual percentage increase in the gross domestic product (in current dollars) during the 3-year period beginning with the first quarter of the fourth previous year to the first quarter of the previous year minus the percentage increase (if any) in the number of eligible individuals residing in any State the United States from the first quarter of the second previous year to the first quarter of the previous year.

(c) DEFINITIONS.—In this title:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase, lease, construction, or renovation of capital facilities and for equipment and includes return on equity capital.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional

education expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

SEC. 1502. COMPUTATION OF INDIVIDUAL AND STATE CAPITATION AMOUNTS.

(a) CAPITATION AMOUNTS.—

(1) INDIVIDUAL CAPITATION AMOUNTS.—In establishing the national health security budget under section 1501(a) and in computing the national average per capita cost under subsection (b) for each year, the Board shall establish a method for computing the capitation amount for each eligible individual residing in each State. The capitation amount for an eligible individual in a State classified within a risk group (established under subsection (d)(2)) is the product of—

(A) a national average per capita cost for all covered health care services (computed under subsection (b));

(B) the State adjustment factor (established under subsection (c)) for the State; and

(C) the risk adjustment factor (established under subsection (d)) for the risk group.

(2) STATE CAPITATION AMOUNT.—

(A) IN GENERAL.—For purposes of this title, the term ''State capitation amount'' means, for a State for a year, the sum of the capitation amounts computed under paragraph (1) for all the residents of the State in the year, as estimated by the Board before the beginning of the year involved.

(B) USE OF STATISTICAL MODEL.—The Board may provide for the computation of State capitation amounts based on statistical models that fairly reflect the elements that comprise the State capitation amount described in subparagraph (A).

(C) POPULATION INFORMATION.—The Bureau of the Census shall assist the Board in determining the number, place of residence, and risk group classification of eligible individuals.

(b) COMPUTATION OF NATIONAL AVERAGE PER CAPITA COST.—

(1) FOR 2010.—For 2010, the national average per capita cost under this paragraph is equal to—

(A) the average per capita health care expenditures in the United States in 2008 (as estimated by the Board);

(B) increased to 2009 by the Board's estimate of the actual amount of such per capita expenditures during 2009; and

(C) updated to 2010 by the national health security spending growth limit specified in section 1501(b)(2) for 2010.

(2) FOR SUCCEEDING YEARS.—For each succeeding year, the national average per capita cost under this subsection is equal to the national average per capita cost computed under this subsection for the previous year increased by the national health security spending growth limit (specified in section 1501(b)(2)) for the year involved.

(c) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the Board shall develop for each State a factor to adjust the national average per capita costs to reflect differences between the State and the United States in—

(A) average labor and nonlabor costs that are necessary to provide covered health services;

(B) any social, environmental, or geographic condition affecting health status or the need for health care services, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d);

(C) the geographic distribution of the State's population, particularly the proportion of the population residing in medically underserved areas, to the extent such a condition is not taken into account in the establishment of risk groups under subsection (d); and

(D) any other factor relating to operating costs required to assure equitable distribution of funds among the States.

(2) MODIFICATION OF HEALTH PROFESSIONAL EDUCATION COMPONENT.—With respect to the portion of the national health security budget allocated to expenditures for health professional education, the Board shall modify the State adjustment factors so as to take into account—

(A) differences among States in health professional education programs in operation as of the date of the enactment of this title; and

(B) differences among States in their relative need for expenditures for health professional education, taking into account the health professional education expenditures proposed in State health security budgets under section 1503(a).

(3) BUDGET NEUTRALITY.—The State adjustment factors, as modified under paragraph (2), shall be applied under this subsection in a manner that results in neither an increase nor a decrease in the total amount of the Federal contributions to all State health security programs under subsection (b) as a result of the application of such factors.

(4) PHASE-IN.—In applying State adjustment factors under this subsection during the 5-year period beginning with 2010, the Board shall phase-in, over such period, the use of factors described in paragraph (1) in a manner so that the adjustment factor for a State is based on a blend of such factors and a factor that reflects the relative actual average per capita costs of health services of the different States as of the time of enactment of this title.

(5) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the State adjustment factors under this subsection.

(d) ADJUSTMENTS FOR RISK GROUP CLASSIFICATION.—

(1) IN GENERAL.—The Board shall develop an adjustment factor to the national average per capita costs computed under subsection (b) for individuals classified in each risk group (as designated under paragraph (2)) to reflect the difference between the average national average per capita costs and the national average per capita cost for individuals classified in the risk group.

(2) RISK GROUPS.—The Board shall designate a series of risk groups, determined by age, health indicators, and other factors that represent distinct patterns of health care services utilization and costs.

(3) PERIODIC ADJUSTMENT.—In establishing the national health security budget before the beginning of each year, the Board shall provide for appropriate adjustments in the risk adjustment factors under this subsection.

SEC. 1503. STATE HEALTH SECURITY BUDGETS.

(a) ESTABLISHMENT AND SUBMISSION OF BUDGETS.—

(1) IN GENERAL.—Each State health security program shall establish and submit to the Board for each year a proposed and a final State health security budget, which specifies the following:

(A) The total expenditures (including expenditures for administrative costs) to be made under the program in the State for covered health care services under this title, consistent with subsection (b), broken down as follows:

(i) By the 4 components (described in section 1501(a)(2)), consistent with subsection (b).

(ii) Within the operating component—

(I) expenditures for operating costs of hospitals and other facility-based services in the State;

(II) expenditures for payment to comprehensive health service organizations;

(III) expenditures for payment of services provided by health care practitioners; and

(IV) expenditures for other covered items and services.

Amounts included in the operating component include amounts that may be used by providers for capital expenditures.

(B) The total revenues required to meet the State health security expenditures.

(2) PROPOSED BUDGET DEADLINE.—The proposed budget for a year shall be submitted under paragraph (1) not later than June 1 before the year.

(3) FINAL BUDGET.—The final budget for a year shall—

(A) be established and submitted under paragraph (1) not later than October 1 before the year, and

(B) take into account the amounts established under the national health security budget under section 1501 for the year.

(4) ADJUSTMENT IN ALLOCATIONS PERMITTED.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), in the case of a final budget, a State may change the allocation of amounts among components.

(B) NOTICE.—No such change may be made unless the State has provided prior notice of the change to the Board.

(C) DENIAL.—Such a change may not be made if the Board, within such time period as the Board specifies, disapproves such change.

(b) EXPENDITURE LIMITS.—

(1) IN GENERAL.—The total expenditures specified in each State health security budget under subsection (a)(1) shall take into account Federal contributions made under section 1504.

(2) LIMIT ON CLAIMS PROCESSING AND BILLING EXPENDITURES.—Each State health security budget shall provide that State administrative expenditures, including expenditures for claims processing and billing, shall not exceed 3 percent of the total expenditures under the State health security program, unless the Board determines, on a case-by-case basis, that additional administrative expenditures would improve health care quality and cost effectiveness.

(3) WORKER ASSISTANCE.—A State health security program may provide that, for budgets for years before 2013, up to 1 percent of the budget may be used for purposes of programs providing assistance to workers who are currently performing functions in the administration of the health insurance system and who may experience economic dislocation as a result of the implementation of the program.

(c) APPROVAL PROCESS FOR CAPITAL EXPENDITURES PERMITTED.—Nothing in this subtitle shall be construed as preventing a State health security program from providing for a process for the approval of capital expenditures based on information derived from regional planning agencies.

SEC. 1504. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Each State with an approved State health security program is entitled to receive, from amounts in the American Health Security Trust Fund, on a monthly basis each year, of an amount equal to one-twelfth of the product of—

(1) the State capitation amount (computed under section 1502(a)(2)) for the State for the year; and

(2) the Federal contribution percentage (established under subsection (b)).

(b) FEDERAL CONTRIBUTION PERCENTAGE.—The Board shall establish a formula for the

establishment of a Federal contribution percentage for each State. Such formula shall take into consideration a State's per capita income and revenue capacity and such other relevant economic indicators as the Board determines to be appropriate. In addition, during the 5-year period beginning with 2010, the Board may provide for a transition adjustment to the formula in order to take into account current expenditures by the State (and local governments thereof) for health services covered under the State health security program. The weighted-average Federal contribution percentage for all States shall equal 86 percent and in no event shall such percentage be less than 81 percent nor more than 91 percent.

(c) USE OF PAYMENTS.—All payments made under this section may only be used to carry out the State health security program.

(d) EFFECT OF SPENDING EXCESS OR SURPLUS.—

(1) SPENDING EXCESS.—If a State exceeds it's budget in a given year, the State shall continue to fund covered health services from its own revenues.

(2) SURPLUS.—If a State provides all covered health services for less than the budgeted amount for a year, it may retain its Federal payment for that year for uses consistent with this title.

SEC. 1505. ACCOUNT FOR HEALTH PROFESSIONAL EDUCATION EXPENDITURES.

(a) SEPARATE ACCOUNT.—Each State health security program shall—

(1) include a separate account for health professional education expenditures; and

(2) specify the general manner, consistent with subsection (b), in which such expenditures are to be distributed among different types of institutions and the different areas of the State.

(b) DISTRIBUTION RULES.—The distribution of funds from the account must take into account the potentially higher costs of placing health professional students in clinical education programs in health professional shortage areas.

PART II—PAYMENTS BY STATES TO PROVIDERS

SEC. 1510. PAYMENTS TO HOSPITALS AND OTHER FACILITY-BASED SERVICES FOR OPERATING EXPENSES ON THE BASIS OF APPROVED GLOBAL BUDGETS.

(a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—Payment for operating expenses for institutional and facility-based care, including hospital services and nursing facility services, under State health security programs shall be made directly to each institution or facility by each State health security program under an annual prospective global budget approved under the program. Such a budget shall include payment for outpatient care and non-facility-based care that is furnished by or through the facility. In the case of a hospital that is wholly owned (or controlled) by a comprehensive health service organization that is paid under section 1513 on the basis of a global budget, the global budget of the organization shall include the budget for the hospital.

(b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

(1) IN GENERAL.—The prospective global budget for an institution or facility shall—

(A) be developed through annual negotiations between—

(i) a panel of individuals who are appointed by the Governor of the State and who represent consumers, labor, business, and the State government; and

(ii) the institution or facility; and

(B) be based on a nationally uniform system of cost accounting established under standards of the Board.

(2) CONSIDERATIONS.—In developing a budget through negotiations, there shall be taken into account at least the following:

(A) With respect to inpatient hospital services, the number, and classification by diagnosis-related group, of discharges.

(B) An institution's or facility's past expenditures.

(C) The extent to which debt service for capital expenditures has been included in the proposed operating budget.

(D) The extent to which capital expenditures are financed directly or indirectly through reductions in direct care to patients, including (but not limited to) reductions in registered nursing staffing patterns or changes in emergency room or primary care services or availability.

(E) Change in the consumer price index and other price indices.

(F) The cost of reasonable compensation to health care practitioners.

(G) The compensation level of the institution's or facility's work force.

(H) The extent to which the institution or facility is providing health care services to meet the needs of residents in the area served by the institution or facility, including the institution's or facility's occupancy level.

(I) The institution's or facility's previous financial and clinical performance, based on utilization and outcomes data provided under this title.

(J) The type of institution or facility, including whether the institution or facility is part of a clinical education program or serves a health professional education, research or other training purpose.

(K) Technological advances or changes.

(L) Costs of the institution or facility associated with meeting Federal and State regulations.

(M) The costs associated with necessary public outreach activities.

(N) In the case of a for-profit facility, a reasonable rate of return on equity capital, independent of those operating expenses necessary to fulfill the objectives of this title.

(O) Incentives to facilities that maintain costs below previous reasonable budgeted levels without reducing the care provided.

(P) With respect to facilities that provide mental health services and substance abuse treatment services, any additional costs involved in the treatment of dually diagnosed individuals.

The portion of such a budget that relates to expenditures for health professional education shall be consistent with the State health security budget for such expenditures.

(3) PROVISION OF REQUIRED INFORMATION; DIAGNOSIS-RELATED GROUP.—No budget for an institution or facility for a year may be approved unless the institution or facility has submitted on a timely basis to the State health security program such information as the program or the Board shall specify, including in the case of hospitals information on discharges classified by diagnosis-related group.

(c) ADJUSTMENTS IN APPROVED BUDGETS.—

(1) ADJUSTMENTS TO GLOBAL BUDGETS THAT CONTRACT WITH COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.—Each State health security program shall develop an administrative mechanism for reducing operating funds to institutions or facilities in proportion to payments made to such institutions or facilities for services contracted for by a comprehensive health service organization.

(2) AMENDMENTS.—In accordance with standards established by the Board, an operating and capital budget approved under this section for a year may be amended before, during, or after the year if there is a substantial change in any of the factors relevant to budget approval.

(d) DONATIONS PERMISSIBLE.—The States health security programs may permit institutions and facilities to raise funds from private sources to pay for newly constructed facilities, major renovations, and equipment. The expenditure of such funds, whether for operating or capital expenditures, does not obligate the State health security program to provide for continued support for such expenditures unless included in an approved global budget.

SEC. 1511. PAYMENTS TO HEALTH CARE PRACTITIONERS BASED ON PROSPECTIVE FEE SCHEDULE.

(a) FEE FOR SERVICE.—

(1) IN GENERAL.—Every independent health care practitioner is entitled to be paid, for the provision of covered health services under the State health security program, a fee for each billable covered service.

(2) GLOBAL FEE PAYMENT METHODOLOGIES.—The Board shall establish models and encourage State health security programs to implement alternative payment methodologies that incorporate global fees for related services (such as all outpatient procedures for treatment of a condition) or for a basic group of services (such as primary care services) furnished to an individual over a period of time, in order to encourage continuity and efficiency in the provision of services. Such methodologies shall be designed to ensure a high quality of care.

(3) BILLING DEADLINES; ELECTRONIC BILLING.—A State health security program may deny payment for any service of an independent health care practitioner for which it did not receive a bill and appropriate supporting documentation (which had been previously specified) within 30 days after the date the service was provided. Such a program may require that bills for services for which payment may be made under this section, or for any class of such services, be submitted electronically.

(b) PAYMENT RATES BASED ON NEGOTIATED PROSPECTIVE FEE SCHEDULES.—With respect to any payment method for a class of services of practitioners, the State health security program shall establish, on a prospective basis, a payment schedule. The State health security program may establish such a schedule after negotiations with organizations representing the practitioners involved. Such fee schedules shall be designed to provide incentives for practitioners to choose primary care medicine, including general internal medicine and pediatrics, over medical specialization. Nothing in this section shall be construed as preventing a State from adjusting the payment schedule amounts on a quarterly or other periodic basis depending on whether expenditures under the schedule will exceed the budgeted amount with respect to such expenditures.

(c) BILLABLE COVERED SERVICE DEFINED.—In this section, the term ''billable covered service'' means a service covered under section 1101 for which a practitioner is entitled to compensation by payment of a fee determined under this section.

SEC. 1512. PAYMENTS TO COMPREHENSIVE HEALTH SERVICE ORGANIZATIONS.

(a) IN GENERAL.—Payment under a State health security program to a comprehensive health service organization to its enrollees shall be determined by the State—

(1) based on a global budget described in section 1510; or

(2) based on the basic capitation amount described in subsection (b) for each of its enrollees.

(b) BASIC CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic capitation amount described in this subsection for an enrollee shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for covered health care services for an enrollee, based on actuarial

characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the organization.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of covered health care services that are not provided by the comprehensive health service organization under section 1203(a).

SEC. 1513. PAYMENTS FOR COMMUNITY-BASED PRIMARY HEALTH SERVICES.

(a) IN GENERAL.—In the case of community-based primary health services, subject to subsection (b), payments under a State health security program shall—

(1) be based on a global budget described in section 1510;

(2) be based on the basic primary care capitation amount described in subsection (c) for each individual enrolled with the provider of such services; or

(3) be made on a fee-for-service basis under section 1511.

(b) PAYMENT ADJUSTMENT.—Payments under subsection (a) may include, consistent with the budgets developed under this title—

(1) an additional amount, as set by the State health security program, to cover the costs incurred by a provider which serves persons not covered by this title whose health care is essential to overall community health and the control of communicable disease, and for whom the cost of such care is otherwise uncompensated;

(2) an additional amount, as set by the State health security program, to cover the reasonable costs incurred by a provider that furnishes case management services (as defined in section 1915(g)(2) of the Social Security Act), transportation services, and translation services; and

(3) an additional amount, as set by the State health security program, to cover the costs incurred by a provider in conducting health professional education programs in connection with the provision of such services.

(c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

(1) IN GENERAL.—The basic primary care capitation amount described in this subsection for an enrollee with a provider of community-based primary health services shall be determined by the State health security program on the basis of the average amount of expenditures that is estimated would be made under the State health security program for such an enrollee, based on actuarial characteristics (as defined by the State health security program).

(2) ADJUSTMENT FOR SPECIAL HEALTH NEEDS.—The State health security program shall adjust such average amounts to take into account the special health needs, including a disproportionate number of medically underserved individuals, of populations served by the provider.

(3) ADJUSTMENT FOR SERVICES NOT PROVIDED.—The State health security program shall adjust such average amounts to take into account the cost of community-based primary health services that are not provided by the provider.

(d) COMMUNITY-BASED PRIMARY HEALTH SERVICES DEFINED.—In this section, the term ''community-based primary health services'' has the meaning given such term in section 1102(a).

SEC. 1514. PAYMENTS FOR PRESCRIPTION DRUGS.

(a) ESTABLISHMENT OF LIST.—

(1) IN GENERAL.—The Board shall establish a list of approved prescription drugs and biologicals that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this title.

(2) EXCLUSIONS.—The Board may exclude reimbursement under this title for ineffective, unsafe, or over-priced products where better alternatives are determined to be available.

(b) PRICES.—For each such listed prescription drug or biological covered under this title, for insulin, and for medical foods, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this title as the cost of a drug to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with product manufacturers and distributors in determining the applicable product price or prices.

(c) CHARGES BY INDEPENDENT PHARMACIES.—Each State health security program shall provide for payment for a prescription drug or biological or insulin furnished by an independent pharmacy based on the drug's cost to the pharmacy (not in excess of the applicable product price established under subsection (b)) plus a dispensing fee. In accordance with standards established by the Board, each State health security program, after consultation with representatives of the pharmaceutical profession, shall establish schedules of dispensing fees, designed to afford reasonable compensation to independent pharmacies after taking into account variations in their cost of operation resulting from regional differences, differences in the volume of prescription drugs dispensed, differences in services provided, the need to maintain expenditures within the budgets established under this title, and other relevant factors.

SEC. 1515. PAYMENTS FOR APPROVED DEVICES AND EQUIPMENT.

(a) ESTABLISHMENT OF LIST.—The Board shall establish a list of approved durable medical equipment and therapeutic devices and equipment (including eyeglasses, hearing aids, and prosthetic appliances), that the Board determines are necessary for the maintenance or restoration of health or of employability or self-management and eligible for coverage under this title.

(b) CONSIDERATIONS AND CONDITIONS.—In establishing the list under subsection (a), the Board shall take into consideration the efficacy, safety, and cost of each item contained on such list, and shall attach to any item such conditions as the Board determines appropriate with respect to the circumstances under which, or the frequency with which, the item may be prescribed.

(c) PRICES.—For each such listed item covered under this title, the Board shall from time to time determine a product price or prices which shall constitute the maximum to be recognized under this title as the cost of the item to a provider thereof. The Board may conduct negotiations, on behalf of State health security programs, with equipment and device manufacturers and distributors in determining the applicable product price or prices.

(d) EXCLUSIONS.—The Board may exclude from coverage under this title ineffective, unsafe, or overpriced products where better alternatives are determined to be available.

SEC. 1516. PAYMENTS FOR OTHER ITEMS AND SERVICES.

In the case of payment for other covered health services, the amount of payment under a State health security program shall be established by the program—

(1) in accordance with payment methodologies which are specified by the Board, after consultation with the American Health Security Advisory Council, or methodologies established by the State under section 1519; and

(2) consistent with the State health security budget.

SEC. 1517. PAYMENT INCENTIVES FOR MEDICALLY UNDERSERVED AREAS.

(a) MODEL PAYMENT METHODOLOGIES.—In addition to the payment amounts otherwise provided in this title, the Board shall establish model payment methodologies and other incentives that promote the provision of covered health care services in medically underserved areas, particularly in rural and inner-city underserved areas.

(b) CONSTRUCTION.—Nothing in this subtitle shall be construed as limiting the authority of State health security programs to increase payment amounts or otherwise provide additional incentives, consistent with the State health security budget, to encourage the provision of medically necessary and appropriate services in underserved areas.

SEC. 1518. AUTHORITY FOR ALTERNATIVE PAYMENT METHODOLOGIES.

A State health security program, as part of its plan under section 1304(a), may use a payment methodology other than a methodology required under this part so long as—

(1) such payment methodology does not affect the entitlement of individuals to coverage, the weighting of fee schedules to encourage an increase in the number of primary care providers, the ability of individuals to choose among qualified providers, the benefits covered under the program, or the compliance of the program with the State health security budget under part I; and

(2) the program submits periodic reports to the Board showing the operation and effectiveness of the alternative methodology, in order for the Board to evaluate the appropriateness of applying the alternative methodology to other States.

PART III—MANDATORY ASSIGNMENT AND ADMINISTRATIVE PROVISIONS

SEC. 1520. MANDATORY ASSIGNMENT.

(a) NO BALANCE BILLING.—Payments for benefits under this title shall constitute payment in full for such benefits and the entity furnishing an item or service for which payment is made under this title shall accept such payment as payment in full for the item or service and may not accept any payment or impose any charge for any such item or service other than accepting payment from the State health security program in accordance with this title.

(b) ENFORCEMENT.—If an entity knowingly and willfully bills for an item or service or accepts payment in violation of subsection (a), the Board may apply sanctions against the entity in the same manner as sanctions could have been imposed under section 1842(j)(2) of the Social Security Act for a violation of section 1842(j)(1) of such Act. Such sanctions are in addition to any sanctions that a State may impose under its State health security program.

SEC. 1521. PROCEDURES FOR REIMBURSEMENT; APPEALS.

(a) PROCEDURES FOR REIMBURSEMENT.—In accordance with standards issued by the Board, a State health security program shall establish a timely and administratively simple procedure to assure payment within 60 days of the date of submission of clean claims by providers under this title.

(b) APPEALS PROCESS.—Each State health security program shall establish an appeals process to handle all grievances pertaining to payment to providers under this title.

Subtitle G—Financing Provisions; American Health Security Trust Fund

SEC. 1530. AMENDMENT OF 1986 CODE; SECTION 15 NOT TO APPLY.

(a) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(b) SECTION 15 NOT TO APPLY.—The amendments made by part II shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

PART I—AMERICAN HEALTH SECURITY TRUST FUND

SEC. 1531. AMERICAN HEALTH SECURITY TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the American Health Security Trust Fund (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this title.

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 2011), out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the aggregate increase in tax liabilities under the Internal Revenue Code of 1986 which is attributable to the application of the amendments made by this subtitle. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—Notwithstanding any other provision of law, there are hereby appropriated to the Trust Fund for each fiscal year (beginning with fiscal year 2011) the amounts that would otherwise have been appropriated to carry out the following programs:

(A) The medicare program, under parts A, B, and D of title XVIII of the Social Security Act (other than amounts attributable to any premiums under such parts).

(B) The medicaid program, under State plans approved under title XIX of such Act.

(C) The Federal employees health benefit program, under chapter 89 of title 5, United States Code.

(D) The TRICARE program (formerly known as the CHAMPUS program), under chapter 55 of title 10, United States Code.

(E) The maternal and child health program (under title V of the Social Security Act), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Board, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health services the payment of which may be made under this title.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act shall apply to the Trust Fund under this title in the same manner as they applied to the Federal Hospital Insurance Trust Fund under part A of title XVIII of such Act, except that the American Health Security Standards Board shall constitute the Board of Trustees of the Trust Fund.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund after the settlement of claims for payments under title XVIII have been completed, shall be transferred into the American Health Security Trust Fund.

PART II—TAXES BASED ON INCOME AND WAGES

SEC. 1535. PAYROLL TAX ON EMPLOYERS.

(a) IN GENERAL.—Section 3111 (relating to tax on employers) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

''(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 8.7 percent of the wages (as defined in section 3121(a)) paid by him with respect to employment (as defined in section 3121(b)).''.

(b) SELF-EMPLOYMENT INCOME.—section 1401 (relating to rate of tax on self-employment income) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new subsection:

''(c) HEALTH CARE.—In addition to other taxes, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 8.7 percent of the amount of the self-employment income for such taxable year.''.

(c) COMPARABLE TAXES FOR RAILROAD SERVICES.—

(1) TAX ON EMPLOYERS.—Section 3221 is amended by redesignating subsection (c) as subsections (d) and inserting after subsection (b) the following new subsection:

''(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 8.7 percent of the compensation paid by such employer for services rendered to such employer.''.

(2) TAX ON EMPLOYEE REPRESENTATIVES.—Section 3211 (relating to tax on employee representatives) is amended by redesignating subsection (c) as subsection (d) and inserting after subsection (b) the following new paragraph:

''(c) HEALTH CARE.—In addition to other taxes, there is hereby imposed on the income of each employee representative a tax equal to 8.7 percent of the compensation received during the calendar year by such employee representative for services rendered by such employee representative.''.

(3) NO APPLICABLE BASE.—Subparagraph (A) of section 3231(e)(2) is amended by adding at the end thereof the following new clause:

''(iv) HEALTH CARE TAXES.—Clause (i) shall not apply to the taxes imposed by sections 3221(c) and 3211(c).''.

(4) TECHNICAL AMENDMENT.—

(A) Subsection (d) of section 3211, as redesignated by paragraph (2), is amended by striking ''and (b)'' and inserting '', (b), and (c)''.

(B) Subsection (d) of section 3221, as redesignated by paragraph (1), is amended by striking ''and (b)'' and inserting '', (b), and (c)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to remuneration paid after December 31, 2010.

SEC. 1536. HEALTH CARE INCOME TAX.

(a) GENERAL RULE.—Subchapter A of chapter 1 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

''PART VIII—HEALTH CARE INCOME TAX ON INDIVIDUALS

''Sec. 59B. Health care income tax.

''SEC. 59B. HEALTH CARE INCOME TAX.

''(a) IMPOSITION OF TAX.—In the case of an individual, there is hereby imposed a tax (in addition to any other tax imposed by this subtitle) equal to 2.2 percent of the taxable income of the taxpayer for the taxable year.

''(b) NO CREDITS AGAINST TAX; NO EFFECT ON MINIMUM TAX.—The tax imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

''(1) the amount of any credit allowable under this chapter, or

''(2) the amount of the minimum tax imposed by section 55.

''(c) SPECIAL RULES.—

''(1) TAX TO BE WITHHELD, ETC.—For purposes of this title, the tax imposed by this section shall be treated as imposed by section 1.

''(2) REIMBURSEMENT OF TAX BY EMPLOYER NOT INCLUDIBLE IN GROSS INCOME.—The gross income of an employee shall not include any payment by his employer to reimburse the employee for the tax paid by the employee under this section.

''(3) OTHER RULES.—The rules of section 59A(d) shall apply to the tax imposed by this section.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 is amended by adding at the end the following new item:

''PART VIII—HEALTH CARE INCOME TAX ON INDIVIDUALS''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

Subtitle H—Conforming Amendments to the Employee Retirement Income Security Act of 1974

SEC. 1601. ERISA INAPPLICABLE TO HEALTH COVERAGE ARRANGEMENTS UNDER STATE HEALTH SECURITY PROGRAMS.

Section 4 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003) is amended—

(1) in subsection (a), by striking ''(b) or (c)'' and inserting ''(b), (c), or (d)''; and

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

''(d) The provisions of this title shall not apply to any arrangement forming a part of a State health security program established pursuant to section 1001(b) of the American Health Security Act of 2009.''.

SEC. 1602. EXEMPTION OF STATE HEALTH SECURITY PROGRAMS FROM ERISA PREEMPTION.

Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)) (as amended by sections 174(b)(3)(B) and 182(b) of this title) is amended by adding at the end the following new paragraph:

''(8) Subsection (a) of this section shall not apply to State health security programs established pursuant to section 1001(b) of the American Health Security Act of 2009.''.

SEC. 1603. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF BENEFITS UNDER STATE HEALTH SECURITY PROGRAMS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF STATE HEALTH SECURITY PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION

''SEC. 519. (a) Subject to subsection (b), no employee benefit plan may provide benefits

which duplicate payment for any items or services for which payment may be made under a State health security program established pursuant to section 1001(b) of the American Health Security Act of 2009.

''(b)(1) Each workers compensation carrier that is liable for payment for workers compensation services furnished in a State shall reimburse the State health security plan for the State in which the services are furnished for the cost of such services.

''(2) In this subsection:

''(A) The term 'workers compensation carrier' means an insurance company that underwrites workers compensation medical benefits with respect to 1 or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits.

''(B) The term 'workers compensation medical benefits' means, with respect to an enrollee who is an employee subject to the workers compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee.

''(C) The term 'workers compensation services' means items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term-care services) commonly used for treatment of work-related injuries and illnesses.''.

(b) CONFORMING AMENDMENT.—Section 4(b) of such Act (29 U.S.C. 1003(b)) is amended by adding at the end the following: ''Paragraph (3) shall apply subject to section 519(b) (relating to reimbursement of State health security plans by workers compensation carriers).''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 518 the following new items:

''Sec. 519. Prohibition of employee benefits duplicative of state health security program benefits; coordination in case of workers' compensation.''.

SEC. 1604. REPEAL OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 502(a) of such Act (29 U.S.C. 1132(a)) is amended—

(A) by striking paragraph (7); and

(B) by redesignating paragraphs (8), (9), and (10) as paragraphs (7), (8), and (9), respectively.

(2) Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by striking ''paragraph (1) or (4) of section 606,''.

(3) Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended—

(A) in paragraph (7), by striking ''section 206(d)(3)(B)(i)),'' and all that follows and inserting ''section 206(d)(3)(B)(i)).''; and

(B) by striking paragraph (8).

(4) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by striking the items relating to part 6 of subtitle B of title I of such Act.

SEC. 1605. EFFECTIVE DATE OF SUBTITLE.

The amendments made by this subtitle shall take effect January 1, 2012.

Subtitle I—Additional Conforming Amendments

SEC. 1701. REPEAL OF CERTAIN PROVISIONS IN INTERNAL REVENUE CODE OF 1986.

The provisions of titles III and IV of the Health Insurance Portability and Accountability Act of 1996, other than subtitles D and H of title III and section 342, are repealed and the provisions of law that were amended or repealed by such provisions are hereby restored as if such provisions had not been enacted.

SEC. 1702. REPEAL OF CERTAIN PROVISIONS IN THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is repealed and the items relating to such part in the table of contents in section 1 of such Act are repealed.

(b) CONFORMING AMENDMENT.—Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended by striking paragraph (9).

SEC. 1703. REPEAL OF CERTAIN PROVISIONS IN THE PUBLIC HEALTH SERVICE ACT AND RELATED PROVISIONS.

(a) IN GENERAL.—Titles XXII and XXVII of the Public Health Service Act are repealed.

(b) ADDITIONAL AMENDMENTS.—

(1) Section 1301(b) of such Act (42 U.S.C. 300e(b)) is amended by striking paragraph (6).

(2) Sections 104 and 191 of the Health Insurance Portability and Accountability Act of 1996 are repealed.

SEC. 1704. EFFECTIVE DATE OF SUBTITLE.

The amendments made by this title shall take effect January 1, 2013.

TITLE II—HEALTH CARE QUALITY IMPROVEMENTS

SEC. 2001. HEALTH CARE DELIVERY SYSTEM RESEARCH; QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Title IX of the 5 Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 931 through 938 as sections 941 through 948, respectively;

(3) in section 948(1), as so redesignated, by striking '' '931' '' and inserting '' '941' ''; and

(4) by inserting after section 926 the following:

"PART D—HEALTH CARE QUALITY IMPROVEMENT PROGRAMS

"SEC. 931. HEALTH CARE DELIVERY SYSTEM RESEARCH.

''(a) PURPOSE.—The purposes of this section are to—

''(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as 'best practices') in health care quality, safety, and value; and

''(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

''(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), or any other relevant agency or department designated by the Director, shall—

''(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;

''(2) conduct or support activities consistent with the purposes described in subsection (a), and for—

''(A) best practices for quality improvement practices in the delivery of health care services; and

''(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;

''(3) identify health care providers, including health care systems, single institutions, and individual providers, that—

''(A) deliver consistently high-quality, efficient health care services (as determined by the Secretary); and

''(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

''(4) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

''(5) find ways to translate such information rapidly and effectively into practice, and document the sustainability of those improvements;

''(6) create strategies for quality improvement through the development of tools, methodologies, and interventions that can successfully reduce variations in the delivery of health care;

''(7) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and system design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

''(8) provide for the development of best practices in the delivery of health care services that—

''(A) have a high likelihood of success, based on structured review of empirical evidence;

''(B) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings;

''(C) are designed to be readily adapted by health care providers in a variety of settings; and

''(D) where applicable, assist health care providers in working with other health care providers across the continuum of care and in engaging patients and their families in improving the care and patient health outcomes;

''(9) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children's health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

''(10) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to carry out the activities under paragraphs (1) through (9).

''(c) RESEARCH FUNCTIONS OF CENTER.—

''(1) IN GENERAL.—The Center shall support, such as through a contract or other mechanism, research on health care delivery system improvement and the development of tools to facilitate adoption of best practices

that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

''(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

''(A) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

''(B) reduce preventable morbidity, mortality, and associated costs of morbidity and mortality by building capacity for patient safety research;

''(C) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

''(D) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

''(i) the implementation of a national application of Intensive Care Unit improvement projects relating to the adult (including geriatric), pediatric, and neonatal patient populations;

''(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Entercoccus infections and other emerging infections; and

''(iii) practical methods for reducing preventable hospital admissions and readmissions;

''(E) expand demonstration projects for improving the quality of children's health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

''(F) identify and mitigate hazards by—

''(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

''(ii) using the results of such analyses to develop scientific methods of response to such events;

''(G) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

''(H) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

''(d) DISSEMINATION OF RESEARCH FINDINGS.—

''(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

''(2) LINKAGE TO HEALTH INFORMATION TECHNOLOGY.—The Secretary shall ensure that research findings and results generated by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the health information technology extension program under section 3012, as well as any relevant standards, certification criteria, or implementation specifications.

''(e) PRIORITIZATION.—The Director shall identify and regularly update a list of processes or systems on which to focus research and dissemination activities of the Center, taking into account—

''(1) the cost to Federal health programs;

''(2) consumer assessment of health care experience;

''(3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

''(4) the potential impact of such processes or systems on health status and function of patients, including vulnerable populations including children;

''(5) the areas of insufficient evidence identified under subsection (c)(2)(B); and

''(6) the evolution of meaningful use of health information technology, as defined in section 3000.

''(f) FUNDING.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal years 2010 through 2014.

''SEC. 932. QUALITY IMPROVEMENT TECHNICAL ASSISTANCE AND IMPLEMENTATION.

''(a) IN GENERAL.—The Director, through the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), shall award—

''(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for which there are disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

''(2) implementation grants or contracts to eligible entities to implement the models and practices described under paragraph (1).

''(b) ELIGIBLE ENTITIES.—

''(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

''(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, primary care extension program established under section 399W, a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and

''(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

''(2) IMPLEMENTATION AWARD.—To be eligible to receive an implementation grant or contract under subsection (a)(2), an entity—

''(A) may be a hospital or other health care provider or consortium or providers, as determined by the Secretary; and

''(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

''(c) APPLICATION.—

''(1) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

''(A) a plan for a sustainable business model that may include a system of—

''(i) charging fees to institutions and providers that receive technical support from the entity; and

''(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations; and

''(B) such other information as the Director may require.

''(2) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

''(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

''(i) financial cost, staffing requirements, and timeline for implementation; and

''(ii) pre- and projected post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

''(B) such other information as the Director may require.

''(d) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(e) EVALUATION.—

''(1) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

''(A) the success of such entity in achieving the implementation, by the health care institutions and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 931;

''(B) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

''(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by such entity.

''(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.

''(f) COORDINATION.—The entities that receive a grant or contract under this section shall coordinate with health information technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement, system delivery reform, and best practices information.''.

SEC. 2002. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a program to provide grants to or enter into contracts with eligible entities to establish

community-based interdisciplinary, interprofessional teams (referred to in this section as ''health teams'') to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants;

(5) agree to provide services to eligible individuals with chronic conditions in accordance with the payment methodology established under subsection (c) of such section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS FOR HEALTH TEAMS.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs; and

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDERS.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) REPORTING TO SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) DEFINITION OF PRIMARY CARE.—In this section, the term ''primary care'' means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 2003. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 2001, is further amended by inserting after section 932 the following:

''SEC. 933. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

''(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center established in section 931 (referred to in this section as the 'Center'), shall establish a program to provide grants or contracts to eligible entities to implement medication management (referred to in this section as 'MTM') services provided by licensed pharmacists, as a collaborative, multidisciplinary, inter-professional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases. The Secretary shall commence the program under this section not later than May 1, 2010.

''(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

''(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e);

''(2) submit to the Secretary a plan for achieving long-term financial sustainability;

''(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3502 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W;

''(4) submit a plan for meeting the requirements under subsection (c); and

''(5) submit to the Secretary such other information as the Secretary may require.

''(c) MTM SERVICES TO TARGETED INDIVIDUALS.—The MTM services provided with the assistance of a grant or contract awarded under subsection (a) shall, as allowed by State law including applicable collaborative pharmacy practice agreements, include—

''(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

''(2) formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient;

''(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

''(4) monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

''(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and additional followup interventions on a schedule developed collaboratively with the prescriber;

''(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

''(7) providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

''(8) providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens;

''(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

''(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

''(d) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant or contract awarded under subsection (a) shall be offered to targeted individuals who—

''(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements);

''(2) take any 'high risk' medications;

''(3) have 2 or more chronic diseases, as identified by the Secretary; or

''(4) have undergone a transition of care, or other factors, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

''(e) CONSULTATION WITH EXPERTS.—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, public-private, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with this group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

''(f) REPORTING TO THE SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures endorsed by the entity with a contract under section 1890 of the Social Security Act, as determined by the Secretary.

''(g) EVALUATION AND REPORT.—The Secretary shall submit to the relevant committees of Congress a report which shall—

''(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintained better health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program;

''(2) assess changes in overall health care resource use by targeted individuals;

''(3) assess patient and prescriber satisfaction with MTM services;

''(4) assess the impact of patient-cost sharing requirements on medication adherence and recommendations for modifications;

''(5) identify and evaluate other factors that may impact clinical and economic outcomes, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

''(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

''(h) GRANTS OR CONTRACTS TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary may award grants or contracts to eligible entities for the purpose of funding the development of performance measures that assess the use and effectiveness of medication therapy management services.''.

SEC. 2004. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

(A) in the section heading, by inserting ''**FOR TRAUMA SYSTEMS**'' after ''**GRANTS**''; and

(B) in subsection (a), by striking ''Administrator of the Health Resources and Services Administration'' and inserting ''Assistant Secretary for Preparedness and Response'';

(2) by inserting after section 1203 the following:

''SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSE.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

''(b) ELIGIBLE ENTITY; REGION.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means—

''(A) a State or a partnership of 1 or more States and 1 or more local governments; or

''(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

''(2) REGION.—The term 'region' means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

''(3) EMERGENCY SERVICES.—The term 'emergency services' includes acute, prehospital, and trauma care.

''(c) PILOT PROJECTS.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a pilot project to design, implement, and evaluate an emergency medical and trauma system that—

''(1) coordinates with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;

''(2) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion;

''(3) allows for the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

''(4) includes a consistent region-wide prehospital, hospital, and interfacility data management system that—

''(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;

''(B) reports data to appropriate Federal and State databanks and registries; and

''(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

''(d) APPLICATION.—

''(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

''(2) APPLICATION INFORMATION.—Each application shall include—

''(A) an assurance from the eligible entity that the proposed system—

''(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office);

''(ii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

''(iii) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

''(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

''(v) includes a regional medical direction, patient tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the national and State emergency preparedness system; and

''(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children and adolescents; and

''(B) such other information as the Secretary may require.

''(e) REQUIREMENT OF MATCHING FUNDS.—

''(1) IN GENERAL.—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant was made, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

''(2) NON-FEDERAL CONTRIBUTIONS.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

''(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 330(b)(3)).

''(g) REPORT.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or

grant described in shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

''(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

''(2) the system characteristics that contribute to the effectiveness and efficiency of the program (or lack thereof);

''(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

''(4) the State and local legislation necessary to implement and to maintain the system;

''(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

''(6) recommendations on the utilization of available funding for future regionalization efforts.

''(h) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).''; and

(3) in section 1232—

(A) in subsection (a), by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated $24,000,000 for each of fiscal years 2010 through 2014.''; and

(B) by inserting after subsection (c) the following:

''(d) AUTHORITY.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts from the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.''.

(b) SUPPORT FOR EMERGENCY MEDICINE RESEARCH.—Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by inserting after the section 498C the following:

''SEC. 498D. SUPPORT FOR EMERGENCY MEDICINE RESEARCH.

''(a) EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine, including—

''(1) the basic science of emergency medicine;

''(2) the model of service delivery and the components of such models that contribute to enhanced patient health outcomes;

''(3) the translation of basic scientific research into improved practice; and

''(4) the development of timely and efficient delivery of health services.

''(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including—

''(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

''(2) the role of pediatric emergency services as an integrated component of the overall health system;

''(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

''(4) pediatric training in professional education; and

''(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

''(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimated economic impact of, and savings that result from, the implementation of coordinated emergency care systems.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 2005. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

Part D of title IX of the Public Health Service Act, as amended by section 2003, is further amended by adding at the end the following:

''SEC. 934. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

''(a) PURPOSE.—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engages the patient, caregiver or authorized representative in decisionmaking, provides patients, caregivers or authorized representatives with information about trade-offs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

''(b) DEFINITIONS.—In this section:

''(1) PATIENT DECISION AID.—The term 'patient decision aid' means an educational tool that helps patients, caregivers or authorized representatives 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.

''(2) 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, caregivers or authorized representatives regarding the benefits, harms and scientific evidence for each treatment option, the use of such care should depend on the informed patient choice among clinically appropriate treatment options.

''(c) ESTABLISHMENT OF INDEPENDENT STANDARDS FOR PATIENT DECISION AIDS FOR PREFERENCE SENSITIVE CARE.—

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

''(A) IN GENERAL.—For purposes of supporting consensus-based standards for patient decision aids for preference sensitive care and a certification process for patient decision aids for use in the Federal health programs and by other interested parties, the Secretary shall have in effect a contract with the entity with a contract under section 1890 of the Social Security Act. 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 section, 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).

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

''(A) DEVELOP AND IDENTIFY STANDARDS FOR PATIENT DECISION AIDS.—The entity shall synthesize evidence and convene a broad range of experts and key stakeholders to develop and identify consensus-based standards to evaluate patient decision aids for preference sensitive care.

''(B) ENDORSE PATIENT DECISION AIDS.—The entity shall review patient decision aids and develop a certification process whether patient decision aids meet the standards developed and identified under subparagraph (A). The entity shall give priority to the review and certification of patient decision aids for preference sensitive care.

''(d) PROGRAM TO DEVELOP, UPDATE AND PATIENT DECISION AIDS TO ASSIST HEALTH CARE PROVIDERS AND PATIENTS.—

''(1) IN GENERAL.—The Secretary, acting through the Director, and in coordination with heads of other relevant agencies, such as the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall establish a program to award grants or contracts—

''(A) to develop, update, and produce patient decision aids for preference sensitive care to assist health care providers in educating patients, caregivers, and authorized representatives concerning the relative safety, relative effectiveness (including possible health outcomes and impact on functional status), and relative cost of treatment or, where appropriate, palliative care options;

''(B) to test such materials to ensure such materials are balanced and evidence based in aiding health care providers and patients, caregivers, and authorized representatives to make informed decisions about patient care and can be easily incorporated into a broad array of practice settings; and

''(C) to educate providers on the use of such materials, including through academic curricula.

''(2) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1)—

''(A) shall be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers;

''(B) shall present up-to-date clinical evidence about the risks and benefits of treatment options in a form and manner that is age-appropriate and can be adapted for patients, caregivers, and authorized representatives from a variety of cultural and educational backgrounds to reflect the varying needs of consumers and diverse levels of health literacy;

''(C) shall, where appropriate, explain why there is a lack of evidence to support one treatment option over another; and

''(D) shall address health care decisions across the age span, including those affecting vulnerable populations including children.

''(3) DISTRIBUTION.—The Director shall ensure that patient decision aids produced with grants or contracts under this section are available to the public.

''(4) NONDUPLICATION OF EFFORTS.—The Director shall ensure that the activities under

this section of the Agency and other agencies, including the Centers for Disease Control and Prevention and the National Institutes of Health, are free of unnecessary duplication of effort.

''(e) GRANTS TO SUPPORT SHARED DECISIONMAKING IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decisionmaking using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options.

''(2) SHARED DECISIONMAKING RESOURCE CENTERS.—

''(A) IN GENERAL.—The Secretary shall provide grants for the establishment and support of Shared Decisionmaking Resource Centers (referred to in this subsection as 'Centers') to provide technical assistance to 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 decisionmaking by providers.

''(B) OBJECTIVES.—The objective of a Center is to enhance and promote the adoption of patient decision aids and shared decisionmaking through—

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

''(ii) the dissemination of best practices and research on the implementation and effective use of patient decision aids.

''(3) SHARED DECISIONMAKING PARTICIPATION GRANTS.—

''(A) IN GENERAL.—The Secretary shall provide grants to health care providers for the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

''(B) PREFERENCE.—In order to facilitate the use of best practices, the Secretary shall provide a preference in making grants under this subsection to health care providers who participate in training by Shared Decisionmaking Resource Centers or comparable training.

''(C) LIMITATION.—Funds under this paragraph shall not be used to purchase or implement use of patient decision aids other than those certified under the process identified in subsection (c).

''(4) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this subsection on the use of patient decision aids.

''(f) FUNDING.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.''.

SEC. 2006. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Commissioner of Food and Drugs, shall determine whether the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking 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 research on decisionmaking and social and cognitive psychology and consult with drug manufacturers, clinicians, patients and consumers, experts in health literacy, representatives of racial and ethnic minorities, and experts in women's and pediatric health.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to 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.—If the Secretary determines under subsection (a) that the addition of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decisionmaking by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) CLARIFICATION.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 2007. DEMONSTRATION PROGRAM TO INTEGRATE QUALITY IMPROVEMENT AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

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

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program; or

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $5 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make publicly available, and disseminate the results of such evaluations on as wide a basis as is practicable.

(e) REPORTS.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 2008. IMPROVING WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

''SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.

''(a) ESTABLISHMENT OF OFFICE.—There is established within the Office of the Secretary, an Office on Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

''(b) DUTIES.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

''(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, and public and health care professional education, for issues of particular concern to women throughout their lifespan;

''(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

''(3) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

''(4) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

''(5) establish a National Women's Health Information Center to—

''(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

''(B) facilitate access to such information;

''(C) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

''(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

''(6) coordinate efforts to promote women's health programs and policies with the private sector; and

''(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under subsection (c), and between the Office and health professionals and the general public.

''(c) GRANTS AND CONTRACTS REGARDING DUTIES.—

''(1) AUTHORITY.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, contracts, and interagency agreements with, public and private entities, agencies, and organizations.

''(2) EVALUATION AND DISSEMINATION.—The Secretary shall directly or through contracts with public and private entities, agencies, and organizations, provide for evaluations of projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

''(d) REPORTS.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(2) TRANSFER OF FUNCTIONS.—There are transferred to the Office on Women's Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women's Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.—Part A of title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

''SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVENTION OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director of the Centers for Disease Control and Prevention, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of such Centers.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers' activity regarding women's health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers' work, including prevention programs, public and professional education, services, and treatment;

''(2) establish short-range and long-range goals and objectives within the Centers for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to prevention, research, education and training, service delivery, and policy development, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Centers;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).

''(c) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of all age, ethnic, and racial groups, means diseases, disorders, and conditions—

''(1) unique to, significantly more serious for, or significantly more prevalent in women; and

''(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) of the Public Health Service Act (42 U.S.C. 287d(a)) is amended by inserting ''and who shall report directly to the Director'' before the period at the end thereof.

(d) SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION.—Section 501(f) of the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting ''who shall report directly to the Administrator'' before the period;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3), the following:

''(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women's Health.''.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C of title IX of the Public Health Service Act (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 925 and 926 as sections 926 and 927, respectively; and

(2) by inserting after section 924 the following:

''SEC. 925. ACTIVITIES REGARDING WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Director of Healthcare and Research Quality.

''(b) PURPOSE.—The official designated under subsection (a) shall—

''(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice protocols and the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

''(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the Agency;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Agency policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4)).''.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(f) HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Title VII of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the following:

''SEC. 713. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women's Health. The Office shall be headed by a director who shall be appointed by the Administrator.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Administrator on the current Administration level of activity regarding women's health across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

''(3) identify projects in women's health that should be conducted or supported by the bureaus of the Administration;

''(4) consult with health professionals, nongovernmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

''(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) CONTINUED ADMINISTRATION OF EXISTING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women's health on the date of enactment of this section.

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

''(1) ADMINISTRATION.—The term 'Administration' means the Health Resources and Services Administration.

''(2) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Health Resources and Services Administration.

''(3) OFFICE.—The term 'Office' means the Office of Women's Health established under this section in the Administration.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(g) FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN'S HEALTH.—Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

''SEC. 1011. OFFICE OF WOMEN'S HEALTH.

''(a) ESTABLISHMENT.—There is established within the Office of the Commissioner, an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

''(b) PURPOSE.—The Director of the Office shall—

''(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the 'Administration') levels of activity regarding women's participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across, where appropriate, age, biological, and sociocultural contexts;

''(2) establish short-range and long-range goals and objectives within the Administration for issues of particular concern to women's health within the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

''(3) provide information to women and health care providers on those areas in which differences between men and women exist;

''(4) consult with pharmaceutical, biologics, and device manufacturers, health professionals with expertise in women's issues, consumer organizations, and women's health professionals on Administration policy with regard to women;

''(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

''(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(4) of the Public Health Service Act).

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

(h) NO NEW REGULATORY AUTHORITY.—Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women's health (including the Office of Research on Women's Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women's health issues (including the Associate Administrator for Women's Services under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of this section shall not be terminated, reorganized, or have any of it's powers or duties transferred unless such termination, reorganization, or transfer is approved by Congress through the adoption of a concurrent resolution of approval.

(j) RULE OF CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed to limit the authority of the Secretary of Health and Human Services with respect to women's health, or with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 2009. PATIENT NAVIGATOR PROGRAM.

Section 340A of the Public Health Service Act (42 U.S.C. 256a) is amended—

(1) by striking subsection (d)(3) and inserting the following:

''(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.'';

(2) in subsection (e), by adding at the end the following:

''(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main focus or intervention of the navigator involved.''; and

(3) in subsection (m)—

(A) in paragraph (1), by striking ''and $3,500,000 for fiscal year 2010.'' and inserting ''$3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''; and

(B) in paragraph (2), by striking ''2010'' and inserting ''2015''.

SEC. 2010. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this title (or an amendment made by this title), there is authorized to be appropriated such sums as may be necessary to carry out this title (and such amendments made by this title).

TITLE III—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 3001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.

(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the ''National Prevention, Health Promotion and Public Health Council'' (referred to in this section as the ''Council'').

(b) CHAIRPERSON.—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) COMPOSITION.—The Council shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Agriculture;

(3) the Secretary of Education;

(4) the Chairman of the Federal Trade Commission;

(5) the Secretary of Transportation;

(6) the Secretary of Labor;

(7) the Secretary of Homeland Security;

(8) the Administrator of the Environmental Protection Agency;

(9) the Director of the Office of National Drug Control Policy;

(10) the Director of the Domestic Policy Council;

(11) the Assistant Secretary for Indian Affairs;

(12) the Chairman of the Corporation for National and Community Service; and

(13) the head of any other Federal agency that the chairperson determines is appropriate.

(d) PURPOSES AND DUTIES.—The Council shall—

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care in the United States;

(2) after obtaining input from relevant stakeholders, develop a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;

(3) provide recommendations to the President and Congress concerning the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion, and public health goals, including the reduction of tobacco use, sedentary behavior, and poor nutrition;

(4) consider and propose evidence-based models, policies, and innovative approaches for the promotion of transformative models of prevention, integrative health, and public health on individual and community levels across the United States;

(5) establish processes for continual public input, including input from State, regional, and local leadership communities and other relevant stakeholders, including Indian tribes and tribal organizations;

(6) submit the reports required under subsection (g); and

(7) carry out other activities determined appropriate by the President.

(e) MEETINGS.—The Council shall meet at the call of the Chairperson.

(f) ADVISORY GROUP.—

(1) IN GENERAL.—The President shall establish an Advisory Group to the Council to be known as the ''Advisory Group on Prevention, Health Promotion, and Integrative and Public Health'' (hereafter referred to in this section as the ''Advisory Group''). The Advisory Group shall be within the Department of Health and Human Services and report to the Surgeon General.

(2) COMPOSITION.—

(A) IN GENERAL.—The Advisory Group shall be composed of not more than 25 non-Federal members to be appointed by the President.

(B) REPRESENTATION.—In appointing members under subparagraph (A), the President shall ensure that the Advisory Group includes a diverse group of licensed health professionals, including integrative health practitioners who have expertise in—

(i) worksite health promotion;

(ii) community services, including community health centers;

(iii) preventive medicine;

(iv) health coaching;

(v) public health education;

(vi) geriatrics; and

(vii) rehabilitation medicine.

(3) PURPOSES AND DUTIES.—The Advisory Group shall develop policy and program recommendations and advise the Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.

(g) NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY.—Not later than 1 year after the date of enactment of this Act, the Chairperson, in consultation with the Council, shall develop and make public a national prevention, health promotion and public health strategy, and shall review and revise such strategy periodically. Such strategy shall—

(1) set specific goals and objectives for improving the health of the United States through federally-supported prevention, health promotion, and public health programs, consistent with ongoing goal setting efforts conducted by specific agencies;

(2) establish specific and measurable actions and timelines to carry out the strategy, and determine accountability for meeting those timelines, within and across Federal departments and agencies; and

(3) make recommendations to improve Federal efforts relating to prevention, health promotion, public health, and integrative health care practices to ensure Federal efforts are consistent with available standards and evidence.

(h) REPORT.—Not later than July 1, 2010, and annually thereafter through January 1, 2015, the Council shall submit to the President and the relevant committees of Congress, a report that—

(1) describes the activities and efforts on prevention, health promotion, and public health and activities to develop a national strategy conducted by the Council during the period for which the report is prepared;

(2) describes the national progress in meeting specific prevention, health promotion, and public health goals defined in the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet these goals;

(3) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the 5 leading disease killers in the United States;

(4) contains specific science-based initiatives to achieve the measurable goals of Healthy People 2010 regarding nutrition, exercise, and smoking cessation, and targeting the 5 leading disease killers in the United States;

(5) contains specific plans for consolidating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010);

(6) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

(7) contains specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under paragraph (4).

(i) PERIODIC REVIEWS.—The Secretary and the Comptroller General of the United States shall jointly conduct periodic reviews, not less than every 5 years, and evaluations of every Federal disease prevention and health promotion initiative, program, and agency. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with an analysis posted on such agencies' public Internet websites.

SEC. 3002. PREVENTION AND PUBLIC HEALTH FUND.

(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the ''Fund''), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

(1) for fiscal year 2010, $500,000,000;

(2) for fiscal year 2011, $750,000,000;

(3) for fiscal year 2012, $1,000,000,000;

(4) for fiscal year 2013, $1,250,000,000;

(5) for fiscal year 2014, $1,500,000,000; and

(6) for fiscal year 2015, and each fiscal year thereafter, $2,000,000,000.

(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs.

(d) TRANSFER AUTHORITY .—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

SEC. 3003. CLINICAL AND COMMUNITY PREVENTIVE SERVICES.

(a) PREVENTIVE SERVICES TASK FORCE.—Section 915 of the Public Health Service Act (42 U.S.C. 299b-4) is amended by striking subsection (a) and inserting the following:

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) ESTABLISHMENT AND PURPOSE.—The Director shall convene an independent Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community, and updating previous clinical preventive recommendations, to be published in the Guide to Clinical Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, Congress and other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such recommendations shall consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

''(2) DUTIES.—The duties of the Task Force shall include—

''(A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific sub-populations and age groups;

''(B) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions;

''(C) improved integration with Federal Government health objectives and related target setting for health improvement;

''(D) the enhanced dissemination of recommendations;

''(E) the provision of technical assistance to those health care professionals, agencies and organizations that request help in implementing the Guide recommendations; and

''(F) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

''(3) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of the Guide's recommendations.

''(4) COORDINATION WITH COMMUNITY PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

''(5) OPERATION.—Operation. In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

''(6) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such members, shall be independent and, to the extent practicable, not subject to political pressure.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.''.

(b) COMMUNITY PREVENTIVE SERVICES TASK FORCE.—

(1) IN GENERAL.—Part P of title III of the Public Health Service Act, as amended by paragraph (2), is amended by adding at the end the following:

''SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

''(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the 'Task Force') to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the 'Guide'), for individuals and organizations delivering population-based services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress and other policy-makers. Community preventive services include any policies, programs, processes or activities designed to affect or otherwise affecting health at the population level.

''(b) DUTIES.—The duties of the Task Force shall include—

''(1) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific populations and age groups, as well as the social, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations and age groups;

''(2) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions, including health impact assessment and population health modeling;

''(3) improved integration with Federal Government health objectives and related target setting for health improvement;

''(4) the enhanced dissemination of recommendations;

''(5) the provision of technical assistance to those health care professionals, agencies, and organizations that request help in implementing the Guide recommendations; and

''(6) providing yearly reports to Congress and related agencies identifying gaps in research and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

''(c) ROLE OF AGENCY.—The Director shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources, and assistance to those organizations requesting it for implementation of Guide recommendations.

''(d) COORDINATION WITH PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force's recommendations interact at the nexus of clinic and community.

''(e) OPERATION.—In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.''.

(2) TECHNICAL AMENDMENTS.—

(A) Section 399R of the Public Health Service Act (as added by section 2 of the ALS Registry Act (Public Law 110-373; 122 Stat. 4047)) is redesignated as section 399S.

(B) Section 399R of such Act (as added by section 3 of the Prenatally and Postnatally Diagnosed Conditions Awareness Act (Public Law 110–374; 122 Stat. 4051)) is redesignated as section 399T.

SEC. 3004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall provide for the planning and implementation of a national public–private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—

(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

(3) encourages healthy behaviors linked to the prevention of chronic diseases;

(4) explains the preventive services covered under health plans offered through the American Health Security Program;

(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies; and

(6) includes general health promotion information.

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine to provide ongoing advice on evidence-based scientific information for policy, program development, and evaluation.

(c) MEDIA CAMPAIGN.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(2) REQUIREMENT OF CAMPAIGN.—The campaign implemented under paragraph (1)—

(A) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening promotion;

(B) shall be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign;

(C) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(D) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(E) may include the use of humor and nationally recognized positive role models.

(3) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (1) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(d) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(e) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities, to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration.

(f) PERSONALIZED PREVENTION PLANS.—

(1) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(2) USE.—The website developed under paragraph (1) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(g) INTERNET PORTAL.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(h) PRIORITY FUNDING.—Funding for the activities authorized under this section shall take priority over funding provided through the Centers for Disease Control and Prevention for grants to States and other entities for similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this section.

(i) PUBLIC AWARENESS OF PREVENTIVE AND OBESITY-RELATED SERVICES.—

(1) INFORMATION TO STATES.—The Secretary of Health and Human Services shall provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available through the American Health Security Program.

(2) INFORMATION TO ENROLLEES.—Each State shall design a public awareness campaign regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(3) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of the States' efforts to increase awareness of coverage of obesity-related services.

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

Subtitle B—Increasing Access to Clinical Preventive Services

SEC. 3101. SCHOOL-BASED HEALTH CENTERS.

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(1) PROGRAM.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a program to award grants to eligible entities to support the operation of school-based health centers.

(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity shall—

(A) be a school-based health center or a sponsoring facility of a school-based health center; and

(B) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum an assurance that funds awarded under the grant shall not be used to provide any service that is not authorized or allowed by Federal, State, or local law.

(3) LIMITATION ON USE OF FUNDS.—An eligible entity shall use funds provided under a grant awarded under this subsection only for expenditures for facilities (including the acquisition or improvement of land, or the acquisition, construction, expansion, replacement, or other improvement of any building or other facility), equipment, or similar expenditures, as specified by the Secretary. No funds provided under a grant awarded under this section shall be used for expenditures for personnel or to provide health services.

(4) APPROPRIATIONS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2013, $50,000,000 for the purpose of carrying out this subsection. Funds appropriated under this paragraph shall remain available until expended.

(5) DEFINITIONS.—In this subsection, the terms ''school-based health center'' and ''sponsoring facility'' have the meanings given those terms in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397jj(c)(9)).

(b) GRANTS FOR THE OPERATION OF SCHOOL-BASED HEALTH CENTERS.—Part Q of title III of the Public Health Service Act (42 U.S.C.

280h et seq.) is amended by adding at the end the following:

"SEC. 399Z–1. SCHOOL-BASED HEALTH CENTERS.

''(a) DEFINITIONS; ESTABLISHMENT OF CRITERIA.—In this section:

''(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term 'comprehensive primary health services' means the core services offered by school-based health centers, which shall include the following:

''(A) PHYSICAL.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services.

''(B) MENTAL HEALTH.—Mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.

''(2) MEDICALLY UNDERSERVED CHILDREN AND ADOLESCENTS.—

''(A) IN GENERAL.—The term 'medically underserved children and adolescents' means a population of children and adolescents who are residents of an area designated as a medically underserved area or a health professional shortage area by the Secretary.

''(B) CRITERIA.—The Secretary shall prescribe criteria for determining the specific shortages of personal health services for medically underserved children and adolescents under subparagraph (A) that shall—

''(i) take into account any comments received by the Secretary from the chief executive officer of a State and local officials in a State; and

''(ii) include factors indicative of the health status of such children and adolescents of an area, the accessibility of health services, the availability of health professionals to such children and adolescents, and other factors as determined appropriate by the Secretary.

''(3) SCHOOL-BASED HEALTH CENTER.—The term 'school-based health center' means a health clinic that—

''(A) meets the definition of a school-based health center under section 2110(c)(9)(A) of the Social Security Act and is administered by a sponsoring facility (as defined in section 2110(c)(9)(B) of the Social Security Act);

''(B) provides, at a minimum, comprehensive primary health services during school hours to children and adolescents by health professionals in accordance with established standards, community practice, reporting laws, and other State laws, including parental consent and notification laws that are not inconsistent with Federal law; and

''(C) does not perform abortion services.

''(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the costs of the operation of school-based health centers (referred to in this section as 'SBHCs') that meet the requirements of this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an SBHC (as defined in subsection (a)(3)); and

''(2) submit to the Secretary an application at such time, in such manner, and containing—

''(A) evidence that the applicant meets all criteria necessary to be designated an SBHC;

''(B) evidence of local need for the services to be provided by the SBHC;

''(C) an assurance that—

''(i) SBHC services will be provided to those children and adolescents for whom parental or guardian consent has been obtained in cooperation with Federal, State, and local laws governing health care service provision to children and adolescents;

''(ii) the SBHC has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the SBHC;

''(iii) the SBHC will provide on-site access during the academic day when school is in session and 24-hour coverage through an on-call system and through its backup health providers to ensure access to services on a year-round basis when the school or the SBHC is closed;

''(iv) the SBHC will be integrated into the school environment and will coordinate health services with school personnel, such as administrators, teachers, nurses, counselors, and support personnel, as well as with other community providers co-located at the school;

''(v) the SBHC sponsoring facility assumes all responsibility for the SBHC administration, operations, and oversight; and

''(vi) the SBHC will comply with Federal, State, and local laws concerning patient privacy and student records, including regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 444 of the General Education Provisions Act; and

''(D) such other information as the Secretary may require.

''(d) PREFERENCES AND CONSIDERATION.—In reviewing applications:

''(1) The Secretary may give preference to applicants who demonstrate an ability to serve the following:

''(A) Communities that have evidenced barriers to primary health care and mental health and substance use disorder prevention services for children and adolescents.

''(B) Populations of children and adolescents that have historically demonstrated difficulty in accessing health and mental health and substance use disorder prevention services.

''(2) The Secretary may give consideration to whether an applicant has received a grant under subsection (a) of section 3101 of the Patient Protection and Affordable Care Act.

''(e) WAIVER OF REQUIREMENTS.—The Secretary may—

''(1) under appropriate circumstances, waive the application of all or part of the requirements of this subsection with respect to an SBHC for not to exceed 2 years; and

''(2) upon a showing of good cause, waive the requirement that the SBHC provide all required comprehensive primary health services for a designated period of time to be determined by the Secretary.

''(f) USE OF FUNDS.—

''(1) FUNDS.—Funds awarded under a grant under this section—

''(A) may be used for—

''(i) acquiring and leasing equipment (including the costs of amortizing the principle of, and paying interest on, loans for such equipment);

''(ii) providing training related to the provision of required comprehensive primary health services and additional health services;

''(iii) the management and operation of health center programs;

''(iv) the payment of salaries for physicians, nurses, and other personnel of the SBHC; and

''(B) may not be used to provide abortions.

''(2) CONSTRUCTION.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings to install on the school property.

''(3) LIMITATIONS.—

''(A) IN GENERAL.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3)(B) with respect to activities carried out at a SBHC shall not be eligible to receive additional funding under this section.

''(B) NO OVERLAPPING GRANT PERIOD.—No entity that has received funding under section 330 for a grant period shall be eligible for a grant under this section for with respect to the same grant period.

''(g) MATCHING REQUIREMENT.—

''(1) IN GENERAL.—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant (which may be provided in cash or in-kind) to carry out the activities supported by the grant.

''(2) WAIVER.—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year for the SBHC if the Secretary determines that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section.

''(h) SUPPLEMENT, NOT SUPPLANT.—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds.

''(i) EVALUATION.—The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring quality performance under the awards made under this section.

''(j) AGE APPROPRIATE SERVICES.—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual.

''(k) PARENTAL CONSENT.—An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual if such individual is considered a minor under applicable State law.

''(l) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.''.

SEC. 3102. ORAL HEALTHCARE PREVENTION ACTIVITIES.

(a) IN GENERAL.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES

"SEC. 399LL. ORAL HEALTHCARE PREVENTION EDUCATION CAMPAIGN.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with professional oral health organizations, shall, subject to the availability of appropriations, establish a 5-year national, public education campaign (referred to in this section as the 'campaign') that is focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer.

''(b) REQUIREMENTS.—In establishing the campaign, the Secretary shall—

''(1) ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the Indian Health Care Improvement Act) in a culturally and linguistically appropriate manner; and

''(2) utilize science-based strategies to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants.

''(c) PLANNING AND IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall

begin implementing the 5-year campaign. During the 2-year period referred to in the previous sentence, the Secretary shall conduct planning activities with respect to the campaign.

"SEC. 399LL-1. RESEARCH-BASED DENTAL CARIES DISEASE MANAGEMENT.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities.

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

''(1) be a community-based provider of dental services (as defined by the Secretary), including a Federally-qualified health center, a clinic of a hospital owned or operated by a State (or by an instrumentality or a unit of government within a State), a State or local department of health, a dental program of the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act), a health system provider, a private provider of dental services, medical, dental, public health, nursing, nutrition educational institutions, or national organizations involved in improving children's oral health; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—A grantee shall use amounts received under a grant under this section to demonstrate the effectiveness of research-based dental caries disease management activities.

''(d) USE OF INFORMATION.—The Secretary shall utilize information generated from grantees under this section in planning and implementing the public education campaign under section 399LL.

"SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part, such sums as may be necessary.''.

(b) SCHOOL-BASED SEALANT PROGRAMS.—Section 317M(c)(1) of the Public Health Service Act (42 U.S.C. 247b-14(c)(1)) is amended by striking ''may award grants to States and Indian tribes'' and inserting ''shall award a grant to each of the 50 States and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act)''.

(c) ORAL HEALTH INFRASTRUCTURE.—Section 317M of the Public Health Service Act (42 U.S.C. 247b-14) is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c), the following:

''(d) ORAL HEALTH INFRASTRUCTURE.—

''(1) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into cooperative agreements with State, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and community water fluoridation) to improve oral health.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.''.

(d) UPDATING NATIONAL ORAL HEALTHCARE SURVEILLANCE ACTIVITIES.—

(1) PRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as ''PRAMS'') as it relates to oral healthcare.

(B) STATE REPORTS AND MANDATORY MEASUREMENTS.—

(i) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) MEASUREMENTS.—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory with respect to States for purposes of the State reports under clause (i).

(C) FUNDING.—There is authorized to be appropriated to carry out this paragraph, such sums as may be necessary.

(2) NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.—The Secretary shall develop oral healthcare components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated by the Secretary at least every 6 years. For purposes of this paragraph, the term ''tooth-level surveillance'' means a clinical examination where an examiner looks at each dental surface, on each tooth in the mouth and as expanded by the Division of Oral Health of the Centers for Disease Control and Prevention.

(3) MEDICAL EXPENDITURES PANEL SURVEY.—The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of dental utilization, expenditure, and coverage findings through conduct of a look-back analysis.

(4) NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM.—

(A) APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2010 through 2014 to increase the participation of States in the National Oral Health Surveillance System from 16 States to all 50 States, territories, and District of Columbia.

(B) REQUIREMENTS.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.

Subtitle C—Creating Healthier Communities

SEC. 3201. COMMUNITY TRANSFORMATION GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall award competitive grants to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency;

(B) a local governmental agency;

(C) a national network of community-based organizations;

(D) a State or local non-profit organization; or

(E) an Indian tribe; and

(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant; and

(3) demonstrate a history or capacity, if funded, to develop relationships necessary to engage key stakeholders from multiple sectors within and beyond health care and across a community, such as healthy futures corps and health care providers.

(c) USE OF FUNDS.—

(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this subsection.

(2) COMMUNITY TRANSFORMATION PLAN.—

(A) IN GENERAL.—An eligible entity that receives a grant under this section shall submit to the Director (for approval) a detailed plan that includes the policy, environmental, programmatic, and as appropriate infrastructure changes needed to promote healthy living and reduce disparities.

(B) ACTIVITIES.—Activities within the plan may focus on (but not be limited to)—

(i) creating healthier school environments, including increasing healthy food options, physical activity opportunities, promotion of healthy lifestyle, emotional wellness, and prevention curricula, and activities to prevent chronic diseases;

(ii) creating the infrastructure to support active living and access to nutritious foods in a safe environment;

(iii) developing and promoting programs targeting a variety of age levels to increase access to nutrition, physical activity and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;

(iv) assessing and implementing worksite wellness programming and incentives;

(v) working to highlight healthy options at restaurants and other food venues;

(vi) prioritizing strategies to reduce racial and ethnic disparities, including social, economic, and geographic determinants of health; and

(vii) addressing special populations needs, including all age groups and individuals with disabilities, and individuals in both urban and rural areas.

(3) COMMUNITY-BASED PREVENTION HEALTH ACTIVITIES.—

(A) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to implement a variety of programs, policies, and infrastructure improvements to promote healthier lifestyles.

(B) ACTIVITIES.—An eligible entity shall implement activities detailed in the community transformation plan under paragraph (2).

(C) IN-KIND SUPPORT.—An eligible entity may provide in-kind resources such as staff, equipment, or office space in carrying out activities under this section.

(4) EVALUATION.—

(A) IN GENERAL.—An eligible entity shall use amounts provided under a grant under this section to conduct activities to measure changes in the prevalence of chronic disease risk factors among community members participating in preventive health activities

(B) TYPES OF MEASURES.—In carrying out subparagraph (A), the eligible entity shall, with respect to residents in the community, measure—

(i) changes in weight;

(ii) changes in proper nutrition;

(iii) changes in physical activity;

(iv) changes in tobacco use prevalence;

(v) changes in emotional well-being and overall mental health;

(vi) other factors using community-specific data from the Behavioral Risk Factor Surveillance Survey; and

(vii) other factors as determined by the Secretary.

(C) REPORTING.—An eligible entity shall annually submit to the Director a report containing an evaluation of activities carried out under the grant.

(5) DISSEMINATION.—A grantee under this section shall—

(A) meet at least annually in regional or national meetings to discuss challenges, best practices, and lessons learned with respect to activities carried out under the grant; and

(B) develop models for the replication of successful programs and activities and the mentoring of other eligible entities.

(d) TRAINING.—

(1) IN GENERAL.—The Director shall develop a program to provide training for eligible entities on effective strategies for the prevention and control of chronic disease and the link between physical, emotional, and social well-being.

(2) COMMUNITY TRANSFORMATION PLAN.—The Director shall provide appropriate feedback and technical assistance to grantees to establish community transformation plans

(3) EVALUATION.—The Director shall provide a literature review and framework for the evaluation of programs conducted as part of the grant program under this section, in addition to working with academic institutions or other entities with expertise in outcome evaluation.

(e) PROHIBITION.—A grantee shall not use funds provided under a grant under this section to create video games or to carry out any other activities that may lead to higher rates of obesity or inactivity.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each fiscal years 2010 through 2014.

SEC. 3202. HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS.

(a) HEALTHY AGING, LIVING WELL.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall award grants to State or local health departments and Indian tribes to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;

(C) design a strategy for improving the health of the 55-to-64 year-old population through community-based public health interventions; and

(D) demonstrate the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLIC HEALTH INTERVENTIONS.—

(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) TYPES OF INTERVENTION ACTIVITIES.—Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) COMMUNITY PREVENTIVE SCREENINGS.—

(i) IN GENERAL.—In addition to community-wide public health interventions, a State or local health department shall use amounts received under a grant under this subsection to conduct ongoing health screening to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes among individuals in both urban and rural areas who are between 55 and 64 years of age.

(ii) TYPES OF SCREENING ACTIVITIES.—Screening activities conducted under this subparagraph may include—

(I) mental health/behavioral health and substance use disorders;

(II) physical activity, smoking, and nutrition; and

(III) any other measures deemed appropriate by the Secretary.

(iii) MONITORING.—Grantees under this section shall maintain records of screening results under this subparagraph to establish the baseline data for monitoring the targeted population

(D) CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.—

(i) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to ensure that individuals between 55 and 64 years of age who are found to have chronic disease risk factors through the screening activities described in subparagraph (C)(ii), receive clinical referral/treatment for follow-up services to reduce such risk.

(ii) PUBLIC HEALTH INTERVENTION PROGRAM.—A State or local health department shall use amounts received under a grant under this subsection to enter into contracts with community health centers or rural health clinics and mental health and substance use disorder service providers to assist in the referral/treatment of at risk patients to community resources for clinical follow-up and help determine eligibility for other public programs.

(E) GRANTEE EVALUATION.—An eligible entity shall use amounts provided under a grant under this subsection to conduct activities to measure changes in the prevalence of chronic disease risk factors among participants.

(4) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of the pilot program under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among individuals who are 63 years of age and older who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.

(b) EVALUATION AND PLAN FOR COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS.—

(1) IN GENERAL.—The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for individuals who are 65 years of age and older.

(2) EVALUATION OF PREVENTION AND WELLNESS PROGRAMS.—

(A) IN GENERAL.—The Secretary shall evaluate community prevention and wellness programs including those that are sponsored by the Administration on Aging, are evidence-based, and have demonstrated potential to help individuals who are 65 years of age and oldervreduce their risk of disease, disability, and injury by making healthy lifestyle choices, including exercise, diet, and self-management of chronic diseases.

(B) EVALUATION.—The evaluation under subparagraph (A) shall consist of the following:

(i) EVIDENCE REVIEW.—The Secretary shall review available evidence, literature, best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for individuals who are 65 years of age and older. The Secretary may determine the scope of the evidence review and such issues to be considered, which shall include, at a minimum—

(I) physical activity, nutrition, and obesity;

(II) falls;

(III) chronic disease self-management; and

(IV) mental health.

(ii) INDEPENDENT EVALUATION OF EVIDENCE-BASED COMMUNITY PREVENTION AND WELLNESS PROGRAMS.—The Assistant Secretary for Aging, shall, to the extent feasible and practicable, conduct an evaluation of existing community prevention and wellness programs that are sponsored by the Administration on Aging to assess the extent to which individuals who are 65 years of age and older participate in such programs—

(I) reduce their health risks, improve their health outcomes, and adopt and maintain healthy behaviors; and

(II) improve their ability to manage their chronic conditions.

(3) REPORT.—Not later than September 30, 2013, the Secretary shall submit to Congress a report that includes—

(A) recommendations for such legislation and administrative action as the Secretary determines appropriate to promote healthy lifestyles and chronic disease self-management for individuals aged 65 and older;

(B) any relevant findings relating to the evidence review under paragraph (2)(B)(i); and

(C) the results of the evaluation under paragraph (2)(B)(ii).

(4) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $50,000,000 to the Centers for Medicare & Medicaid Services Program Management Account. Amounts transferred under the preceding sentence shall remain available until expended.

(5) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the this subsection.

SEC. 3203. REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

"SEC. 510. ESTABLISHMENT OF STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT.

''(a) STANDARDS.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, the Architectural and Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the Food and Drug Administration, promulgate regulatory standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.) setting forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician's offices, clinics, emergency rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

''(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERED.—The standards issued under subsection (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.

''(c) REVIEW AND AMENDMENT.—The Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration, shall periodically review and, as appropriate, amend the standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.).''.

SEC. 3204. IMMUNIZATIONS.

(a) STATE AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

''(l) AUTHORITY TO PURCHASE RECOMMENDED VACCINES FOR ADULTS.—

''(1) IN GENERAL.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).

''(2) STATE PURCHASE.—A State may obtain additional quantities of such adult vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through the purchase of vaccines from manufacturers at the applicable price negotiated by the Secretary under this subsection.''.

(b) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by subsection (a), is further amended by adding at the end the following:

''(m) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION COVERAGE.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to award grants to States to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations.

''(2) STATE PLAN.—To be eligible for a grant under paragraph (1), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a State plan that describes the interventions to be implemented under the grant and how such interventions match with local needs and capabilities, as determined through consultation with local authorities.

''(3) USE OF FUNDS.—Funds received under a grant under this subsection shall be used to implement interventions that are recommended by the Task Force on Community Preventive Services (as established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) or other evidence-based interventions, including—

''(A) providing immunization reminders or recalls for target populations of clients, patients, and consumers;

''(B) educating targeted populations and health care providers concerning immunizations in combination with one or more other interventions;

''(C) reducing out-of-pocket costs for families for vaccines and their administration;

''(D) carrying out immunization-promoting strategies for participants or clients of public programs, including assessments of immunization status, referrals to health care providers, education, provision of on-site immunizations, or incentives for immunization;

''(E) providing for home visits that promote immunization through education, assessments of need, referrals, provision of immunizations, or other services;

''(F) providing reminders or recalls for immunization providers;

''(G) conducting assessments of, and providing feedback to, immunization providers;

''(H) any combination of one or more interventions described in this paragraph; or

''(I) immunization information systems to allow all States to have electronic databases for immunization records.

''(4) CONSIDERATION.—In awarding grants under this subsection, the Secretary shall consider any reviews or recommendations of the Task Force on Community Preventive Services.

''(5) EVALUATION.—Not later than 3 years after the date on which a State receives a grant under this subsection, the State shall submit to the Secretary an evaluation of progress made toward improving immunization coverage rates among high-risk populations within the State.

''(6) REPORT TO CONGRESS.—Not later than 4 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall submit to Congress a report concerning the effectiveness of the demonstration program established under this subsection together with recommendations on whether to continue and expand such program.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.''.

(c) REAUTHORIZATION OF IMMUNIZATION PROGRAM.—Section 317(j) of the Public Health Service Act (42 U.S.C. 247b(j)) is amended—

(1) in paragraph (1), by striking ''for each of the fiscal years 1998 through 2005''; and

(2) in paragraph (2), by striking ''after October 1, 1997,''.

(d) RULE OF CONSTRUCTION REGARDING ACCESS TO IMMUNIZATIONS.—Nothing in this section (including the amendments made by this section), or any other provision of this Act (including any amendments made by this Act) shall be construed to decrease children's access to immunizations.

SEC. 3205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) TECHNICAL AMENDMENTS.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subitem (i), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''; and

(2) in subitem (ii), by inserting at the beginning ''except as provided in clause (H)(ii)(III),''.

(b) LABELING REQUIREMENTS.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

''(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES.—

''(i) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS.—Except for food described in subclause (vii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

''(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS.—Except as provided in subclause (vii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner—

''(I)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

''(II)(aa) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu board, including a drive-through menu board, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

''(bb) a succinct statement concerning suggested daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board;

''(III) in a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

''(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

''(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each

food offered a sign that lists calories per displayed food item or per serving.

''(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

''(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

''(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of such nutrient in the written form required under subclause (ii)(III).

''(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

''(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

''(aa) items that are not listed on a menu or menu board (such as condiments and other items placed on the table or counter for general use);

''(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

''(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days, under terms and conditions established by the Secretary.

''(II) WRITTEN FORMS.—Subparagraph (5)(C) shall apply to any regulations promulgated under subclauses (ii)(III) and (vi).

''(viii) VENDING MACHINES.—

''(I) IN GENERAL.—In the case of an article of food sold from a vending machine that—

''(aa) does not permit a prospective purchaser to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

''(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign in close proximity to each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

''(ix) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

''(I) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to be subject to the requirements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator with the Secretary, as specified by the Secretary by regulation.

''(II) REGISTRATION.—Within 120 days of enactment of this clause, the Secretary shall publish a notice in the Federal Register specifying the terms and conditions for implementation of item (I), pending promulgation of regulations.

''(III) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

''(x) REGULATIONS.—

''(I) PROPOSED REGULATION.—Not later than 1 year after the date of enactment of this clause, the Secretary shall promulgate proposed regulations to carry out this clause.

''(II) CONTENTS.—In promulgating regulations, the Secretary shall—

''(aa) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the Secretary determines; and

''(bb) specify the format and manner of the nutrient content disclosure requirements under this subclause.

''(III) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

''(xi) DEFINITION.—In this clause, the term 'menu' or 'menu board' means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.''

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343-1(a)(4)) is amended by striking ''except a requirement for nutrition labeling of food which is exempt under subclause (i) or (ii) of section 403(q)(5)(A)'' and inserting ''except that this paragraph does not apply to food that is offered for sale in a restaurant or similar retail food establishment that is not part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items unless such restaurant or similar retail food establishment complies with the voluntary provision of nutrition information requirements under section 403(q)(5)(H)(ix)''.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed—

(1) to preempt any provision of State or local law, unless such provision establishes or continues into effect nutrient content disclosures of the type required under section 403(q)(5)(H) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)) and is expressly preempted under subsection (a)(4) of such section;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(ix) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(i) of such Act.

SEC. 3206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

''(s) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

''(1) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized well ness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

''(2) AGREEMENTS.—The Secretary shall enter into agreements with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

''(3) WELLNESS PLANS.—

''(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program under this subsection may include one or more of the following as appropriate to the individual's identified risk factors:

''(i) Nutritional counseling.

''(ii) A physical activity plan.

''(iii) Alcohol and smoking cessation counseling and services.

''(iv) Stress management.

''(v) Dietary supplements that have health claims approved by the Secretary.

''(vi) Compliance assistance provided by a community health center employee.

''(B) RISK FACTORS.—Wellness plan risk factors shall include—

''(i) weight;

''(ii) tobacco and alcohol use;

''(iii) exercise rates;

''(iv) nutritional status; and

''(v) blood pressure.

''(C) COMPARISONS.—Individualized wellness plans shall make comparisons between the individual involved and a control group of individuals with respect to the risk factors described in subparagraph (B).

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, such sums as may be necessary.''.

SEC. 3207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

''(r)(1) An employer shall provide—

''(A) a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time such employee has need to express the milk; and

''(B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

''(2) An employer shall not be required to compensate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.

''(3) An employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business.

''(4) Nothing in this subsection shall preempt a State law that provides greater protections to employees than the protections provided for under this subsection.''.

Subtitle D—Support for Prevention and Public Health Innovation

SEC. 3301. RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, shall provide funding for research in the area of public health services and systems.

(b) REQUIREMENTS OF RESEARCH.—Research supported under this section shall include—

(1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy or Healthy People 2020, and including comparing community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) identifying effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(c) EXISTING PARTNERSHIPS.—Research supported under this section shall be coordinated with the Community Preventive Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector.

(d) ANNUAL REPORT.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

SEC. 3302. UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS.

(a) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

"SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

''(a) DATA COLLECTION.—

''(1) IN GENERAL.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—

''(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;

''(B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated;

''(C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients or participants using, if needed, statistical oversamples of these subpopulations; and

''(D) any other demographic data as deemed appropriate by the Secretary regarding health disparities.

''(2) COLLECTION STANDARDS.—In collecting data described in paragraph (1), the Secretary or designee shall—

''(A) use Office of Management and Budget standards, at a minimum, for race and ethnicity measures;

''(B) develop standards for the measurement of sex, primary language, and disability status;

''(C) develop standards for the collection of data described in paragraph (1) that, at a minimum—

''(i) collects self-reported data by the applicant, recipient, or participant; and

''(ii) collects data from a parent or legal guardian if the applicant, recipient, or participant is a minor or legally incapacitated;

''(D) survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

''(i) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;

''(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria set forth in section 510 of the Rehabilitation Act of 1973; and

''(iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities; and

''(E) require that any reporting requirement imposed for purposes of measuring quality under any ongoing or federally conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services under such programs activities by race, ethnicity, sex, primary language, and disability status.

''(3) DATA MANAGEMENT.—In collecting data described in paragraph (1), the Secretary, acting through the National Coordinator for Health Information Technology shall—

''(A) develop national standards for the management of data collected; and

''(B) develop interoperability and security systems for data management.

''(b) DATA ANALYSIS.—

''(1) IN GENERAL.—For each federally conducted or supported health care or public health program or activity, the Secretary shall analyze data collected under paragraph (a) to detect and monitor trends in health disparities (as defined for purposes of section 485E) at the Federal and State levels.

''(c) DATA REPORTING AND DISSEMINATION.—

''(1) IN GENERAL.—The Secretary shall make the analyses described in (b) available to—

''(A) the Office of Minority Health;

''(B) the National Center on Minority Health and Health Disparities;

''(C) the Agency for Healthcare Research and Quality;

''(D) the Centers for Disease Control and Prevention;

''(E) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act;

''(F) the Office of Rural health;

''(G) other agencies within the Department of Health and Human Services; and

''(H) other entities as determined appropriate by the Secretary.

''(2) REPORTING OF DATA.—The Secretary shall report data and analyses described in (a) and (b) through—

''(A) public postings on the Internet websites of the Department of Health and Human Services; and

''(B) any other reporting or dissemination mechanisms determined appropriate by the Secretary.

''(3) AVAILABILITY OF DATA.—The Secretary may make data described in (a) and (b) available for additional research, analyses, and dissemination to other Federal agencies, non-governmental entities, and the public, in accordance with any Federal agency's data user agreements.

''(d) LIMITATIONS ON USE OF DATA.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual.

''(e) PROTECTION AND SHARING OF DATA.—

''(1) PRIVACY AND OTHER SAFEGUARDS.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that—

''(A) all data collected pursuant to subsection (a) is protected—

''(i) under privacy protections that are at least as broad as those that the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033); and

''(ii) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary; and

''(B) all appropriate information security safeguards are used in the collection, analysis, and sharing of data collected pursuant to subsection (a).

''(2) DATA SHARING.—The Secretary shall establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services specified in subsection (c)(1).

''(f) DATA ON RURAL UNDERSERVED POPULATIONS.—The Secretary shall ensure that any data collected in accordance with this section regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations.

''(g) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

''(h) REQUIREMENT FOR IMPLEMENTATION.—Notwithstanding any other provision of this section, data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.

''(i) CONSULTATION.—The Secretary shall consult with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the Bureau of the Census, the Commissioner of Social Security, and the head of other appropriate Federal agencies in carrying out this section.''.

SEC. 3303. CDC AND EMPLOYER-BASED WELLNESS PROGRAMS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), by section 3102, is further amended by adding at the end the following:

"PART U—EMPLOYER-BASED WELLNESS PROGRAM

"SEC. 399MM. TECHNICAL ASSISTANCE FOR EMPLOYER-BASED WELLNESS PROGRAMS.

''In order to expand the utilization of evidence-based prevention and health promotion approaches in the workplace, the Director shall—

''(1) provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers' employer-based wellness programs, including—

''(A) measuring the participation and methods to increase participation of employees in such programs;

''(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees' health behaviors, health outcomes, and health care expenditures; and

''(C) evaluating such programs as they relate to changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

''(2) build evaluation capacity among workplace staff by training employers on

how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

"SEC. 399MM–1. NATIONAL WORKSITE HEALTH POLICIES AND PROGRAMS STUDY.

''(a) IN GENERAL.—In order to assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, not later than 2 years after the date of enactment of this part, and at regular intervals (to be determined by the Director) thereafter, the Director shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.

''(b) REPORT.—Upon the completion of each study under subsection (a), the Director shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health policies and programs.

"SEC. 399MM–2. PRIORITIZATION OF EVALUATION BY SECRETARY.

''The Secretary shall evaluate, in accordance with this part, all programs funded through the Centers for Disease Control and Prevention before conducting such an evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.

"SEC. 399MM–3. PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS.

''Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.''.

SEC. 3304. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

Title XXVIII of the Public Health Service Act (42 U.S.C. 300hh et seq.) is amended by adding at the end the following:

"Subtitle C—Strengthening Public Health Surveillance Systems

"SEC. 2821. EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

''(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Epidemiology and Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments may also be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in improving surveillance for, and response to, infectious diseases and other conditions of public health importance by—

''(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

''(2) enhancing laboratory practice as well as systems to report test orders and results electronically;

''(3) improving information systems including developing and maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

''(4) developing and implementing prevention and control strategies.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $190,000,000 for each of fiscal years 2010 through 2013, of which—

''(1) not less than $95,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

''(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

''(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).''.

SEC. 3305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.—

(1) CONVENING.—Not later than 1 year after funds are appropriated to carry out this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as ''the Conference'').

(2) PURPOSES.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(3) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine declines to enter into an agreement under paragraph (1), the Secretary of Health and Human Services may enter into such agreement with another appropriate entity.

(4) REPORT.—A report summarizing the Conference's findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following:

"SEC. 409J. PAIN RESEARCH.

''(a) RESEARCH INITIATIVES.—

''(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

''(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

''(3) DEFINITION.—In this subsection, the term 'Pain Consortium' means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

''(b) INTERAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—

''(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of the enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the 'Committee'), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The Committee shall be composed of the following voting members:

''(i) Not more than 7 voting Federal representatives appoint by the Secretary from agencies that conduct pain care research and treatment.

''(ii) 12 additional voting members appointed under subparagraph (B).

''(B) ADDITIONAL MEMBERS.—The Committee shall include additional voting members appointed by the Secretary as follows:

''(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

''(ii) 6 members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and service organizations for individuals with pain-related conditions.

''(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary determines to be appropriate.

''(3) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

''(4) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH, but in no case less often than once each year.

''(5) DUTIES.—The Committee shall—

''(A) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

''(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

''(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication of effort;

''(D) make recommendations on how best to disseminate information on pain care; and

''(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

''(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.''.

(c) PAIN CARE EDUCATION AND TRAINING.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following new section:

"SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.

''(a) IN GENERAL.—The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

''(b) CERTAIN TOPICS.—An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on—

''(1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

''(2) applicable laws, regulations, rules, and policies on controlled substances, including the degree to which misconceptions and concerns regarding such laws, regulations, rules, and policies, or the enforcement thereof, may create barriers to patient access to appropriate and effective pain care;

''(3) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

''(4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

''(5) recent findings, developments, and improvements in the provision of pain care.

''(c) EVALUATION OF PROGRAMS.—The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice of pain care.

''(d) PAIN CARE DEFINED.—For purposes of this section the term 'pain care' means the assessment, diagnosis, treatment, or management of acute or chronic pain regardless of causation or body location.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2010 through 2012. Amounts appropriated under this subsection shall remain available until expended.''.

SEC. 3306. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

''(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014.''.

Subtitle E—Miscellaneous Provisions

SEC. 3401. SENSE OF THE SENATE CONCERNING CBO SCORING.

(a) FINDING.—The Senate finds that the costs of prevention programs are difficult to estimate due in part because prevention initiatives are hard to measure and results may occur outside the 5 and 10 year budget windows.

(b) SENSE OF CONGRESS.—It is the sense of the Senate that Congress should work with the Congressional Budget Office to develop better methodologies for scoring progress to be made in prevention and wellness programs.

SEC. 3402. EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.

To determine whether existing Federal health and wellness initiatives are effective in achieving their stated goals, the Secretary of Health and Human Services shall—

(1) conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the Federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees, and health conditions, including workplace fitness, healthy food and beverages, and incentives in the Federal Employee Health Benefits Program; and

(2) submit to Congress a report concerning such evaluation, which shall include conclusions concerning the reasons that such existing programs have proven successful or not successful and what factors contributed to such conclusions.

TITLE IV—HEALTH CARE WORKFORCE

Subtitle A—Purpose and Definitions

SEC. 4001. PURPOSE.

The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, minority, health disparity, and rural populations by—

(1) gathering and assessing comprehensive data in order for the health care workforce to meet the health care needs of individuals, including research on the supply, demand, distribution, diversity, and skills needs of the health care workforce;

(2) increasing the supply of a qualified health care workforce to improve access to and the delivery of health care services for all individuals;

(3) enhancing health care workforce education and training to improve access to and the delivery of health care services for all individuals; and

(4) providing support to the existing health care workforce to improve access to and the delivery of health care services for all individuals.

SEC. 4002. DEFINITIONS.

(a) THIS TITLE.—In this title:

(1) ALLIED HEALTH PROFESSIONAL.—The term ''allied health professional'' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences, and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) HEALTH CARE CAREER PATHWAY.—The term ''healthcare career pathway'' means a rigorous, engaging, and high quality set of courses and services that—

(A) includes an articulated sequence of academic and career courses, including 21st century skills;

(B) is aligned with the needs of healthcare industries in a region or State;

(C) prepares students for entry into the full range of postsecondary education options, including registered apprenticeships, and careers;

(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;

(E) meets State academic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applicable industry standards; and

(F) leads to 2 or more credentials, including—

(i) a secondary school diploma; and

(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.

(3) INSTITUTION OF HIGHER EDUCATION.—The term ''institution of higher education'' has the meaning given the term in sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002).

(4) LOW INCOME INDIVIDUAL, STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.—

(A) LOW-INCOME INDIVIDUAL.—The term ''low-income individual'' has the meaning given that term in section 101 of the Workforce investment Act of 1998 (29 U.S.C. 2801).

(B) STATE WORKFORCE INVESTMENT BOARD; LOCAL WORKFORCE INVESTMENT BOARD.—The terms ''State workforce investment board'' and ''local workforce investment board'', refer to a State workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.

(5) POSTSECONDARY EDUCATION.—The term ''postsecondary education'' means—

(A) a 4-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward an associate or a baccalaureate degree, offered by an institution of higher education; or

(B) a certificate or registered apprenticeship program at the postsecondary level offered by an institution of higher education or a non-profit educational institution.

(6) REGISTERED APPRENTICESHIP PROGRAM.—The term ''registered apprenticeship program'' means an industry skills training program at the postsecondary level that combines technical and theoretical training through structure on the job learning with related instruction (in a classroom or through distance learning) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to enhance job proficiency, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.

(b) TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.—Section 799B of the Public Health Service Act (42 U.S.C. 295p) is amended—

(1) by striking paragraph (3) and inserting the following:

''(3) PHYSICIAN ASSISTANT EDUCATION PROGRAM.—The term 'physician assistant education program' means an educational program in a public or private institution in a State that—

''(A) has as its objective the education of individuals who, upon completion of their studies in the program, be qualified to provide primary care medical services with the supervision of a physician; and

''(B) is accredited by the Accreditation Review Commission on Education for the Physician Assistant.''; and

(2) by adding at the end the following:

''(12) AREA HEALTH EDUCATION CENTER.—The term 'area health education center' means a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has received an award under subsection (a)(1) or (a)(2) of section 751, satisfies the requirements in section 751(d)(1), and has as one of its principal functions the operation of an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.

''(13) AREA HEALTH EDUCATION CENTER PROGRAM.—The term 'area health education center program' means cooperative program consisting of an entity that has received an award under subsection (a)(1) or (a)(2) of section 751 for the purpose of planning, developing, operating, and evaluating an area health education center program and one or more area health education centers, which carries out the required activities described in section 751(c), satisfies the program requirements in such section, has as one of its

principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards.

''(14) CLINICAL SOCIAL WORKER.—The term 'clinical social worker' has the meaning given the term in section 1861(hh)(1) of the Social Security Act (42 U.S.C. 1395x(hh)(1)).

''(15) CULTURAL COMPETENCY.—The term 'cultural competency' shall be defined by the Secretary in a manner consistent with section 1707(d)(3).

''(16) DIRECT CARE WORKER.—The term 'direct care worker' has the meaning given that term in the 2010 Standard Occupational Classifications of the Department of Labor for Home Health Aides [31–1011], Psychiatric Aides [31–1013], Nursing Assistants [31–1014], and Personal Care Aides [39–9021].

''(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).

''(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'frontier health professional shortage area' means an area—

''(A) with a population density less than 6 persons per square mile within the service area; and

''(B) with respect to which the distance or time for the population to access care is excessive.

''(19) GRADUATE PSYCHOLOGY.—The term 'graduate psychology' means an accredited program in professional psychology.

''(20) HEALTH DISPARITY POPULATION.—The term 'health disparity population' has the meaning given such term in section 903(d)(1).

''(21) HEALTH LITERACY.—The term 'health literacy' means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.

''(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term 'mental health service professional' means an individual with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.

''(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term 'one-stop delivery system' means a one-stop delivery system described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)).

''(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term 'paraprofessional child and adolescent mental health worker' means an individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.

''(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms 'racial and ethnic minority group' and 'racial and ethnic minority population' have the meaning given the term 'racial and ethnic minority group' in section 1707.

''(26) RURAL HEALTH CLINIC.—The term 'rural health clinic' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).''.

(c) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 296) is amended—

(1) in paragraph (2)—

(A) by striking ''means a'' and inserting ''means an accredited (as defined in paragraph 6)''; and

(B) by striking the period as inserting the following: ''where graduates are—

''(A) authorized to sit for the National Council Licensure EXamination-Registered Nurse (NCLEX–RN); or

''(B) licensed registered nurses who will receive a graduate or equivalent degree or training to become an advanced education nurse as defined by section 811(b).''; and

(2) by adding at the end the following:

''(16) ACCELERATED NURSING DEGREE PROGRAM.—The term 'accelerated nursing degree program' means a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a BSN or MSN degree in an accelerated time frame as determined by the accredited school of nursing.

''(17) BRIDGE OR DEGREE COMPLETION PROGRAM.—The term 'bridge or degree completion program' means a program of education in professional nursing offered by an accredited school of nursing, as defined in paragraph (2), that leads to a baccalaureate degree in nursing. Such programs may include, Registered Nurse (RN) to Bachelor's of Science of Nursing (BSN) programs, RN to MSN (Master of Science of Nursing) programs, or BSN to Doctoral programs.''.

Subtitle B—Innovations in the Health Care Workforce

SEC. 4101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—

(1) serves as a national resource for Congress, the President, States, and localities;

(2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities administered by one or more of such Departments;

(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;

(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommend ways to address such barriers; and

(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.

(b) ESTABLISHMENT.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the ''Commission'').

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General, without regard to section 5 of the Federal Advisory Committee Act (5 U.S.C. App.).

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation, and a balance between urban, suburban, rural, and frontier representatives.

(B) INCLUSION.—

(i) IN GENERAL.—The membership of the Commission shall include no less than one representative of—

(I) the health care workforce and health professionals;

(II) employers;

(III) third-party payers;

(IV) individuals skilled in the conduct and interpretation of health care services and health economics research;

(V) representatives of consumers;

(VI) labor unions;

(VII) State or local workforce investment boards; and

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(ii) ADDITIONAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(C) MAJORITY NON-PROVIDERS.—Individuals who are directly involved in health professions education or practice shall not constitute a majority of the membership of the Commission.

(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978. Members of the Commission shall not be treated as special government employees under title 18, United States Code.

(3) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(C) INITIAL APPOINTMENTS.—The Comptroller General shall make initial appointments of members to the Commission not later than September 30, 2010.

(4) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of tile 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate. Personnel of the Commission shall not be treated as employees of

the Government Accountability Office for any purpose.

(5) CHAIRMAN, VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the chairmanship or vice chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(6) MEETINGS.—The Commission shall meet at the call of the chairman, but no less frequently than on a quarterly basis.

(d) DUTIES.—

(1) RECOGNITION, DISSEMINATION, AND COMMUNICATION.—The Commission shall—

(A) recognize efforts of Federal, State, and local partnerships to develop and offer health care career pathways of proven effectiveness;

(B) disseminate information on promising retention practices for health care professionals; and

(C) communicate information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce.

(2) REVIEW OF HEALTH CARE WORKFORCE AND ANNUAL REPORTS.—In order to develop a fiscally sustainable integrated workforce that supports a high-quality, readily accessible health care delivery system that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and projected health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning related policies; and

(D) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority area as described in paragraph (4).

(3) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, skill sets, and demands, with projected demands during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the education and training infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), with recommendations on whether such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq);

(D) the implications of new and existing Federal policies which affect the health care workforce, including titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2801 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, such as minorities, rural populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority medical students to serve in their home communities, if designated as medical underserved community.

(4) HIGH PRIORITY AREAS.—

(A) IN GENERAL.—The initial high priority topics described in this paragraph include each of the following:

(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.

(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.

(iii) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels.

(II) Oral health care workforce capacity at all levels.

(III) Mental and behavioral health care workforce capacity at all levels.

(IV) Allied health and public health care workforce capacity at all levels.

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.

(VI) The geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

(B) FUTURE DETERMINATIONS.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development areas that require special attention.

(5) GRANT PROGRAM.—The Commission shall—

(A) review implementation progress reports on, and report to Congress about, the State Health Care Workforce Development Grant program established in section 4102;

(B) in collaboration with the Department of Labor and in coordination with the Department of Education and other relevant Federal agencies, make recommendations to the fiscal and administrative agent under section 4102(b) for grant recipients under section 4102;

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute this information to Congress, relevant Federal agencies, and to the public.

(6) STUDY.—The Commission shall study effective mechanisms for financing education and training for careers in health care, including public health and allied health.

(7) RECOMMENDATIONS.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(8) ASSESSMENT.—The Commission shall assess and receive reports from the National Center for Health Care Workforce Analysis established under section 761(b) of the Public Service Health Act (as amended by section 4103).

(e) CONSULTATION WITH FEDERAL, STATE, AND LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZATIONS.—

(1) IN GENERAL.—The Commission shall consult with Federal agencies (including the Departments of Health and Human Services, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary health care organizations, professional societies, and other relevant public-private health care partnerships.

(2) OBTAINING OFFICIAL DATA.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the Executive Branch information necessary to enable the Commission to carry out this section.

(3) DETAIL OF FEDERAL GOVERNMENT EMPLOYEES.—An employee of the Federal Government may be detailed to the Commission without reimbursement. The detail of such an employee shall be without interruption or loss of civil service status.

(f) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States determines to be necessary to ensure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an executive director that shall not exceed the rate of basic pay payable for level V of the Executive Schedule and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the internal organization and operation of the Commission.

(g) POWERS.—

(1) DATA COLLECTION.—In order to carry out its functions under this section, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section, including coordination with the Bureau of Labor Statistics;

(B) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(C) adopt procedures allowing interested parties to submit information for the Commission's use in making reports and recommendations.

(2) ACCESS OF THE GOVERNMENT ACCOUNTABILITY OFFICE TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(3) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by an independent public accountant under contract to the Commission.

(h) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations. Amounts so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

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

(3) GIFTS AND SERVICES.—The Commission may not accept gifts, bequeaths, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

(i) DEFINITIONS.—In this section:

(1) HEALTH CARE WORKFORCE.—The term ''health care workforce'' includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(2) HEALTH PROFESSIONALS.—The term ''health professionals'' includes—

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, community health workers, school nurses, certified nurse midwives, podiatrists, licensed complementary and alternative medicine providers, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and integrative health practitioners;

(B) national representatives of health professionals;

(C) representatives of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists, oral health care industry dentistry and dental hygiene, and physician assistants;

(D) representatives of public and private teaching hospitals, and ambulatory health facilities, including Federal medical facilities; and

(E) any other health professional the Comptroller General of the United States determines appropriate.

SEC. 4102. STATE HEALTH CARE WORKFORCE DEVELOPMENT GRANTS.

(a) ESTABLISHMENT.—There is established a competitive health care workforce development grant program (referred to in this section as the ''program'') for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels.

(b) FISCAL AND ADMINISTRATIVE AGENT.—The Health Resources and Services Administration of the Department of Health and Human Services (referred to in this section as the ''Administration'') shall be the fiscal and administrative agent for the grants awarded under this section. The Administration is authorized to carry out the program, in consultation with the National Health Care Workforce Commission (referred to in this section as the ''Commission''), which shall review reports on the development, implementation, and evaluation activities of the grant program, including—

(1) administering the grants;

(2) providing technical assistance to grantees; and

(3) reporting performance information to the Commission.

(c) PLANNING GRANTS.—

(1) AMOUNT AND DURATION.—A planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than $150,000.

(2) ELIGIBILITY.—To be eligible to receive a planning grant, an entity shall be an eligible partnership. An eligible partnership shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employer, labor organization, a public 2-year institution of higher education, a public 4-year institution of higher education, the recognized State federation of labor, the State public secondary education agency, the State P–16 or P–20 Council if such a council exists, and a philanthropic organization that is actively engaged in providing learning, mentoring, and work opportunities to recruit, educate, and train individuals for, and retain individuals in, careers in health care and related industries.

(3) FISCAL AND ADMINISTRATIVE AGENT.—The Governor of the State receiving a planning grant has the authority to appoint a fiscal and an administrative agency for the partnership.

(4) APPLICATION.—Each State partnership desiring a planning grant shall submit an application to the Administrator of the Administration at such time and in such manner, and accompanied by such information as the Administrator may reasonable require. Each application submitted for a planning grant shall describe the members of the State partnership, the activities for which assistance is sought, the proposed performance benchmarks to be used to measure progress under the planning grant, a budget for use of the funds to complete the required activities described in paragraph (5), and such additional assurance and information as the Administrator determines to be essential to ensure compliance with the grant program requirements.

(5) REQUIRED ACTIVITIES.—A State partnership receiving a planning grant shall carry out the following:

(A) Analyze State labor market information in order to create health care career pathways for students and adults, including dislocated workers.

(B) Identify current and projected high demand State or regional health care sectors for purposes of planning career pathways.

(C) Identify existing Federal, State, and private resources to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships.

(D) Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licensure.

(E) Describe State secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling.

(F) Identify Federal or State policies or rules to developing a coherent and comprehensive health care workforce development strategy and barriers and a plan to resolve these barriers.

(G) Participate in the Administration's evaluation and reporting activities.

(6) PERFORMANCE AND EVALUATION.—Before the State partnership receives a planning grant, such partnership and the Administrator of the Administration shall jointly determine the performance benchmarks that will be established for the purposes of the planning grant.

(7) MATCH.—Each State partnership receiving a planning grant shall provide an amount, in cash or in kind, that is not less that 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local or private sources to carry out the activities.

(8) REPORT.—

(A) REPORT TO ADMINISTRATION.—Not later than 1 year after a State partnership receives a planning grant, the partnership shall submit a report to the Administration on the State's performance of the activities under the grant, including the use of funds, including matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices and a profile of the activities of each State grant recipient.

(d) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—The Administration shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will address current and projected workforce demands within the State; and

(B) inform the Commission and Congress about the awards made.

(2) DURATION.—An implementation grant shall be awarded for a period of no more than 2 years, except in those cases where the Administration determines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) ELIGIBILITY.—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of such grant; or

(B) completed a satisfactory application, including a plan to coordinate with required

partners and complete the required activities during the 2 year period of the implementation grant.

(4) FISCAL AND ADMINISTRATIVE AGENT.—A State partnership receiving an implementation grant shall appoint a fiscal and an administration agent for the implementation of such grant.

(5) APPLICATION.—Each eligible State partnership desiring an implementation grant shall submit an application to the Administration at such time, in such manner, and accompanied by such information as the Administration may reasonably require. Each application submitted shall include—

(A) a description of the members of the State partnership;

(B) a description of how the State partnership completed the required activities under the planning grant, if applicable;

(C) a description of the activities for which implementation grant funds are sought, including grants to regions by the State partnership to advance coherent and comprehensive regional health care workforce planning activities;

(D) a description of how the State partnership will coordinate with required partners and complete the required partnership activities during the duration of an implementation grant;

(E) a budget proposal of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds required;

(F) proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;

(G) a description of how the State partnership will collect data to report progress in grant activities; and

(H) such additional assurances as the Administration determines to be essential to ensure compliance with grant requirements.

(6) REQUIRED ACTIVITIES.—

(A) IN GENERAL.—A State partnership that receives an implementation grant may reserve not less than 60 percent of the grant funds to make grants to be competitively awarded by the State partnership, consistent with State procurement rules, to encourage regional partnerships to address health care workforce development needs and to promote innovative health care workforce career pathway activities, including career counseling, learning, and employment.

(B) ELIGIBLE PARTNERSHIP DUTIES.—An eligible State partnership receiving an implementation grant shall—

(i) identify and convene regional leadership to discuss opportunities to engage in statewide health care workforce development planning, including the potential use of competitive grants to improve the development, distribution, and diversity of the regional health care workforce; the alignment of curricula for health care careers; and the access to quality career information and guidance and education and training opportunities;

(ii) in consultation with key stakeholders and regional leaders, take appropriate steps to reduce Federal, State, or local barriers to a comprehensive and coherent strategy, including changes in State or local policies to foster coherent and comprehensive health care workforce development activities, including health care career pathways at the regional and State levels, career planning information, retraining for dislocated workers, and as appropriate, requests for Federal program or administrative waivers;

(iii) develop, disseminate, and review with key stakeholders a preliminary statewide strategy that addresses short- and long-term health care workforce development supply versus demand;

(iv) convene State partnership members on a regular basis, and at least on a semiannual basis;

(v) assist leaders at the regional level to form partnerships, including technical assistance and capacity building activities;

(vi) collect and assess data on and report on the performance benchmarks selected by the State partnership and the Administration for implementation activities carried out by regional and State partnerships; and

(vii) participate in the Administration's evaluation and reporting activities.

(7) PERFORMANCE AND EVALUATION.—Before the State partnership receives an implementation grant, it and the Administrator shall jointly determine the performance benchmarks that shall be established for the purposes of the implementation grant.

(8) MATCH.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.

(9) REPORTS.—

(A) REPORT TO ADMINISTRATION.—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on the performance of the State of the grant activities, including a description of the use of the funds, including matched funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing implementation activities, performance, and fund utilization of the State grantees, including an identification of promising practices and a profile of the activities of each State grantee.

(e) AUTHORIZATION FOR APPROPRIATIONS.—

(1) PLANNING GRANTS.—There are authorized to be appropriated to award planning grants under subsection (c) $8,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

(2) IMPLEMENTATION GRANTS.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 4103. HEALTH CARE WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e);

(2) by striking subsection (b) and inserting the following:

''(b) NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.—

''(1) ESTABLISHMENT.—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the 'National Center').

''(2) PURPOSES.—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 4101 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

''(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues;

''(B) carry out the activities under section 792(a);

''(C) annually evaluate programs under this title;

''(D) develop and publish performance measures and benchmarks for programs under this title; and

''(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

''(3) COLLABORATION AND DATA SHARING.—

''(A) IN GENERAL.—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

''(B) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with relevant professional and educational organizations or societies.

''(c) STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.—

''(1) IN GENERAL.—The Secretary shall award grants to, or enter into contracts with, eligible entities for purposes of—

''(A) collecting, analyzing, and reporting data regarding programs under this title to the National Center and to the public; and

''(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

''(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

''(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

''(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—

''(1) IN GENERAL.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

''(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

''(A) studying practice patterns; and

''(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

''(3) GUIDELINES.—A longitudinal evaluation shall comply with guidelines issued under sections 749(d)(4), 757(d)(4), and 762(a)(4).

''(4) ELIGIBLE ENTITIES.—To be eligible to obtain an increase under this section, an entity shall be a recipient of a grant or contract under this title.''; and

(3) in subsection (e), as so redesignated—

(A) by striking paragraph (1) and inserting the following:

''(1) IN GENERAL.—

''(A) NATIONAL CENTER.—To carry out subsection (b), there are authorized to be appropriated $7,500,000 for each of fiscal years 2010 through 2014.

''(B) STATE AND REGIONAL CENTERS.—To carry out subsection (c), there are authorized to be appropriated $4,500,000 for each of fiscal years 2010 through 2014.

''(C) GRANTS FOR LONGITUDINAL EVALUATIONS.—To carry out subsection (d), there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.''; and

(4) in paragraph (2), by striking ''subsection (a)'' and inserting ''paragraph (1)''.

(b) TRANSFERS.—Not later than 180 days after the date of enactment of this Act, the responsibilities and resources of the National Center for Health Workforce Analysis, as in effect on the date before the date of enactment of this Act, shall be transferred to the National Center for Health Care Workforce Analysis established under section 761 of the Public Health Service Act, as amended by subsection (a).

(c) USE OF LONGITUDINAL EVALUATIONS.—Section 791(a)(1) of the Public Health Service Act (42 U.S.C. 295j(a)(1)) is amended—

(1) in subparagraph (A), by striking ''or'' at the end;

(2) in subparagraph (B), by striking the period and inserting ''; or''; and

(3) by adding at the end the following:

''(C) utilizes a longitudinal evaluation (as described in section 761(d)(2)) and reports data from such system to the national workforce database (as established under section 761(b)(2)(E)).''.

(d) PERFORMANCE MEASURES; GUIDELINES FOR LONGITUDINAL EVALUATIONS.—

(1) ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY.—Section 748(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this part;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

''(5) recommend appropriation levels for programs under this part.''.

(2) ADVISORY COMMITTEE ON INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.—Section 756(d) of the Public Health Service Act is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this part;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this part; and

''(5) recommend appropriation levels for programs under this part.''.

(3) ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.—Section 762(a) of the Public Health Service Act (42 U.S.C. 294o(a)) is amended—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(3) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D;

''(4) develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this title, except for programs under part C or D; and

''(5) recommend appropriation levels for programs under this title, except for programs under part C or D.''.

Subtitle C—Increasing the Supply of the Health Care Workforce

SEC. 4201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.

(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE.—Section 723 of the Public Health Service Act (42 U.S.C. 292s) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking subparagraph (B) and inserting the following:

''(B) to practice in such care for 10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first.''; and

(B) by striking paragraph (3) and inserting the following:

''(3) NONCOMPLIANCE BY STUDENT.—Each agreement entered into with a student pursuant to paragraph (1) shall provide that, if the student fails to comply with such agreement, the loan involved will begin to accrue interest at a rate of 2 percent per year greater than the rate at which the student would pay if compliant in such year.''; and

(2) by adding at the end the following:

''(d) SENSE OF CONGRESS.—It is the sense of Congress that funds repaid under the loan program under this section should not be transferred to the Treasury of the United States or otherwise used for any other purpose other than to carry out this section.''.

(b) STUDENT LOAN GUIDELINES.—The Secretary of Health and Human Services shall not require parental financial information for an independent student to determine financial need under section 723 of the Public Health Service Act (42 U.S.C. 292s) and the determination of need for such information shall be at the discretion of applicable school loan officer. The Secretary shall amend guidelines issued by the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 4202. NURSING STUDENT LOAN PROGRAM.

(a) LOAN AGREEMENTS.—Section 836(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

(1) by striking ''$2,500'' and inserting ''$3,300'';

(2) by striking ''$4,000'' and inserting ''$5,200''; and

(3) by striking ''$13,000'' and all that follows through the period and inserting ''$17,000 in the case of any student during fiscal years 2010 and 2011. After fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate of the loans.''.

(b) LOAN PROVISIONS.—Section 836(b) of the Public Health Service Act (42 U.S.C. 297b(b)) is amended—

(1) in paragraph (1)(C), by striking ''1986'' and inserting ''2000''; and

(2) in paragraph (3), by striking ''the date of enactment of the Nurse Training Amendments of 1979'' and inserting ''September 29, 1995''.

SEC. 4203. HEALTH CARE WORKFORCE LOAN REPAYMENT 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 C—Recruitment and Retention Programs

''SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.

''(a) ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

''(b) PROGRAM ADMINISTRATION.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

''(1) such qualified health professionals will agree to provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified pediatric subspecialty that has a sufficient pediatric population to support such pediatric subspecialty, as determined by the Secretary; and

''(2) the Secretary agrees to make payments on the principal and interest of undergraduate, graduate, or graduate medical education loans of professionals described in paragraph (1) of not more than $35,000 a year for each year of agreed upon service under such paragraph for a period of not more than 3 years during the qualified health professional's—

''(A) participation in an accredited pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental health subspecialty residency or fellowship; or

''(B) employment as a pediatric medical subspecialist, pediatric surgical specialist, or child and adolescent mental health professional serving an area or population described in such paragraph.

''(c) IN GENERAL.—

''(1) ELIGIBLE INDIVIDUALS.—

''(A) PEDIATRIC MEDICAL SPECIALISTS AND PEDIATRIC SURGICAL SPECIALISTS.—For purposes of contracts with respect to pediatric medical specialists and pediatric surgical specialists, the term 'qualified health professional' means a licensed physician who—

''(i) is entering or receiving training in an accredited pediatric medical subspecialty or pediatric surgical specialty residency or fellowship; or

''(ii) has completed (but not prior to the end of the calendar year in which this section is enacted) the training described in subparagraph (B).

''(B) CHILD AND ADOLESCENT MENTAL AND BEHAVIORAL HEALTH.—For purposes of contracts with respect to child and adolescent mental and behavioral health care, the term 'qualified health professional' means a health care professional who—

''(i) has received specialized training or clinical experience in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family therapy, school counseling, or professional counseling;

''(ii) has a license or certification in a State to practice allopathic medicine, osteopathic medicine, psychology, school psychology, psychiatric nursing, social work, school social work, marriage and family therapy, school counseling, or professional counseling; or

''(iii) is a mental health service professional who completed (but not before the end of the calendar year in which this section is enacted) specialized training or clinical experience in child and adolescent mental health described in clause (i).

''(2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—The Secretary may not enter into a contract under this subsection with an eligible individual unless—

''(A) the individual agrees to work in, or for a provider serving, a health professional shortage area or medically underserved area, or to serve a medically underserved population;

''(B) the individual is a United States citizen or a permanent legal United States resident; and

''(C) if the individual is enrolled in a graduate program, the program is accredited, and the individual has an acceptable level of academic standing (as determined by the Secretary).

''(d) PRIORITY.—In entering into contracts under this subsection, the Secretary shall give priority to applicants who—

''(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

''(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

''(3) demonstrate financial need.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)(1)(A) and $20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).''.

SEC. 4204. 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.), as amended by section 4203, is further amended by adding at the end the following:

''SEC. 776. 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.

''(b) ELIGIBILITY.—To be eligible to participate in the Program, an individual shall—

''(1)(A) be accepted for enrollment, or be enrolled, as a student in an accredited academic educational institution in a State or territory in the final year of a course of study or program leading to a public health or health professions degree or certificate; and have accepted employment with a Federal, State, local, or tribal public health agency, or a related training fellowship, as recognized by the Secretary, to commence upon graduation;

''(B)(i) have graduated, during the preceding 10-year period, from an accredited educational institution in a State or territory and received a public health or health professions degree or certificate; and

''(ii) be employed by, or have accepted employment with, a Federal, State, local, or tribal public health agency or a related training fellowship, as recognized by the Secretary;

''(2) be a United States citizen; and

''(3)(A) submit an application to the Secretary to participate in the Program;

''(B) execute a written contract as required in subsection (c); and

''(4) not have received, for the same service, a reduction of loan obligations under section 455(m), 428J, 428K, 428L, or 460 of the Higher Education Act of 1965.

''(c) CONTRACT.—The written contract (referred to in this section as the 'written contract') 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 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 in the full-time employment of a Federal, State, local, or tribal public health agency or a related fellowship program 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 to a priority service area (as determined by the Secretary) in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

''(4) 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;

''(5) a statement of the damages to which the United States is entitled, under this section 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 this section.

''(d) PAYMENTS.—

''(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for tuition expenses incurred by the individual.

''(2) PAYMENTS FOR YEARS SERVED.—For each year of obligated service that an individual contracts to serve under subsection (c) 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.

''(3) TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from payments under paragraph (2) on behalf of an individual, 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.

''(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a health professions or other related school, the date of the initiation of the period of obligated service may be postponed as approved by the Secretary.

''(f) BREACH OF CONTRACT.—An individual who fails to comply with the contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 338E for breaches of loan repayment contracts under section 338B.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $195,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SEC. 4205. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings, as recognized by the Secretary of Health and Human Services by authorizing an Allied Health Loan Forgiveness Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1078–11) is amended—

(1) in subsection (b), by adding at the end the following:

''(18) ALLIED HEALTH PROFESSIONALS.—The individual is employed full-time as an allied health professional—

''(A) in a Federal, State, local, or tribal public health agency; or

''(B) in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''; and

(2) in subsection (g)—

(A) by redesignating paragraphs (1) through (9) as paragraphs (2) through (10), respectively; and

(B) by inserting before paragraph (2) (as redesignated by subparagraph (A)) the following:

''(1) ALLIED HEALTH PROFESSIONAL.—The term 'allied health professional' means an allied health professional as defined in section 799B(5) of the Public Heath Service Act (42 U.S.C. 295p(5)) who—

''(A) has graduated and received an allied health professions degree or certificate from an institution of higher education; and

''(B) is employed with a Federal, State, local or tribal public health agency, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.''.

SEC. 4206. GRANTS FOR STATE AND LOCAL PROGRAMS.

(a) IN GENERAL.—Section 765(d) of the Public Health Service Act (42 U.S.C. 295(d)) is amended—

(1) in paragraph (7), by striking ''; or'' and inserting a semicolon;

(2) by redesignating paragraph (8) as paragraph (9); and

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

''(8) public health workforce loan repayment programs; or''.

(b) TRAINING FOR MID-CAREER PUBLIC HEALTH PROFESSIONALS.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 4204, is further amended by adding at the end the following:

''SEC. 777. TRAINING FOR MID-CAREER PUBLIC AND ALLIED 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 and allied health workforce to receive additional training in the field of public health and allied 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 public or allied health or a related discipline, as determined by the Secretary

''(2) ELIGIBLE INDIVIDUALS.—The term 'eligible individuals' includes those individuals employed in public and allied health positions at the Federal, State, tribal, or local level who are interested in retaining or upgrading their education.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $60,000,000 for fiscal year 2010 and such sums as may be necessary

for each of fiscal years 2011 through 2015. Fifty percent of appropriated funds shall be allotted to public health mid-career professionals and 50 percent shall be allotted to allied health mid-career professionals.''.

SEC. 4207. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

''(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

''(1) For fiscal year 2010, $320,461,632.

''(2) For fiscal year 2011, $414,095,394.

''(3) For fiscal year 2012, $535,087,442.

''(4) For fiscal year 2013, $691,431,432.

''(5) For fiscal year 2014, $893,456,433.

''(6) For fiscal year 2015, $1,154,510,336.

''(7) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

''(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.''.

SEC. 4208. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330A the following:

''SEC. 330A–1. GRANTS TO NURSE–MANAGED HEALTH CLINICS.

''(a) DEFINITIONS.—

''(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term 'comprehensive primary health care services' means the primary health services described in section 330(b)(1).

''(2) NURSE-MANAGED HEALTH CLINIC.—The term 'nurse-managed health clinic' means a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.

''(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the cost of the operation of nurse-managed health clinics that meet the requirements of this section.

''(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an NMHC; and

''(2) submit to the Secretary an application at such time, in such manner, and containing—

''(A) assurances that nurses are the major providers of services at the NMHC and that at least 1 advanced practice nurse holds an executive management position within the organizational structure of the NMHC;

''(B) an assurance that the NMHC will continue providing comprehensive primary health care services or wellness services without regard to income or insurance status of the patient for the duration of the grant period; and

''(C) an assurance that, not later than 90 days of receiving a grant under this section, the NMHC will establish a community advisory committee, for which a majority of the members shall be individuals who are served by the NMHC.

''(d) GRANT AMOUNT.—The amount of any grant made under this section for any fiscal year shall be determined by the Secretary, taking into account—

''(1) the financial need of the NMHC, considering State, local, and other operational funding provided to the NMHC; and

''(2) other factors, as the Secretary determines appropriate.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''.

SEC. 4209. ELIMINATION OF CAP ON COMMISSIONED CORPS.

Section 202 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking ''not to exceed 2,800''.

SEC. 4210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

''SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

''(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

''(3) APPOINTMENT.—Commissioned officers of the Ready Reserve Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

''(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

''(5) WARRANT OFFICERS.—Warrant officers may be appointed to the Service for the purpose of providing support to the health and delivery systems maintained by the Service and any warrant officer appointed to the Service shall be considered for purposes of this Act and title 37, United States Code, to be a commissioned officer within the Commissioned Corps of the Service.

''(b) ASSIMILATING RESERVE CORP OFFICERS INTO THE REGULAR CORPS.—Effective on the date of enactment of the Patient Protection and Affordable Care Act, all individuals classified as officers in the Reserve Corps under this section (as such section existed on the day before the date of enactment of such Act) and serving on active duty shall be deemed to be commissioned officers of the Regular Corps.

''(c) PURPOSE AND USE OF READY RESEARCH.—

''(1) PURPOSE.—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed service's reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

''(2) USES.—The Ready Reserve Corps shall—

''(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

''(B) be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed service reserve personnel;

''(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Corps members, as well as for deployment to respond to public health emergencies, both foreign and domestic; and

''(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 799B) to improve access to health services.

''(d) FUNDING.—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2010 through 2014 for recruitment and training and $12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps.''.

Subtitle D—Enhancing Health Care Workforce Education and Training

SEC. 4301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANTSHIP.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

''SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

''(a) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, academically affiliated physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

''(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship program in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary;

''(B) to provide need-based financial assistance in the form of traineeships and fellowships to medical students, interns, residents, practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of the fields defined in subparagraph (A);

''(C) to plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs;

''(D) to plan, develop, and operate a program for the training of physicians teaching in community-based settings;

''(E) to provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;

''(F) to plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in programs to provide such training;

''(G) to plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act, which may include—

''(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes (as defined by the Secretary for purposes of this section);

''(ii) developing tools and curricula relevant to patient-centered medical homes; and

''(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and

''(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

''(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

''(b) CAPACITY BUILDING IN PRIMARY CARE.—

''(1) IN GENERAL.—The Secretary may make grants to or enter into contracts with accredited schools of medicine or osteopathic medicine to establish, maintain, or improve—

''(A) academic units or programs that improve clinical teaching and research in fields defined in subsection (a)(1)(A); or

''(B) programs that integrate academic administrative units in fields defined in subsection (a)(1)(A) to enhance interdisciplinary recruitment, training, and faculty development.

''(2) PREFERENCE IN MAKING AWARDS UNDER THIS SUBSECTION.—In making awards of grants and contracts under paragraph (1), the Secretary shall give preference to any qualified applicant for such an award that agrees to expend the award for the purpose of—

''(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

''(B) substantially expanding such units or programs.

''(3) PRIORITIES IN MAKING AWARDS.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to qualified applicants that—

''(A) proposes a collaborative project between academic administrative units of primary care;

''(B) proposes innovative approaches to clinical teaching using models of primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health care settings and integration physical and mental health provision;

''(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

''(D) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

''(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

''(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;

''(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

''(H) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act; or

''(I) provide training in cultural competency and health literacy.

''(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

''(c) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For purposes of carrying out this section (other than subsection (b)(1)(B)), there are authorized to be appropriated $125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

''(2) TRAINING PROGRAMS.—Fifteen percent of the amount appropriated pursuant to paragraph (1) in each such fiscal year shall be allocated to the physician assistant training programs described in subsection (a)(1)(F), which prepare students for practice in primary care.

''(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $750,000 for each of fiscal years 2010 through 2014.''.

SEC. 4302. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by inserting after section 747, as amended by section 4301, the following:

''SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible entities to enable such entities to provide new training opportunities for direct care workers who are employed in long-term care settings such as nursing homes (as defined in section 1908(e)(1) of the Social Security Act (42 U.S.C. 1396g(e)(1)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall—

''(1) be an institution of higher education (as defined in section 102 of the Higher Education Act of 1965 (20 U.S.C. 1002)) that—

''(A) is accredited by a nationally recognized accrediting agency or association listed under section 101(c) of the Higher Education Act of 1965 (20 U.S.C. 1001(c)); and

''(B) has established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community based services to individuals with disabilities, or other long-term care provider; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant under this section to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs provided by such entity.

''(d) ELIGIBLE INDIVIDUAL.—

''(1) ELIGIBILITY.—To be eligible for assistance under this section, an individual shall be enrolled in courses provided by a grantee under this subsection and maintain satisfactory academic progress in such courses.

''(2) CONDITION OF ASSISTANCE.—As a condition of receiving assistance under this section, an individual shall agree that, following completion of the assistance period, the individual will work in the field of geriatrics, disability services, long term services and supports, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for the period of fiscal years 2011 through 2013.''.

SEC. 4303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by—

(1) redesignating section 748, as amended by section 4103 of this Act, as section 749; and

(2) inserting after section 747A, as added by section 4302, the following:

''SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

''(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such grant or contract—

''(A) to plan, develop, and operate, or participate in, an approved professional training program in the field of general dentistry, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees, that emphasizes training for general, pediatric, or public health dentistry;

''(B) to provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in need thereof, who are participants in any such program, and who plan to work in the practice of general, pediatric, public heath dentistry, or dental hygiene;

''(C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

''(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry;

''(E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may be departments, divisions or other units);

''(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

''(G) to create a loan repayment program for faculty in dental programs; and

''(H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

''(2) FACULTY LOAN REPAYMENT.—

''(A) IN GENERAL.—A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry described in such subsection to plan, develop, and operate a loan repayment program under which—

''(i) individuals agree to serve full-time as faculty members; and

''(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loans of the individuals.

''(B) MANNER OF PAYMENTS.—With respect to the payments described in subparagraph (A)(ii), upon completion by an individual of each of the first, second, third, fourth, and fifth years of service, the program shall pay an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual's student loan balance as calculated based on principal and interest owed at the initiation of the agreement.

''(b) ELIGIBLE ENTITY.—For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public health dentistry shall include entities that have programs in dental or dental hygiene schools, or approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities may partner with schools of public health to permit the education of dental students, residents, and dental hygiene students for a master's year in public health at a school of public health.

''(c) PRIORITIES IN MAKING AWARDS.—With respect to training provided for under this section, the Secretary shall give priority in awarding grants or contracts to the following:

''(1) Qualified applicants that propose collaborative projects between departments of primary care medicine and departments of general, pediatric, or public health dentistry.

''(2) Qualified applicants that have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers, who enter and remain in general, pediatric, or public health dentistry.

''(3) Qualified applicants that have a record of training individuals who are from a rural or disadvantaged background, or from underrepresented minorities.

''(4) Qualified applicants that establish formal relationships with Federally qualified health centers, rural health centers, or accredited teaching facilities and that conduct training of students, residents, fellows, or faculty at the center or facility.

''(5) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

''(6) Qualified applicants that include educational activities in cultural competency and health literacy.

''(7) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

''(8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and vulnerable elderly.

''(d) APPLICATION.—An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(e) DURATION OF AWARD.—The period during which payments are made to an entity from an award of a grant or contract under subsection (a) shall be 5 years. The provision of such payments shall be subject to annual approval by the Secretary and subject to the availability of appropriations for the fiscal year involved to make the payments.

''(f) AUTHORIZATIONS OF APPROPRIATIONS.—For the purpose of carrying out subsections (a) and (b), there is authorized to be appropriated $30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

''(g) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.''.

SEC. 4304. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECT.

Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. 256f et seq.) is amended by adding at the end the following:

''SEC. 340G–1. DEMONSTRATION PROGRAM.

''(a) IN GENERAL.—

''(1) AUTHORIZATION.—The Secretary is authorized to award grants to 15 eligible entities to enable such entities to establish a demonstration program to establish training programs to train, or to employ, alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities.

''(2) DEFINITION.—The term 'alternative dental health care providers' includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.

''(b) TIMEFRAME.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section, and shall conclude not later than 7 years after such date of enactment.

''(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) be—

''(A) an institution of higher education, including a community college;

''(B) a public-private partnership;

''(C) a federally qualified health center;

''(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);

''(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization providing dental services; or

''(F) a public hospital or health system;

''(2) be within a program accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution; and

''(3) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(d) ADMINISTRATIVE PROVISIONS.—

''(1) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not less than $4,000,000 for the 5-year period during which the demonstration project being conducted.

''(2) DISBURSEMENT OF FUNDS.—

''(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, the Secretary may disperse to any entity receiving a grant under this section not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.

''(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under subparagraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

''(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

''(f) EVALUATION.—The Secretary shall contract with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

''(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.''.

SEC. 4305. GERIATRIC EDUCATION AND TRAINING; CAREER AWARDS; COMPREHENSIVE GERIATRIC EDUCATION.

(a) WORKFORCE DEVELOPMENT; CAREER AWARDS.—Section 753 of the Public Health Service Act (42 U.S.C. 294c) is amended by adding at the end the following:

''(d) GERIATRIC WORKFORCE DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary shall award grants or contracts under this subsection to entities that operate a geriatric education center pursuant to subsection (a)(1).

''(2) APPLICATION.—To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(3) USE OF FUNDS.—Amounts awarded under a grant or contract under paragraph (1) shall be used to—

''(A) carry out the fellowship program described in paragraph (4); and

''(B) carry out 1 of the 2 activities described in paragraph (5).

''(4) FELLOWSHIP PROGRAM.—

''(A) IN GENERAL.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses (referred to in this subsection as a 'fellowship') that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members in medical schools and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills.

''(B) LOCATION.—A fellowship shall be offered either at the geriatric education center that is sponsoring the course, in collaboration with other geriatric education centers, or at medical schools, schools of dentistry, schools of nursing, schools of pharmacy,

schools of social work, graduate programs in psychology, or allied health and other health professions schools approved by the Secretary with which the geriatric education centers are affiliated.

''(C) CME CREDIT.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing health profession education requirements. As a condition of such acceptance, the recipient shall agree to subsequently provide a minimum of 18 hours of voluntary instructional support through a geriatric education center that is providing clinical training to students or trainees in long-term care settings.

''(5) ADDITIONAL REQUIRED ACTIVITIES DESCRIBED.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to carry out 1 of the following 2 activities.

''(A) FAMILY CAREGIVER AND DIRECT CARE PROVIDER TRAINING.—A geriatric education center that receives an award under this subsection shall offer at least 2 courses each year, at no charge or nominal cost, to family caregivers and direct care providers that are designed to provide practical training for supporting frail elders and individuals with disabilities. The Secretary shall require such Centers to work with appropriate community partners to develop training program content and to publicize the availability of training courses in their service areas. All family caregiver and direct care provider training programs shall include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate, safe, and effective use of medications for older adults.

''(B) INCORPORATION OF BEST PRACTICES.—A geriatric education center that receives an award under this subsection shall develop and include material on depression and other mental disorders common among older adults, medication safety issues for older adults, and management of the psychological and behavioral aspects of dementia and communication techniques with individuals who have dementia in all training courses, where appropriate.

''(6) TARGETS.—A geriatric education center that receives an award under this subsection shall meet targets approved by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

''(7) AMOUNT OF AWARD.—An award under this subsection shall be in an amount of $150,000. Not more than 24 geriatric education centers may receive an award under this subsection.

''(8) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

''(9) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,800,000 for the period of fiscal year 2011 through 2014.

''(e) GERIATRIC CAREER INCENTIVE AWARDS.—

''(1) IN GENERAL.—The Secretary shall award grants or contracts under this section to individuals described in paragraph (2) to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management.

''(2) ELIGIBLE INDIVIDUALS.—To be eligible to received an award under paragraph (1), an individual shall—

''(A) be an advanced practice nurse, a clinical social worker, a pharmacist, or student of psychology who is pursuing a doctorate or other advanced degree in geriatrics or related fields in an accredited health professions school; and

''(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(3) CONDITION OF AWARD.—As a condition of receiving an award under this subsection, an individual shall agree that, following completion of the award period, the individual will teach or practice in the field of geriatrics, long-term care, or chronic care management for a minimum of 5 years under guidelines set by the Secretary.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal years 2011 through 2013.''.

(b) EXPANSION OF ELIGIBILITY FOR GERIATRIC ACADEMIC CAREER AWARDS; PAYMENT TO INSTITUTION.—Section 753(c) of the Public Health Service Act 294(c)) is amended—

(1) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively;

(2) by striking paragraph (2) through paragraph (3) and inserting the following:

''(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an Award under paragraph (1), an individual shall—

''(A) be board certified or board eligible in internal medicine, family practice, psychiatry, or licensed dentistry, or have completed any required training in a discipline and employed in an accredited health professions school that is approved by the Secretary;

''(B) have completed an approved fellowship program in geriatrics or have completed specialty training in geriatrics as required by the discipline and any addition geriatrics training as required by the Secretary; and

''(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

''(3) LIMITATIONS.—No Award under paragraph (1) may be made to an eligible individual unless the individual—

''(A) has submitted to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, and the Secretary has approved such application;

''(B) provides, in such form and manner as the Secretary may require, assurances that the individual will meet the service requirement described in paragraph (6); and

''(C) provides, in such form and manner as the Secretary may require, assurances that the individual has a full-time faculty appointment in a health professions institution and documented commitment from such institution to spend 75 percent of the total time of such individual on teaching and developing skills in interdisciplinary education in geriatrics.

''(4) MAINTENANCE OF EFFORT.—An eligible individual that receives an Award under paragraph (1) shall provide assurances to the Secretary that funds provided to the eligible individual under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.''; and

(3) in paragraph (5), as so designated—

(A) in subparagraph (A)—

(i) by inserting ''for individuals who are physicians'' after ''this section''; and

(ii) by inserting after the period at the end the following: ''The Secretary shall determine the amount of an Award under this section for individuals who are not physicians.''; and

(B) by adding at the end the following:

''(C) PAYMENT TO INSTITUTION.—The Secretary shall make payments to institutions which include schools of medicine, osteopathic medicine, nursing, social work, psychology, dentistry, and pharmacy, or other allied health discipline in an accredited health professions school that is approved by the Secretary.''.

(c) COMPREHENSIVE GERIATRIC EDUCATION.—Section 855 of the Public Health Service Act (42 U.S.C. 298) is amended—

(1) in subsection (b)—

(A) in paragraph (3), by striking ''or'' at the end;

(B) in paragraph (4), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(5) establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing, long-term care, gero-psychiatric nursing or other nursing areas that specialize in the care of the elderly population.''; and

(2) in subsection (e), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

SEC. 4306. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

(a) IN GENERAL.—Part D of title VII (42 U.S.C. 294 et seq.) is amended by—

(1) striking section 757;

(2) redesignating section 756 (as amended by section 4103) as section 757; and

(3) inserting after section 755 the following:

''SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

''(a) GRANTS AUTHORIZED.—The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

''(1) baccalaureate, master's, and doctoral degree programs of social work, as well as the development of faculty in social work;

''(2) accredited master's, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

''(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

''(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training of paraprofessional child and adolescent mental health workers.

''(b) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under this section, an institution shall demonstrate—

''(1) participation in the institutions' programs of individuals and groups from different racial, ethnic, cultural, geographic,

religious, linguistic, and class backgrounds, and different genders and sexual orientations;

''(2) knowledge and understanding of the concerns of the individuals and groups described in subsection (a);

''(3) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency;

''(4) the institution will provide to the Secretary such data, assurances, and information as the Secretary may require; and

''(5) with respect to any violation of the agreement between the Secretary and the institution, the institution will pay such liquidated damages as prescribed by the Secretary by regulation.

''(c) INSTITUTIONAL REQUIREMENT.—For grants authorized under subsection (a)(1), at least 4 of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

''(d) PRIORITY.—

''(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

''(A) are accredited by the Council on Social Work Education;

''(B) have a graduation rate of not less than 80 percent for social work students; and

''(C) exhibit an ability to recruit social workers from and place social workers in areas with a high need and high demand population.

''(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

''(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

''(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

''(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

''(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

''(D) offer curriculum taught collaboratively with a family on the consumer and family lived experience or the importance of family-professional or family-paraprofessional partnerships; and

''(E) provide services through a community mental health program described in section 1913(b)(1).

''(e) AUTHORIZATION OF APPROPRIATION.—For the fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

''(1) $8,000,000 for training in social work in subsection (a)(1);

''(2) $12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than $10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

''(3) $10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

''(4) $5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).''.

(b) CONFORMING AMENDMENTS.—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended by striking ''sections 751(a)(1)(A), 751(a)(1)(B), 753(b), 754(3)(A), and 755(b)'' and inserting ''sections 751(b)(1)(A), 753(b), and 755(b)''.

SEC. 4307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING.

(a) TITLE VII.—Section 741 of the Public Health Service Act (42 U.S.C. 293e) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting ''CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS''; and

(B) in paragraph (1), by striking ''for the purpose of'' and all that follows through the period at the end and inserting ''for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.''; and

(2) by striking subsection (b) and inserting the following:

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807.

''(c) DISSEMINATION.—

''(1) IN GENERAL.—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section 270 and such other means as determined appropriate by the Secretary.

''(2) EVALUATION.—The Secretary shall evaluate the adoption and the implementation of cultural competency, prevention, and public health, and working with individuals with a disability training curricula, and the facilitate inclusion of these competency measures in quality measurement systems as appropriate.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.''.

(b) TITLE VIII.—Section 807 of the Public Health Service Act (42 U.S.C. 296e–1) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting ''CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY GRANTS''; and

(B) by striking ''for the purpose of'' and all that follows through ''health care.'' and inserting ''for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs, and for other purposes determined as appropriate by the Secretary.''; and

(2) by redesignating subsection (b) as subsection (d);

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

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with the entities described in section 741(b). The Secretary shall coordinate with curricula and research and demonstration projects developed under such section 741.

''(c) DISSEMINATION.—Model curricula developed under this section shall be disseminated and evaluated in the same manner as model curricula developed under section 741, as described in subsection (c) of such section.''; and

(4) in subsection (d), as so redesignated—

(A) by striking ''subsection (a)'' and inserting ''this section''; and

(B) by striking ''2001 through 2004'' and inserting ''2010 through 2015''.

SEC. 4308. ADVANCED NURSING EDUCATION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296j) is amended—

(1) in subsection (c)—

(A) in the subsection heading, by striking ''AND NURSE MIDWIFERY PROGRAMS''; and

(B) by striking ''and nurse midwifery'';

(2) in subsection (f)—

(A) by striking paragraph (2); and

(B) by redesignating paragraph (3) as paragraph (2); and

(3) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(4) by inserting after subsection (c), the following:

''(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for support under this section are educational programs that—

''(1) have as their objective the education of midwives; and

''(2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.''.

SEC. 4309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.

(a) IN GENERAL.—Section 831 of the Public Health Service Act (42 U.S.C. 296p) is amended—

(1) in the section heading, by striking ''**RETENTION**'' and inserting ''**QUALITY**'';

(2) in subsection (a)—

(A) in paragraph (1), by adding ''or'' after the semicolon;

(B) by striking paragraph (2); and

(C) by redesignating paragraph (3) as paragraph (2);

(3) in subsection (b)(3), by striking ''managed care, quality improvement'' and inserting ''coordinated care'';

(4) in subsection (g), by inserting '', as defined in section 801(2),'' after ''school of nursing''; and

(5) in subsection (h), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) NURSE RETENTION GRANTS.—Title VIII of the Public Health Service Act is amended by inserting after section 831 (42 U.S.C. 296b) the following:

''SEC. 831A. NURSE RETENTION GRANTS.

''(a) RETENTION PRIORITY AREAS.—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse retention programs pursuant to subsection (b) or (c).

''(b) GRANTS FOR CAREER LADDER PROGRAM.—The Secretary may award grants to,

and enter into contracts with, eligible entities for programs—

''(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses, to become baccalaureate prepared registered nurses or advanced education nurses in order to meet the needs of the registered nurse workforce;

''(2) developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or

''(3) to assist individuals in obtaining education and training required to enter the nursing profession and advance within such profession.

''(c) ENHANCING PATIENT CARE DELIVERY SYSTEMS.—

''(1) GRANTS.—The Secretary may award grants to eligible entities to improve the retention of nurses and enhance patient care that is directly related to nursing activities by enhancing collaboration and communication among nurses and other health care professionals, and by promoting nurse involvement in the organizational and clinical decision-making processes of a health care facility.

''(2) PRIORITY.—In making awards of grants under this subsection, the Secretary shall give preference to applicants that have not previously received an award under this subsection (or section 831(c) as such section existed on the day before the date of enactment of this section).

''(3) CONTINUATION OF AN AWARD.—The Secretary shall make continuation of any award under this subsection beyond the second year of such award contingent on the recipient of such award having demonstrated to the Secretary measurable and substantive improvement in nurse retention or patient care.

''(d) OTHER PRIORITY AREAS.—The Secretary may award grants to, or enter into contracts with, eligible entities to address other areas that are of high priority to nurse retention, as determined by the Secretary.

''(e) REPORT.—The Secretary shall submit to the Congress before the end of each fiscal year a report on the grants awarded and the contracts entered into under this section. Each such report shall identify the overall number of such grants and contracts and provide an explanation of why each such grant or contract will meet the priority need of the nursing workforce.

''(f) ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' includes an accredited school of nursing, as defined by section 801(2), a health care facility, or a partnership of such a school and facility.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2012.''.

SEC. 4310. LOAN REPAYMENT AND SCHOLARSHIP PROGRAM.

(a) LOAN REPAYMENTS AND SCHOLARSHIPS.—Section 846(a)(3) of the Public Health Service Act (42 U.S.C. 297n(a)(3)) is amended by inserting before the semicolon the following: '', or in a accredited school of nursing, as defined by section 801(2), as nurse faculty''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—Title VIII (42 U.S.C. 296 et seq.) is amended—

(1) by redesignating section 810 (relating to prohibition against discrimination by schools on the basis of sex) as section 809 and moving such section so that it follows section 808;

(2) in sections 835, 836, 838, 840, and 842, by striking the term ''this subpart'' each place it appears and inserting ''this part'';

(3) in section 836(h), by striking the last sentence;

(4) in section 836, by redesignating subsection (l) as subsection (k);

(5) in section 839, by striking ''839'' and all that follows through ''(a)'' and inserting ''839. (a)'';

(6) in section 835(b), by striking ''841'' each place it appears and inserting ''871'';

(7) by redesignating section 841 as section 871, moving part F to the end of the title, and redesignating such part as part I;

(8) in part G—

(A) by redesignating section 845 as section 851; and

(B) by redesignating part G as part F;

(9) in part H—

(A) by redesignating sections 851 and 852 as sections 861 and 862, respectively; and

(B) by redesignating part H as part G; and

(10) in part I—

(A) by redesignating section 855, as amended by section 4305, as section 865; and

(B) by redesignating part I as part H.

SEC. 4311. NURSE FACULTY LOAN PROGRAM.

(a) IN GENERAL.—Section 846A of the Public Health Service Act (42 U.S.C. 297n–1) is amended—

(1) in subsection (a)—

(A) in the subsection heading, by striking ''ESTABLISHMENT'' and inserting ''SCHOOL OF NURSING STUDENT LOAN FUND''; and

(B) by inserting ''accredited'' after ''agreement with any'';

(2) in subsection (c)—

(A) in paragraph (2), by striking ''$30,000'' and all that follows through the semicolon and inserting ''$35,500, during fiscal years 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan;''; and

(B) in paragraph (3)(A), by inserting ''an accredited'' after ''faculty member in'';

(3) in subsection (e), by striking ''a school'' and inserting ''an accredited school''; and

(4) in subsection (f), by striking ''2003 through 2007'' and inserting ''2010 through 2014''.

(b) ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.—Title VIII of the Public Health Service Act is amended by inserting after section 846A (42 U.S.C. 297n–1) the following:

''SEC. 847. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing faculty.

''(b) AGREEMENTS.—Each agreement entered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a total period, in the aggregate, of at least 4 years during the 6-year period beginning on the later of—

''(1) the date on which the individual receives a master's or doctorate nursing degree from an accredited school of nursing; or

''(2) the date on which the individual enters into an agreement under this subsection.

''(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

''(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on, any loan of that individual obtained to pay for such degree;

''(2) for an individual who has completed a master's in nursing or equivalent degree in nursing—

''(A) payments may not exceed $10,000 per calendar year; and

''(B) total payments may not exceed $40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan); and

''(3) for an individual who has completed a doctorate or equivalent degree in nursing—

''(A) payments may not exceed $20,000 per calendar year; and

''(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (adjusted for subsequent fiscal years as provided for in the same manner as in paragraph (2)(B)).

''(d) BREACH OF AGREEMENT.—

''(1) IN GENERAL.—In the case of any agreement made under subsection (b), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under such subsection.

''(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of liability under such paragraph if compliance by the individual with the agreement involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be unconscionable.

''(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

''(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

''(e) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible individual' means an individual who—

''(1) is a United States citizen, national, or lawful permanent resident;

''(2) holds an unencumbered license as a registered nurse; and

''(3) has either already completed a master's or doctorate nursing program at an accredited school of nursing or is currently enrolled on a full-time or part-time basis in such a program.

''(f) PRIORITY.—For the purposes of this section and section 846A, funding priority will be awarded to School of Nursing Student Loans that support doctoral nursing students or Individual Student Loan Repayment that support doctoral nursing students.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 4312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 4310, is amended to read as follows:

''SEC. 871. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are

authorized to be appropriated $338,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2016.''.

SEC. 4313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUTCOMES.

''(a) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.

''(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

''(1) to educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;

''(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;

''(3) to identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

''(4) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

''(c) APPLICATION.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

''(1) propose to target geographic areas—

''(A) with a high percentage of residents who suffer from chronic diseases; or

''(B) with a high infant mortality rate;

''(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) have documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

''(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

''(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

''(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

''(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

''(k) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker', as defined by the Department of Labor as Standard Occupational Classification [21–1094] means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and healthcare agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with healthcare providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health;

''(F) by providing referral and follow-up services or otherwise coordinating care; and

''(G) by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs.

''(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant in the program under this section resides.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means a public or nonprofit private entity (including a State or public subdivision of a State, a public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act)), or a consortium of any such entities.

''(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community identified by a State—

''(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

''(B) a significant portion of which is a health professional shortage area as designated under section 332.''.

SEC. 4314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 4206, is further amended by adding at the end the following:

''SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

''(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce shortages in State and local health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

''(b) SPECIFIC USES.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention in a manner that is designed to alleviate shortages of the type described in subsection (a).

''(c) OTHER PROGRAMS.—The Secretary may provide for the expansion of other applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

''(d) WORK OBLIGATION.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of satisfying work obligations stipulated in contracts under section 338I(j).

''(e) GENERAL SUPPORT.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $39,500,000 for each of fiscal years 2010 through 2013, of which—

''(1) $5,000,000 shall be made available in each such fiscal year for epidemiology fellowship training program activities under subsections (b) and (c);

''(2) $5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b);

''(3) $5,000,000 shall be made available in each such fiscal year for the Public Health Informatics Fellowship Program under subsection (e); and

''(4) $24,500,000 shall be made available for expanding the Epidemic Intelligence Service under subsection (a).''.

SEC. 4315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

''PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

''SEC. 271. ESTABLISHMENT.

''(a) UNITED STATES PUBLIC HEALTH SERVICES TRACK.—

''(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this part as the 'Track'), at sites to be selected by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, public health, epidemiology, and emergency preparedness and response. It shall be so organized as to graduate not less than—

''(A) 150 medical students annually, 10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences;

''(B) 100 dental students annually;

''(C) 250 nursing students annually;

''(D) 100 public health students annually;

''(E) 100 behavioral and mental health professional students annually;

''(F) 100 physician assistant or nurse practitioner students annually; and

''(G) 50 pharmacy students annually.

''(2) LOCATIONS.—The Track shall be located at existing and accredited, affiliated health professions education training programs at academic health centers located in regions of the United States determined appropriate by the Surgeon General, in consultation with the National Health Care Workforce Commission established in section 4101 of the Patient Protection and Affordable Care Act.

''(b) NUMBER OF GRADUATES.—Except as provided in subsection (a), the number of persons to be graduated from the Track shall

be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of first-year enrollments in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

''(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe subject to the requirements of subsection (a).

''(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient-centered, interdisciplinary, and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

''(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care, to balance urban, tertiary, and inpatient venues.

''SEC. 272. ADMINISTRATION.

''(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services. The National Health Care Workforce Commission shall assist the Surgeon General in an advisory capacity.

''(b) FACULTY.—

''(1) IN GENERAL.—The Surgeon General, after considering the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so as to place the employees of the Track faculty on a comparable basis with the employees of fully accredited schools of the health professions within the United States.

''(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

''(3) NONAPPLICATION OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

''(c) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may negotiate affiliation agreements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for payments for educational services provided students participating in Department of Health and Human Services educational programs.

''(d) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

''(1) Postdoctoral, postgraduate, and technological programs.

''(2) A cooperative program for medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students.

''(3) Other programs that the Surgeon General determines necessary in order to operate the Track in a cost-effective manner.

''(e) CONTINUING MEDICAL EDUCATION.—The Surgeon General shall establish programs in continuing medical education for members of the health professions to the end that high standards of health care may be maintained within the United States.

''(f) AUTHORITY OF THE SURGEON GENERAL.—

''(1) IN GENERAL.—The Surgeon General is authorized—

''(A) to enter into contracts with, accept grants from, and make grants to any nonprofit entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing research, consultation, and education;

''(B) to enter into contracts with entities under which the Surgeon General may furnish the services of such professional, technical, or clerical personnel as may be necessary to fulfill cooperative enterprises undertaken by the Track;

''(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track, including any gift, devise, or bequest for the support of an academic chair, teaching, research, or demonstration project;

''(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

''(E) to accept the voluntary services of guest scholars and other persons.

''(2) LIMITATION.—The Surgeon General may not enter into any contract with an entity if the contract would obligate the Track to make outlays in advance of the enactment of budget authority for such outlays.

''(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Track under an agreement described in paragraph (1) may be appointed to any position within the Track and may be permitted to perform such duties within the Track as the Surgeon General may approve.

''(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee of the Federal Government for the purposes of chapter 171 of title 28, relating to tort claims. Such a person who is not otherwise employed by the Federal Government shall not be considered to be a Federal employee for any other purpose by reason of the provision of such services.

''SEC. 273. STUDENTS; SELECTION; OBLIGATION.

''(a) STUDENT SELECTION.—

''(1) IN GENERAL.—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures prescribed by the Surgeon General. In so prescribing, the Surgeon General shall consider the recommendations of the National Health Care Workforce Commission.

''(2) PRIORITY.—In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minorities.

''(b) CONTRACT AND SERVICE OBLIGATION.—

''(1) CONTRACT.—Upon being admitted to the Track, a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student shall enter into a written contract with the Surgeon General that shall contain—

''(A) an agreement under which—

''(i) subject to subparagraph (B), the Surgeon General agrees to provide the student with tuition (or tuition remission) and a student stipend (described in paragraph (2)) in each school year for a period of years (not to exceed 4 school years) determined by the student, during which period the student is enrolled in the Track at an affiliated or other participating health professions institution pursuant to an agreement between the Track and such institution; and

''(ii) subject to subparagraph (B), the student agrees—

''(I) to accept the provision of such tuition and student stipend to the student;

''(II) to maintain enrollment at the Track until the student completes the course of study involved;

''(III) while enrolled in such course of study, to maintain an acceptable level of academic standing (as determined by the Surgeon General);

''(IV) if pursuing a degree from a school of medicine or osteopathic medicine, dental, public health, or nursing school or a physician assistant, pharmacy, or behavioral and mental health professional program, to complete a residency or internship in a specialty that the Surgeon General determines is appropriate; and

''(V) to serve for a period of time (referred to in this part as the 'period of obligated service') within the Commissioned Corps of the Public Health Service equal to 2 years for each school year during which such individual was enrolled at the College, reduced as provided for in paragraph (3);

''(B) a provision that any financial obligation of the United States arising out of a contract entered into under this part and any obligation of the student which is conditioned thereon, is contingent upon funds being appropriated to carry out this part;

''(C) a statement of the damages to which the United States is entitled for the student's breach of the contract; and

''(D) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this part.

''(2) TUITION AND STUDENT STIPEND.—

''(A) TUITION REMISSION RATES.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept as payment in full the established remission rate under this subparagraph.

''(B) STIPEND.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish and update Federal stipend rates for payment to students under this part.

''(3) REDUCTIONS IN THE PERIOD OF OBLIGATED SERVICE.—The period of obligated service under paragraph (1)(A)(ii)(V) shall be reduced—

''(A) in the case of a student who elects to participate in a high-needs speciality residency (as determined by the National Health Care Workforce Commission), by 3 months for each year of such participation (not to exceed a total of 12 months); and

''(B) in the case of a student who, upon completion of their residency, elects to practice in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for year of full-time practice in such a facility (not to exceed a total of 12 months).

''(c) SECOND 2 YEARS OF SERVICE.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student is enrolled in the Track, training should be designed to prioritize clinical rotations in Federal medical facilities in health professional shortage areas, and emphasize a balance of hospital and community-based experiences, and training within interdisciplinary teams.

''(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST, BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL, PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAINING.—The Surgeon General shall establish provisions applicable with respect to dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students that are comparable to those for medical students under this section, including service obligations, tuition support, and stipend support. The Surgeon General shall give priority to health professions training institutions that train medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students for some significant period of time together, but at a minimum have a discrete and shared core curriculum.

''(e) ELITE FEDERAL DISASTER TEAMS.—The Surgeon General, in consultation with the Secretary, the Director of the Centers for Disease Control and Prevention, and other appropriate military and Federal government agencies, shall develop criteria for the appointment of highly qualified Track faculty, medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students, and graduates to elite Federal disaster preparedness teams to train and to respond to public health emergencies, natural disasters, bioterrorism events, and other emergencies.

''(f) STUDENT DROPPED FROM TRACK IN AFFILIATE SCHOOL.—A medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, or nursing student who, under regulations prescribed by the Surgeon General, is dropped from the Track in an affiliated school for deficiency in conduct or studies, or for other reasons, shall be liable to the United States for all tuition and stipend support provided to the student.

''SEC. 274. FUNDING.

''Beginning with fiscal year 2010, the Secretary shall transfer from the Public Health and Social Services Emergency Fund such sums as may be necessary to carry out this part.''.

Subtitle E—Supporting the Existing Health Care Workforce

SEC. 4401. CENTERS OF EXCELLENCE.

Section 736 of the Public Health Service Act (42 U.S.C. 293) is amended by striking subsection (h) and inserting the following:

''(h) FORMULA FOR ALLOCATIONS.—

''(1) ALLOCATIONS.—Based on the amount appropriated under subsection (i) for a fiscal year, the following subparagraphs shall apply as appropriate:

''(A) IN GENERAL.—If the amounts appropriated under subsection (i) for a fiscal year are $24,000,000 or less—

''(i) the Secretary shall make available $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

''(ii) and available after grants are made with funds under clause (i), the Secretary shall make available—

''(I) 60 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

''(II) 40 percent of such amount for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

''(B) FUNDING IN EXCESS OF $24,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $24,000,000 but are less than $30,000,000—

''(i) 80 percent of such excess amounts shall be made available for grants under subsection (a) to health professions schools that meet the requirements described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e)); and

''(ii) 20 percent of such excess amount shall be made available for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

''(C) FUNDING IN EXCESS OF $30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

''(i) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

''(ii) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

''(iii) not less than $6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

''(iv) after grants are made with funds under clauses (i) through (iii), any remaining excess amount for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

''(D) FUNDING IN EXCESS OF $40,000,000.—If amounts appropriated under subsection (i) for a fiscal year are $40,000,000 or more, the Secretary shall make available—

''(i) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A);

''(ii) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting conditions pursuant to subsection (e));

''(iii) not less than $8,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

''(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

''(2) NO LIMITATION.—Nothing in this subsection shall be construed as limiting the centers of excellence referred to in this section to the designated amount, or to preclude such entities from competing for grants under this section.

''(3) MAINTENANCE OF EFFORT.—

''(A) IN GENERAL.—With respect to activities for which a grant made under this part are authorized to be expended, the Secretary may not make such a grant to a center of excellence for any fiscal year unless the center agrees to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the center for the fiscal year preceding the fiscal year for which the school receives such a grant.

''(B) USE OF FEDERAL FUNDS.—With respect to any Federal amounts received by a center of excellence and available for carrying out activities for which a grant under this part is authorized to be expended, the center shall, before expending the grant, expend the Federal amounts obtained from sources other than the grant, unless given prior approval from the Secretary.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) $50,000,000 for each of the fiscal years 2010 through 2015; and

''(2) and such sums as are necessary for each subsequent fiscal year.''.

SEC. 4402. HEALTH CARE PROFESSIONALS TRAINING FOR DIVERSITY.

(a) LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 738(a)(1) of the Public Health Service Act (42 U.S.C. 293b(a)(1)) is amended by striking ''$20,000 of the principal and interest of the educational loans of such individuals.'' and inserting ''$30,000 of the principal and interest of the educational loans of such individuals.''.

(b) SCHOLARSHIPS FOR DISADVANTAGED STUDENTS.—Section 740(a) of such Act (42 U.S.C. 293d(a)) is amended by striking ''$37,000,000'' and all that follows through ''2002'' and inserting ''$51,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2014''.

(c) REAUTHORIZATION FOR LOAN REPAYMENTS AND FELLOWSHIPS REGARDING FACULTY POSITIONS.—Section 740(b) of such Act (42 U.S.C. 293d(b)) is amended by striking ''appropriated'' and all that follows through the period at the end and inserting ''appropriated, $5,000,000 for each of the fiscal years 2010 through 2014.''.

(d) REAUTHORIZATION FOR EDUCATIONAL ASSISTANCE IN THE HEALTH PROFESSIONS REGARDING INDIVIDUALS FROM A DISADVANTAGED BACKGROUND.—Section 740(c) of such Act (42 U.S.C. 293d(c)) is amended by striking the first sentence and inserting the following: ''For the purpose of grants and contracts under section 739(a)(1), there is authorized to be appropriated $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.''

SEC. 4403. INTERDISCIPLINARY, COMMUNITY-BASED LINKAGES.

(a) AREA HEALTH EDUCATION CENTERS.—Section 751 of the Public Health Service Act (42 U.S.C. 294a) is amended to read as follows:

''SEC. 751. AREA HEALTH EDUCATION CENTERS.

''(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:

''(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the award is made by planning, developing, operating, and evaluating an area health education center program.

''(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to

changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program. For the purposes of this section, the term 'Program' refers to the area health education center program.

''(b) ELIGIBLE ENTITIES; APPLICATION.—

''(1) ELIGIBLE ENTITIES.—

''(A) INFRASTRUCTURE DEVELOPMENT.—For purposes of subsection (a)(1), the term 'eligible entity' means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school. With respect to a State in which no area health education center program is in operation, the Secretary may award a grant or contract under subsection (a)(1) to a school of nursing.

''(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term 'eligible entity' means an entity that has received funds under this section, is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible to receive financial assistance under subsection (a)(1).

''(2) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—

''(1) REQUIRED ACTIVITIES.—An eligible entity shall use amounts awarded under a grant under subsection (a)(1) or (a)(2) to carry out the following activities:

''(A) Develop and implement strategies, in coordination with the applicable one-stop delivery system under section 134(c) of the Workforce Investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural backgrounds into health professions, and support such individuals in attaining such careers.

''(B) Develop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality care, with an emphasis on primary care, in underserved areas or for health disparity populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, and local workforce investment boards, and in health care safety net sites.

''(C) Prepare individuals to more effectively provide health services to underserved areas and health disparity populations through field placements or preceptorships in conjunction with community-based organizations, accredited primary care residency training programs, Federally qualified health centers, rural health clinics, public health departments, or other appropriate facilities.

''(D) Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists, optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.

''(E) Deliver or facilitate continuing education and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.

''(F) Propose and implement effective program and outcomes measurement and evaluation strategies.

''(G) Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.

''(2) INNOVATIVE OPPORTUNITIES.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

''(A) Develop and implement innovative curricula in collaboration with community-based accredited primary care residency training programs, Federally qualified health centers, rural health clinics, behavioral and mental health facilities, public health departments, or other appropriate facilities, with the goal of increasing the number of primary care physicians and other primary care providers prepared to serve in underserved areas and health disparity populations.

''(B) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.

''(C) Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

''(d) REQUIREMENTS.—

''(1) AREA HEALTH EDUCATION CENTER PROGRAM.—In carrying out this section, the Secretary shall ensure the following:

''(A) An entity that receives an award under this section shall conduct at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching facility of the contracting institution for grantees that operate a school of medicine or osteopathic medicine. In States in which an entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

''(i) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the school; and

''(ii) the entity receiving the award maintains a written agreement with a school of medicine or osteopathic medicine to place students from that school in training sites in the area health education center program area.

''(B) An entity receiving funds under subsection (a)(2) does not distribute such funding to a center that is eligible to receive funding under subsection (a)(1).

''(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that each area health education center program includes at least 1 area health education center, and that each such center—

''(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

''(B) is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine or its parent institution, or a consortium of such entities;

''(C) designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;

''(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

''(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

''(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

''(G) has a community-based governing or advisory board that reflects the diversity of the communities involved.

''(e) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance under this section, an entity shall make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs. At least 25 percent of the total required non-Federal contributions shall be in cash. An entity may apply to the Secretary for a waiver of not more than 75 percent of the matching fund amount required by the entity for each of the first 3 years the entity is funded through a grant under subsection (a)(1).

''(f) LIMITATION.—Not less than 75 percent of the total amount provided to an area health education center program under subsection (a)(1) or (a)(2) shall be allocated to the area health education centers participating in the program under this section. To provide needed flexibility to newly funded area health education center programs, the Secretary may waive the requirement in the sentence for the first 2 years of a new area health education center program funded under subsection (a)(1).

''(g) AWARD.—An award to an entity under this section shall be not less than $250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence, the Secretary may reduce the per center amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

''(h) PROJECT TERMS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an award under subsection (a)(1) may not exceed—

''(A) in the case of a program, 12 years; or

''(B) in the case of a center within a program, 6 years.

''(2) EXCEPTION.—The periods described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

''(i) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 791(a) shall not apply to an area health education center funded under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There is authorized to be appropriated to carry out this section $125,000,000 for each of the fiscal years 2010 through 2014.

''(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

''(A) not more than 35 percent shall be used for awards under subsection (a)(1);

''(B) not less than 60 percent shall be used for awards under subsection (a)(2);

''(C) not more than 1 percent shall be used for grants and contracts to implement outcomes evaluation for the area health education centers; and

''(D) not more than 4 percent shall be used for grants and contracts to provide technical assistance to entities receiving awards under this section.

''(3) CARRYOVER FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

''(k) SENSE OF CONGRESS.—It is the sense of the Congress that every State have an area health education center program in effect under this section.''.

(b) CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by striking section 752 and inserting the following:

''SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.

''(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, eligible entities to improve health care, increase retention, increase representation of minority faculty members, enhance the practice environment, and provide information dissemination and educational support to reduce professional isolation through the timely dissemination of research findings using relevant resources.

''(b) ELIGIBLE ENTITIES.—For purposes of this section, the term 'eligible entity' means an entity described in section 799(b).

''(c) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and telelearning activities, with priority for primary care.

''(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $5,000,000 for each of the fiscal years 2010 through 2014, and such sums as may be necessary for each subsequent fiscal year.''.

SEC. 4404. WORKFORCE DIVERSITY GRANTS.

Section 821 of the Public Health Service Act (42 U.S.C. 296m) is amended—

(1) in subsection (a)—

(A) by striking ''The Secretary may'' and inserting the following:

''(1) AUTHORITY.—The Secretary may'';

(B) by striking ''pre-entry preparation, and retention activities'' and inserting the following: ''stipends for diploma or associate degree nurses to enter a bridge or degree completion program, student scholarships or stipends for accelerated nursing degree programs, pre-entry preparation, advanced education preparation, and retention activities''; and

(2) in subsection (b)—

(A) by striking ''First'' and all that follows through ''including the'' and inserting ''National Advisory Council on Nurse Education and Practice and consult with nursing associations including the National Coalition of Ethnic Minority Nurse Associations,''; and

(B) by inserting before the period the following: '', and other organizations determined appropriate by the Secretary''.

SEC. 4405. PRIMARY CARE EXTENSION PROGRAM.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by section 4313, is further amended by adding at the end the following:

''SEC. 399W. PRIMARY CARE EXTENSION PROGRAM.

''(a) ESTABLISHMENT, PURPOSE AND DEFINITION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

''(2) PURPOSE.—The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors (referred to in this section as 'Health Extension Agents').

''(3) DEFINITIONS.—In this section:

''(A) HEALTH EXTENSION AGENT.—The term 'Health Extension Agent' means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

''(B) PRIMARY CARE PROVIDER.—The term 'primary care provider' means a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

''(b) GRANTS TO ESTABLISH STATE HUBS AND LOCAL PRIMARY CARE EXTENSION AGENCIES.—

''(1) GRANTS.—The Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as 'Hubs').

''(2) COMPOSITION OF HUBS.—A Hub established by a State pursuant to paragraph (1)—

''(A) shall consist of, at a minimum, the State health department and the departments of 1 or more health professions schools in the State that train providers in primary care; and

''(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 1153 of the Social Security Act, consumer groups, and other appropriate entities.

''(c) STATE AND LOCAL ACTIVITIES.—

''(1) HUB ACTIVITIES.—Hubs established under a grant under subsection (b) shall—

''(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

''(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

''(C) organize and administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and

''(D) organize State-wide or multistate networks of local-level Primary Care Extension Agencies to share and disseminate information and practices.

''(2) LOCAL PRIMARY CARE EXTENSION AGENCY ACTIVITIES.—

''(A) REQUIRED ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) shall—

''(i) assist primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services, including health homes;

''(ii) develop and support primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assess implementation of practice improvement, share best practices, and involve community clinicians in the generation of new knowledge and identification of important questions for research;

''(iii) participate in a national network of Primary Care Extension Hubs and propose how the Primary Care Extension Agency will share and disseminate lessons learned and best practices; and

''(iv) develop a plan for financial sustainability involving State, local, and private contributions, to provide for the reduction in Federal funds that is expected after an initial 6-year period of program establishment, infrastructure development, and planning.

''(B) DISCRETIONARY ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) may—

''(i) provide technical assistance, training, and organizational support for community health teams established under section 2002 of the Patient Protection and Affordable Care Act;

''(ii) collect data and provision of primary care provider feedback from standardized measurements of processes and outcomes to aid in continuous performance improvement;

''(iii) collaborate with local health departments, community health centers, tribes and tribal entities, and other community agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address the social and primary determinants of health, strengthen the local primary care workforce, and eliminate health disparities;

''(iv) develop measures to monitor the impact of the proposed program on the health of practice enrollees and of the wider community served; and

''(v) participate in other activities, as determined appropriate by the Secretary.

''(d) FEDERAL PROGRAM ADMINISTRATION.—

''(1) GRANTS; TYPES.—Grants awarded under subsection (b) shall be—

''(A) program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

''(B) planning grants, that are awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

''(2) APPLICATIONS.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(3) EVALUATION.—A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by an evaluation panel appointed by the Secretary.

''(4) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluations with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

''(5) LIMITATION.—A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

''(e) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities, as the Secretary determines appropriate.

''(f) AUTHORIZATION OF APPROPRIATIONS.—To awards grants as provided in subsection (d), there are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2014.''.

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

SEC. 4501. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS; EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end the following:

''SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

''(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

''(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

''(2) REQUIREMENTS.—

''(A) AID AND SUPPORTIVE SERVICES.—

''(i) IN GENERAL.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial aid, child care, case management, and other supportive services.

''(ii) TREATMENT.—Any aid, services, or incentives provided to an eligible beneficiary participating in a demonstration project under this section shall not be considered income, and shall not be taken into account for purposes of determining the individual's eligibility for, or amount of, benefits under any means-tested program.

''(B) CONSULTATION AND COORDINATION.—An eligible entity applying for a grant to carry out a demonstration project under this section shall demonstrate in the application that the entity has consulted with the State agency responsible for administering the State TANF program, the local workforce investment board in the area in which the project is to be conducted (unless the applicant is such board), the State workforce investment board established under section 111 of the Workforce Investment Act of 1998, and the State Apprenticeship Agency recognized under the Act of August 16, 1937 (commonly known as the 'National Apprenticeship Act') (or if no agency has been recognized in the State, the Office of Apprenticeship of the Department of Labor) and that the project will be carried out in coordination with such entities.

''(C) ASSURANCE OF OPPORTUNITIES FOR INDIAN POPULATIONS.—The Secretary shall award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

''(3) REPORTS AND EVALUATION.—

''(A) ELIGIBLE ENTITIES.—An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities carried out under the project and a final report on such activities upon the conclusion of the entities' participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

''(B) EVALUATION.—The Secretary shall, by grant, contract, or interagency agreement, evaluate the demonstration projects conducted under this subsection. Such evaluation shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development, and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce's needs.

''(C) REPORT TO CONGRESS.—The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

''(4) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE ENTITY.—The term 'eligible entity' means a State, an Indian tribe or tribal organization, an institution of higher education, a local workforce investment board established under section 117 of the Workforce Investment Act of 1998, a sponsor of an apprenticeship program registered under the National Apprenticeship Act or a community-based organization.

''(B) ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'eligible individual' means a individual receiving assistance under the State TANF program.

''(ii) OTHER LOW-INCOME INDIVIDUALS.—Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

''(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

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

''(E) STATE.—The term 'State' means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

''(F) STATE TANF PROGRAM.—The term 'State TANF program' means the temporary assistance for needy families program funded under part A of title IV.

''(G) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

''(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

''(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

''(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

''(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

''(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

''(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

''(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

''(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

''(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

''(iv) Personal care skills.

''(v) Health care support.

''(vi) Nutritional support.

''(vii) Infection control.

''(viii) Safety and emergency training.

''(ix) Training specific to an individual consumer's needs (including older individuals, younger individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

''(x) Self-Care.

''(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

''(i) The length of the training.

''(ii) The appropriate trainer to student ratio.

''(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

''(iv) Trainer qualifications.

''(v) Content for a 'hands-on' and written certification exam.

''(vi) Continuing education requirements.

''(4) APPLICATION AND SELECTION CRITERIA.—

''(A) IN GENERAL.—

''(i) NUMBER OF STATES.—The Secretary shall enter into agreements with not more than 6 States to conduct demonstration projects under this subsection.

''(ii) REQUIREMENTS FOR STATES.—An agreement entered into under clause (i) shall require that a participating State—

''(I) implement the core training competencies described in paragraph (3)(A); and

''(II) develop written materials and protocols for such core training competencies, including the development of a certification test for personal or home care aides who have completed such training competencies.

''(iii) CONSULTATION AND COLLABORATION WITH COMMUNITY AND VOCATIONAL COLLEGES.—The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

''(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

''(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

''(ii) meet the selection criteria established under subparagraph (C); and

''(iii) meet such additional criteria as the Secretary may specify.

''(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

''(i) geographic and demographic diversity;

''(ii) that the existing training standards for personal or home care aides in each participating State—

''(I) are different from such standards in the other participating States; and

''(II) are different from the core training competencies described in paragraph (3)(A);

''(iii) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

''(iv) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

''(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

''(5) EVALUATION AND REPORT.—

''(A) EVALUATION.—The Secretary shall develop an experimental or control group testing protocol in consultation with an independent evaluation contractor selected by the Secretary. Such contractor shall evaluate—

''(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

''(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

''(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so, what minimum number of hours should be required.

''(B) REPORTS.—

''(i) REPORT ON INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(ii) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(6) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term 'eligible health and long-term care provider' means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(o)), or any other health care provider the Secretary determines appropriate which—

''(i) is licensed or authorized to provide services in a participating State; and

''(ii) receives payment for services under a State health security program.

''(B) PERSONAL OR HOME CARE AIDE.—The term 'personal or home care aide' means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

''(C) STATE.—The term 'State' has the meaning given that term for purposes of title XIX.

''(c) FUNDING.—

''(1) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), $85,000,000 for each of fiscal years 2010 through 2014.

''(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL AND HOME CARE AIDES.—With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such projects. No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.

''(d) NONAPPLICATION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grant awarded under this section.

''(2) LIMITATIONS ON USE OF GRANTS.—Section 2005(a) (other than paragraph (6)) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to payments to States under this title.''.

(b) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is amended by striking ''fiscal year 2009'' and inserting ''each of fiscal years 2009 through 2012''.

SEC. 4502. INCREASING TEACHING CAPACITY.

(a) TEACHING HEALTH CENTERS TRAINING AND ENHANCEMENT.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et. seq.), as amended by section 4303, is further amended by inserting after section 749 the following:

''SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.

''(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

''(b) AMOUNT AND DURATION.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $500,000.

''(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to cover the costs of—

''(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

''(A) curriculum development;

''(B) recruitment, training and retention of residents and faculty:

''(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

''(D) faculty salaries during the development phase; and

''(2) technical assistance provided by an eligible entity.

''(d) APPLICATION.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(e) PREFERENCE FOR CERTAIN APPLICATIONS.—In selecting recipients for grants under this section, the Secretary shall give preference to any such application that documents an existing affiliation agreement with an area health education center program as defined in sections 751 and 799B.

''(f) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means an organization capable of providing technical assistance including an area health education center program as defined in sections 751 and 799B.

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' means an approved graduate medical residency training program (as defined in section 340H) in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

''(3) TEACHING HEALTH CENTER.—

''(A) IN GENERAL.—The term 'teaching health center' means an entity that—

''(i) is a community based, ambulatory patient care center; and

''(ii) operates a primary care residency program.

''(B) INCLUSION OF CERTAIN ENTITIES.—Such term includes the following:

''(i) A Federally qualified health center (as defined in section 1905(l)(2)(B), of the Social Security Act).

''(ii) A community mental health center (as defined in section 1861(ff)(3)(B) of the Social Security Act).

''(iii) A rural health clinic, as defined in section 1861(aa) of the Social Security Act.

''(iv) A health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

''(v) An entity receiving funds under title X of the Public Health Service Act.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.''.

(b) NATIONAL HEALTH SERVICE CORPS TEACHING CAPACITY.—Section 338C(a) of the Public Health Service Act (42 U.S.C. 254m(a)) is amended to read as follows:

''(a) SERVICE IN FULL-TIME CLINICAL PRACTICE.—Except as provided in section 338D, each individual who has entered into a written contract with the Secretary under section 338A or 338B shall provide service in the full-time clinical practice of such individual's profession as a member of the Corps for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.''.

(c) PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

''Subpart XX—Support of Graduate Medical Education in Qualified Teaching Health Centers

''SEC. 340A. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

''(a) PAYMENTS.—Subject to subsection (h)(2), the Secretary shall make payments under this section for direct expenses and for indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing or establishment of new approved graduate medical residency training programs.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the amounts payable under this section to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following amounts:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with sponsoring approved graduate medical residency training programs.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents in such programs.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to qualified teaching health centers under paragraph (1)(A) or paragraph (1)(B) in a fiscal year shall not exceed the amount of funds appropriated under subsection (g) for such payments for that fiscal year.

''(B) LIMITATION.—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments as determined under subsection (c) and (d) do not exceed the total amount of funds appropriated in a fiscal year under subsection (g).

''(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate expenses relating to approved graduate medical residency training programs for a fiscal year is equal to the product of—

''(A) the updated national per resident amount for direct graduate medical education, as determined under paragraph (2); and

''(B) the average number of full-time equivalent residents in the teaching health center's graduate approved medical residency training programs as determined under section 1886(h)(4) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

''(2) UPDATED NATIONAL PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.—The updated per resident amount for direct graduate medical education for a qualified teaching health center for a fiscal year is an amount determined as follows:

''(A) DETERMINATION OF QUALIFIED TEACHING HEALTH CENTER PER RESIDENT AMOUNT.—The Secretary shall compute for each individual qualified teaching health center a per resident amount—

''(i) by dividing the national average per resident amount computed under section 340E(c)(2)(D) into a wage-related portion and a non-wage related portion by applying the proportion determined under subparagraph (B);

''(ii) by multiplying the wage-related portion by the factor applied under section 1886(d)(3)(E) of the Social Security Act (but without application of section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note)) during the preceding fiscal year for the teaching health center's area; and

''(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

''(B) UPDATING RATE.—The Secretary shall update such per resident amount for each such qualified teaching health center as determined appropriate by the Secretary.

''(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

''(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for indirect expenses associated with the additional costs of teaching residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

''(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

''(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching health centers; and

''(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g).

''(3) INTERIM PAYMENT.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under paragraph (1), the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

''(e) CLARIFICATION REGARDING RELATIONSHIP TO OTHER PAYMENTS FOR GRADUATE MEDICAL EDUCATION.—Payments under this section—

''(1) shall be in addition to any payments—

''(A) for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act;

''(B) for direct graduate medical education costs under section 1886(h) of such Act; and

''(C) for direct costs of medical education under section 1886(k) of such Act;

''(2) shall not be taken into account in applying the limitation on the number of total full-time equivalent residents under subparagraphs (F) and (G) of section 1886(h)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such Act for the portion of time that a resident rotates to a hospital; and

''(3) shall not include the time in which a resident is counted toward full-time equivalency by a hospital under paragraph (2) or under section 1886(d)(5)(B)(iv) of the Social Security Act, section 1886(h)(4)(E) of such Act, or section 340E of this Act.

''(f) RECONCILIATION.—The Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section.

''(g) FUNDING.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed $230,000,000, for the period of fiscal years 2011 through 2015.

''(h) ANNUAL REPORTING REQUIRED.—

''(1) ANNUAL REPORT.—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information for the residency academic year completed immediately prior to such fiscal year:

''(A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents.

''(B) The number of approved training positions for residents described in paragraph (4).

''(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year and care for vulnerable populations living in underserved areas.

''(D) Other information as deemed appropriate by the Secretary.

''(2) AUDIT AUTHORITY; LIMITATION ON PAYMENT.—

''(A) AUDIT AUTHORITY.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1).

''(B) LIMITATION ON PAYMENT.—A teaching health center may only receive payment in a cost reporting period for a number of such resident positions that is greater than the base level of primary care resident positions, as determined by the Secretary. For purposes of this subparagraph, the 'base level of primary care residents' for a teaching health center is the level of such residents as of a base period.

''(3) REDUCTION IN PAYMENT FOR FAILURE TO REPORT.—

''(A) IN GENERAL.—The amount payable under this section to a qualified teaching health center for a fiscal year shall be reduced by at least 25 percent if the Secretary determines that—

''(i) the qualified teaching health center has failed to provide the Secretary, as an addendum to the qualified teaching health center's application under this section for such

fiscal year, the report required under paragraph (1) for the previous fiscal year; or

''(ii) such report fails to provide complete and accurate information required under any subparagraph of such paragraph.

''(B) NOTICE AND OPPORTUNITY TO PROVIDE ACCURATE AND MISSING INFORMATION.—Before imposing a reduction under subparagraph (A) on the basis of a qualified teaching health center's failure to provide complete and accurate information described in subparagraph (A)(ii), the Secretary shall provide notice to the teaching health center of such failure and the Secretary's intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information.

''(4) RESIDENTS.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center in any approved graduate medical residency training program.

''(i) REGULATIONS.—The Secretary shall promulgate regulations to carry out this section.

''(j) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' means a residency or other postgraduate medical training program—

''(A) participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary; and

''(B) that meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the American Dental Association).

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' has the meaning given that term in section 749A.

''(3) QUALIFIED TEACHING HEALTH CENTER.—The term 'qualified teaching health center' has the meaning given the term 'teaching health center' in section 749A.''.

SEC. 4503. GRADUATE NURSE EDUCATION DEMONSTRATION.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish a graduate nurse education demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive payment for the hospital's reasonable costs (described in paragraph (2)) for the provision of qualified clinical training to advance practice nurses.

(B) NUMBER.—The demonstration shall include up to 5 eligible hospitals.

(C) WRITTEN AGREEMENTS.—Eligible hospitals selected to participate in the demonstration shall enter into written agreements pursuant to subsection (b) in order to reimburse the eligible partners of the hospital the share of the costs attributable to each partner.

(2) COSTS DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph are the reasonable costs (as described in section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v))) of each eligible hospital for the clinical training costs (as determined by the Secretary) that are attributable to providing advanced practice registered nurses with qualified training.

(B) LIMITATION.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice registered nurses enrolled in a program that provides qualified training during the year and for which the hospital is being reimbursed under the demonstration, as compared to the average number of advanced practice registered nurses who graduated in each year during the period beginning on January 1, 2006, and ending on December 31, 2010 (as determined by the Secretary) from the graduate nursing education program operated by the applicable school of nursing that is an eligible partner of the hospital for purposes of the demonstration.

(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

(4) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this section.

(b) WRITTEN AGREEMENTS WITH ELIGIBLE PARTNERS.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum—

(1) the obligations of the eligible partners with respect to the provision of qualified training; and

(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to partner.

(c) EVALUATION.—Not later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following:

(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration.

(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1).

(3) Other items the Secretary determines appropriate and relevant.

(d) FUNDING.—

(1) IN GENERAL.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration.

(2) PRORATION.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in order to ensure that the aggregate payments do not exceed such amount.

(3) WITHOUT FISCAL YEAR LIMITATION.—Amounts appropriated under this subsection shall remain available without fiscal year limitation.

(e) DEFINITIONS.—In this section:

(1) ADVANCED PRACTICE REGISTERED NURSE.—The term ''advanced practice registered nurse'' includes the following:

(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term ''applicable non-hospital community-based care setting'' means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term ''applicable school of nursing'' means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection (b)) with the eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term ''demonstration'' means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term ''eligible hospital'' means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term ''eligible partners'' includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(7) QUALIFIED TRAINING.—

(A) IN GENERAL.—The term ''qualified training'' means training—

(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title; and

(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural or medically underserved areas.

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

Subtitle G—Improving Access to Health Care Services

SEC. 4601. SPENDING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS).

(a) IN GENERAL.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by striking paragraph (1) and inserting the following:

''(1) GENERAL AMOUNTS FOR GRANTS.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there is authorized to be appropriated the following:

''(A) For fiscal year 2010, $2,988,821,592.

''(B) For fiscal year 2011, $3,862,107,440.

''(C) For fiscal year 2012, $4,990,553,440.

''(D) For fiscal year 2013, $6,448,713,307.

''(E) For fiscal year 2014, $7,332,924,155.

''(F) For fiscal year 2015, $8,332,924,155.

''(G) For fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

''(i) one plus the average percentage increase in costs incurred per patient served; and

''(ii) one plus the average percentage increase in the total number of patients served.''.

(b) RULE OF CONSTRUCTION.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by adding at the end the following:

''(4) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

''(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a Federally certified rural health clinic (as defined in section 1861(aa)(2) of the Social Security Act), a low-volume hospital (as defined for purposes of section 1886 of such Act), a critical access hospital, or a sole community hospital (as defined for purposes of section 1886(d)(5)(D)(iii) of such Act) for the delivery of primary health care services that are available at the clinic or hospital to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that clinic or hospitals.

''(B) ASSURANCES.—In order for a clinic or hospital to receive funds under this section through a contract with a community health center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

''(i) nondiscrimination based on the ability of a patient to pay; and

''(ii) the establishment of a sliding fee scale for low-income patients.''.

SEC. 4602. NEGOTIATED RULEMAKING FOR DEVELOPMENT OF METHODOLOGY AND CRITERIA FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish, through a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e).

(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), State health offices, community organizations, health centers and other affected entities, and other interested parties; and

(B) shall take into account—

(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

(ii) the impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;

(iii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

(iv) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

(b) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(c) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subsection (b), and for purposes of this subsection, the ''target date for publication'', as referred to in section 564(a)(5) of title 5, United Sates Code, shall be July 1, 2010.

(d) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee under section 565(a) of title 5, United States Code, by not later than 30 days after the end of the comment period provided for under section 564(c) of such title; and

(2) the nomination of a facilitator under section 566(c) of such title 5 by not later than 10 days after the date of appointment of the committee.

(e) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary may provide.

(f) FINAL COMMITTEE REPORT.—If the committee is not terminated under subsection (e), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(g) INTERIM FINAL EFFECT.—The Secretary shall publish a rule under this section in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 90 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications for such designations pursuant to such rules and consistent with this section.

(h) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

SEC. 4603. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is amended—

(1) in subsection (a), by striking ''3-year period (with an optional 4th year'' and inserting ''4-year period (with an optional 5th year''; and

(2) in subsection (d)—

(A) by striking ''and such sums'' and inserting ''such sums''; and

(B) by inserting before the period the following: '', $25,000,000 for fiscal year 2010, $26,250,000 for fiscal year 2011, $27,562,500 for fiscal year 2012, $28,940,625 for fiscal year 2013, and $30,387,656 for fiscal year 2014''.

SEC. 4604. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by adding at the end the following:

''SEC. 520K. AWARDS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means a qualified community mental health program defined under section 1913(b)(1).

''(2) SPECIAL POPULATIONS.—The term 'special populations' means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

''(b) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

''(c) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require, including a description of partnerships, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

''(A) the provision, by qualified primary care professionals, of on site primary care services;

''(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordinators of care or, if permitted by the terms of the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;

''(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

''(D) facility modifications needed to bring primary and specialty care professionals on site at the eligible entity.

''(2) LIMITATION.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

''(e) EVALUATION.—Not later than 90 days after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.''.

SEC. 4605. KEY NATIONAL INDICATORS.

(a) DEFINITIONS.—In this section:

(1) ACADEMY.—The term ''Academy'' means the National Academy of Sciences.

(2) COMMISSION.—The term ''Commission'' means the Commission on Key National Indicators established under subsection (b).

(3) INSTITUTE.—The term ''Institute'' means a Key National Indicators Institute as designated under subsection (c)(3).

(b) COMMISSION ON KEY NATIONAL INDICATORS.—

(1) ESTABLISHMENT.—There is established a ''Commission on Key National Indicators''.

(2) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The Commission shall be composed of 8 members, to

be appointed equally by the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.

(C) QUALIFICATIONS.—In making appointments under subparagraph (A), the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.

(D) PERIOD OF APPOINTMENT.—Each member of the Commission shall be appointed for a 2-year term, except that 1 initial appointment shall be for 3 years. Any vacancies shall not affect the power and duties of the Commission but shall be filled in the same manner as the original appointment and shall last only for the remainder of that term.

(E) DATE.—Members of the Commission shall be appointed by not later than 30 days after the date of enactment of this Act.

(F) INITIAL ORGANIZING PERIOD.—Not later than 60 days after the date of enactment of this Act, the Commission shall develop and implement a schedule for completion of the review and reports required under subsection (d).

(G) CO-CHAIRPERSONS.—The Commission shall select 2 Co-Chairpersons from among its members.

(c) DUTIES OF THE COMMISSION.—

(1) IN GENERAL.—The Commission shall—

(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;

(B) make recommendations on how to improve the key national indicators system;

(C) coordinate with Federal Government users and information providers to assure access to relevant and quality data; and

(D) enter into contracts with the Academy.

(2) REPORTS.—

(A) ANNUAL REPORT TO CONGRESS.—Not later than 1 year after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the appropriate Committees of Congress and the President a report that contains a detailed statement of the recommendations, findings, and conclusions of the Commission on the activities of the Academy and a designated Institute related to the establishment of a Key National Indicator System.

(B) ANNUAL REPORT TO THE ACADEMY.—

(i) IN GENERAL.—Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and each subsequent year thereafter, the Commission shall prepare and submit to the Academy and a designated Institute a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators.

(ii) LIMITATION.—The Commission shall not have the authority to direct the Academy or, if established, the Institute, to adopt, modify, or delete any key indicators.

(3) CONTRACT WITH THE NATIONAL ACADEMY OF SCIENCES.—

(A) IN GENERAL.—As soon as practicable after the selection of the 2 Co-Chairpersons of the Commission, the Co-Chairpersons shall enter into an arrangement with the National Academy of Sciences under which the Academy shall—

(i) review available public and private sector research on the selection of a set of key national indicators;

(ii) determine how best to establish a key national indicator system for the United States, by either creating its own institutional capability or designating an independent private nonprofit organization as an Institute to implement a key national indicator system;

(iii) if the Academy designates an independent Institute under clause (ii), provide scientific and technical advice to the Institute and create an appropriate governance mechanism that balances Academy involvement and the independence of the Institute; and

(iv) provide an annual report to the Commission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute's budget and operations.

(B) PARTICIPATION.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and evolving a Key National Indicator System and, if an Institute is established, to provide it with scientific and technical advice.

(C) ESTABLISHMENT OF A KEY NATIONAL INDICATOR SYSTEM.—

(i) IN GENERAL.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall enable the establishment of a key national indicator system by—

(I) creating its own institutional capability; or

(II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(ii) INSTITUTE.—If the Academy designates an Institute under clause (i)(II), such Institute shall be a non-profit entity (as defined for purposes of section 501(c)(3) of the Internal Revenue Code of 1986) with an educational mission, a governance structure that emphasizes independence, and characteristics that make such entity appropriate for establishing a key national indicator system.

(iii) RESPONSIBILITIES.—Either the Academy or the Institute designated under clause (i)(II) shall be responsible for the following:

(I) Identifying and selecting issue areas to be represented by the key national indicators.

(II) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(III) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent processes and the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is established, Institute activities.

(VII) Reporting annually to the Commission regarding its selection of issue areas, key indicators, data, and progress toward establishing a web-accessible database.

(VIII) Responding directly to the Commission in response to any Commission recommendations and to the Academy regarding any inquiries by the Academy.

(iv) GOVERNANCE.—Upon the establishment of a key national indicator system, the Academy shall create an appropriate governance mechanism that incorporates advisory and control functions. If an Institute is designated under clause (i)(II), the governance mechanism shall balance appropriate Academy involvement and the independence of the Institute.

(v) MODIFICATION AND CHANGES.—The Academy shall retain the sole discretion, at any time, to alter its approach to the establishment of a key national indicator system or, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit entity to serve as the Institute.

(vi) CONSTRUCTION.—Nothing in this section shall be construed to limit the ability of the Academy or the Institute designated under clause (i)(II) to receive private funding for activities related to the establishment of a key national indicator system.

(D) ANNUAL REPORT.—As part of the arrangement under subparagraph (A), the National Academy of Sciences shall, not later than 270 days after the date of enactment of this Act, and annually thereafter, submit to the Co-Chairpersons of the Commission a report that contains the findings and recommendations of the Academy.

(d) GOVERNMENT ACCOUNTABILITY OFFICE STUDY AND REPORT.—

(1) GAO STUDY.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(2) GAO FINANCIAL AUDIT.—If an Institute is established under this section, the Comptroller General shall conduct an annual audit of the financial statements of the Institute, in accordance with generally accepted government auditing standards and submit a report on such audit to the Commission and the appropriate authorizing committees of Congress.

(3) GAO PROGRAMMATIC REVIEW.—The Comptroller General of the United States shall conduct programmatic assessments of the Institute established under this section as determined necessary by the Comptroller General and report the findings to the Commission and to the appropriate authorizing committees of Congress.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out the purposes of this section, $10,000,000 for fiscal year 2010, and $7,500,000 for each of fiscal year 2011 through 2018.

(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.

Subtitle H—General Provisions

SEC. 4701. REPORTS.

(a) REPORTS BY SECRETARY OF HEALTH AND HUMAN SERVICES.—On an annual basis, the Secretary of Health and Human Services shall submit to the appropriate Committees of Congress a report on the activities carried out under the amendments made by this title, and the effectiveness of such activities.

(b) REPORTS BY RECIPIENTS OF FUNDS.—The Secretary of Health and Human Services may require, as a condition of receiving funds under the amendments made by this title, that the entity receiving such award submit to such Secretary such reports as the such Secretary may require on activities carried out with such award, and the effectiveness of such activities.

TITLE V—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A—Physician Ownership and Other Transparency

SEC. 5001. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

''(a) TRANSPARENCY REPORTS.—

''(1) PAYMENTS OR OTHER TRANSFERS OF VALUE.—

''(A) IN GENERAL.—On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

''(i) The name of the covered recipient.

''(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

''(iii) The amount of the payment or other transfer of value.

''(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

''(v) A description of the form of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

''(I) cash or a cash equivalent;

''(II) in-kind items or services;

''(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

''(IV) any other form of payment or other transfer of value (as defined by the Secretary).

''(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

''(I) consulting fees;

''(II) compensation for services other than consulting;

''(III) honoraria;

''(IV) gift;

''(V) entertainment;

''(VI) food;

''(VII) travel (including the specified destinations);

''(VIII) education;

''(IX) research;

''(X) charitable contribution;

''(XI) royalty or license;

''(XII) current or prospective ownership or investment interest;

''(XIII) direct compensation for serving as faculty or as a speaker for a medical education program;

''(XIV) grant; or

''(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).

''(vii) If the payment or other transfer of value is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.

''(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.

''(B) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

''(2) PHYSICIAN OWNERSHIP.—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer or applicable group purchasing organization during the preceding year:

''(A) The dollar amount invested by each physician holding such an ownership or investment interest.

''(B) The value and terms of each such ownership or investment interest.

''(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, 'physician' shall be substituted for 'covered recipient' each place it appears.

''(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

''(b) PENALTIES FOR NONCOMPLIANCE.—

''(1) FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

''(2) KNOWING FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

''(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

''(c) PROCEDURES FOR SUBMISSION OF INFORMATION AND PUBLIC AVAILABILITY.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—Not later than October 1, 2011, the Secretary shall establish procedures—

''(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

''(ii) for the Secretary to make such information submitted available to the public.

''(B) DEFINITION OF TERMS.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

''(C) PUBLIC AVAILABILITY.—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

''(i) is searchable and is in a format that is clear and understandable;

''(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(iii) contains information that is able to be easily aggregated and downloaded;

''(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

''(v) contains background information on industry-physician relationships;

''(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

''(vii) contains any other information the Secretary determines would be helpful to the average consumer;

''(viii) does not contain the National Provider Identifier of the covered recipient, and

''(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public.

''(D) CLARIFICATION OF TIME PERIOD FOR REVIEW AND CORRECTIONS.—In no case may the 45-day period for review and submission of corrections to information under subparagraph (C)(ix) prevent such information from being made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

''(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

''(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical investigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

''(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

''(II) Four calendar years after the date such payment or other transfer of value was made.

''(ii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

''(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

''(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

''(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

''(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).

''(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

''(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

''(3) RELATION TO STATE LAWS.—

''(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value.

''(B) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

''(i) not of the type required to be disclosed or reported under this section;

''(ii) described in subsection (e)(10)(B), except in the case of information described in clause (i) of such subsection;

''(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

''(iv) to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

''(C) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

''(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

''(e) DEFINITIONS.—In this section:

''(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(2) APPLICABLE MANUFACTURER.—The term 'applicable manufacturer' means a manufacturer of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(3) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving 1 or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

''(4) COVERED DEVICE.—The term 'covered device' means any device for which payment is available under a State health security program.

''(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered drug, device, biological, or medical supply' means any drug, biological product, device, or medical supply for which payment is available under a State health security program.

''(6) COVERED RECIPIENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered recipient' means the following:

''(i) A physician.

''(ii) A teaching hospital.

''(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

''(7) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

''(8) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

''(9) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'manufacturer of a covered drug, device, biological, or medical supply' means any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

''(10) PAYMENT OR OTHER TRANSFER OF VALUE.—

''(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

''(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

''(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

''(ii) Product samples that are not intended to be sold and are intended for patient use.

''(iii) Educational materials that directly benefit patients or are intended for patient use.

''(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

''(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

''(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

''(vii) Discounts (including rebates).

''(viii) In-kind items used for the provision of charity care.

''(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

''(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

''(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for

the non-medical professional services of such licensed non-medical professional.

''(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

''(11) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r).''.

SEC. 5002. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 5001, is amended by inserting after section 1128G the following new section:

''SEC. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

''(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

''(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(b) DEFINITIONS.—In this section:

''(1) APPLICABLE DRUG.—The term 'applicable drug' means a drug—

''(A) which is subject to subsection (b) of such section 503; and

''(B) for which payment is available under a State health security program.

''(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term 'authorized distributor of record' has the meaning given that term in subsection (e)(3)(A) of such section.

''(3) MANUFACTURER.—The term 'manufacturer' has the meaning given that term for purposes of subsection (d) of such section.''.

Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 5101. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

''(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

''(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

''(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 5101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

''(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

''(2) INFORMATION DESCRIBED.—

''(A) IN GENERAL.—The following information is described in this paragraph:

''(i) The information described in subsections (a) and (b), subject to subparagraph (C).

''(ii) The identity of and information on—

''(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

''(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

''(III) each person or entity who is an additional disclosable party of the facility.

''(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

''(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

''(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

''(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

''(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

''(3) REPORTING.—

''(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under a State health security program, that the information reported by the facility in accordance with such final regulations is, to the best of the facility's knowledge, accurate and current.

''(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

''(4) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

''(5) DEFINITIONS.—In this subsection:

''(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

''(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

''(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

''(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

''(B) FACILITY.—The term 'facility' means a disclosing entity which is—

''(i) a skilled nursing facility (as defined in section 1819(a)); or

''(ii) a nursing facility (as defined in section 1919(a)).

''(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

''(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

''(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

''(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

''(iii) a general partnership, the partners of the general partnership;

''(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

''(v) a trust, the trustees of the trust;

''(vi) an individual, contact information for the individual; and

''(vii) any other person or entity, such information as the Secretary determines appropriate.''.

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the Secretary of Health and Human Services

shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—

(A) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(B) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

SEC. 5102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 5001 and 5002, is amended by inserting after section 1128H the following new section:

"SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES.

''(a) DEFINITION OF FACILITY.—In this section, the term 'facility' means—

''(1) a skilled nursing facility (as defined in section 1819(a)); or

''(2) a nursing facility (as defined in section 1919(a)).

''(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

''(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under paragraph (2).

''(2) DEVELOPMENT OF REGULATIONS.—

''(A) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regulations for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(B) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program shall, in the case of an organization that operates 5 or more facilities, vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

''(C) EVALUATION.—Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(3) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subsection, the term 'compliance and ethics program' means, with respect to a facility, a program of the operating organization that—

''(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(B) includes at least the required components specified in paragraph (4).

''(4) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

''(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

''(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(c) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

''(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection.''.

SEC. 5104. STANDARDIZED COMPLAINT FORM.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(f) STANDARDIZED COMPLAINT FORM.—

''(1) DEVELOPMENT BY THE SECRETARY.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

''(2) COMPLAINT FORMS AND RESOLUTION PROCESSES.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

''(i) a resident of a facility; and

''(ii) any person acting on the resident's behalf.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 5105. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(g) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other

verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(2) include resident census data and information on resident case mix;

''(3) include a regular reporting schedule; and

''(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

PART II—TARGETING ENFORCEMENT

SEC. 5111. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

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

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

''(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

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

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

''(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

''(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

''(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

''(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

''(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

''(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—Section 1919(h)(5)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 5112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the demonstration project under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the demonstration project under this section for a 2-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this section not later than 1 year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the demonstration project under this section based on criteria selected by the Secretary, including where evidence suggests that a number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities participating in the ''Special

Focus Facility'' program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

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

(g) DEFINITIONS.—In this section:

(1) ADDITIONAL DISCLOSABLE PARTY.—The term ''additional disclosable party'' has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added by section 4201(a).

(2) FACILITY.—The term ''facility'' means a skilled nursing facility or a nursing facility.

(3) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(h) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall evaluate the demonstration project conducted under this section.

(2) REPORT.—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

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

SEC. 5113. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(h) NOTIFICATION OF FACILITY CLOSURE.—

''(1) IN GENERAL.—Any individual who is the administrator of a facility must—

''(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

''(ii) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the date that the Secretary determines appropriate;

''(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

''(2) RELOCATION.—

''(A) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(B) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

''(3) SANCTIONS.—Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

''(A) shall be subject to a civil monetary penalty of up to $100,000;

''(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

''(C) shall be subject to any other penalties that may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(b) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(1) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to section 1128I(h), shall terminate''; and

(2) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''subsection (c)(2) and section 1128I(h)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 5114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(c) DURATION AND IMPLEMENTATION.—

(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) DEFINITIONS.—In this section:

(1) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

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

(3) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

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

(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 5121. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the

case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

SEC. 5201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program remain valid for a period of time specified by the Secretary.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

(A) CONVICTION FOR A RELEVANT CRIME.—The term ''conviction for a relevant crime'' means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) DISQUALIFYING INFORMATION.—The term ''disqualifying information'' means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ''finding of patient or resident abuse'' means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) DIRECT PATIENT ACCESS EMPLOYEE.—The term ''direct patient access employee'' means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under a State health security program:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—

(i) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle D—Patient-Centered Outcomes Research

SEC. 5301. PATIENT-CENTERED OUTCOMES RESEARCH.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

''PART D—COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

''SEC. 1181. (a) DEFINITIONS.—In this section:

''(1) BOARD.—The term 'Board' means the Board of Governors established under subsection (f).

''(2) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH; RESEARCH.—

''(A) IN GENERAL.—The terms 'comparative clinical effectiveness research' and 'research' mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

''(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

''(3) CONFLICT OF INTEREST.—The term 'conflict of interest' means an association, including a financial or personal association, that have the potential to bias or have the appearance of biasing an individual's decisions in matters related to the Institute or the conduct of activities under this section.

''(4) REAL CONFLICT OF INTEREST.—The term 'real conflict of interest' means any instance where a member of the Board, the methodology committee established under subsection (d)(6), or an advisory panel appointed under subsection (d)(4), or a close relative of such member, has received or could receive either of the following:

''(A) A direct financial benefit of any amount deriving from the result or findings of a study conducted under this section.

''(B) A financial benefit from individuals or companies that own or manufacture medical treatments, services, or items to be studied under this section that in the aggregate exceeds $10,000 per year. For purposes of the preceding sentence, a financial benefit includes honoraria, fees, stock, or other financial benefit and the current value of the member or close relative's already existing stock holdings, in addition to any direct financial benefit deriving from the results or findings of a study conducted under this section.

''(b) PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

''(1) ESTABLISHMENT.—There is authorized to be established a nonprofit corporation, to be known as the 'Patient-Centered Outcomes Research Institute' (referred to in this section as the 'Institute') which is neither an agency nor establishment of the United States Government.

''(2) APPLICATION OF PROVISIONS.—The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

''(c) PURPOSE.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

''(d) DUTIES.—

''(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA.—

''(A) IDENTIFYING RESEARCH PRIORITIES.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

''(B) ESTABLISHING RESEARCH PROJECT AGENDA.—The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

''(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

''(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (1)(B) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

''(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

''(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

''(iii) Any other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

''(B) CONTRACTS FOR THE MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

''(i) CONTRACTS.—

''(I) IN GENERAL.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with the following:

''(aa) Appropriate agencies and instrumentalities of the Federal Government.

''(bb) Appropriate academic research, private sector research, or study-conducting entities.

''(II) PREFERENCE.—In entering into contracts under subclause (I), the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

''(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

''(I) abide by the transparency and conflicts of interest requirements under subsection (h) that apply to the Institute with respect to the research managed or conducted under such contract;

''(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

''(III) consult with the expert advisory panels for clinical trials and rare disease appointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

''(IV) subject to clause (iv), permit a researcher who conducts original research under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication;

''(V) have appropriate processes in place to manage data privacy and meet ethical standards for the research;

''(VI) comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

''(VII) comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

''(iii) COVERAGE OF COPAYMENTS OR COINSURANCE.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

''(iv) REQUIREMENTS FOR PUBLICATION OF RESEARCH.—Any research published under clause (ii)(IV) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph. If the Institute determines that those requirements are not met, the Institute shall not enter into another contract with the agency, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not less than 5 years).

''(C) REVIEW AND UPDATE OF EVIDENCE.—The Institute shall review and update evidence on a periodic basis as appropriate.

''(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular subtypes, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

''(E) DIFFERENCES IN TREATMENT MODALITIES.—Research shall be designed, as appropriate, to take into account different characteristics of treatment modalities that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

''(3) DATA COLLECTION.—

''(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services, as well as provide access to the data networks, as the Institute and its contractors may require to carry out this section. The Institute may also request and obtain data from Federal, State, or private entities, including data from clinical databases and registries.

''(B) USE OF DATA.—The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

''(4) APPOINTING EXPERT ADVISORY PANELS.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

''(ii) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

''(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE.—In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

''(B) COMPOSITION.—An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

''(5) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

''(6) ESTABLISHING METHODOLOGY COMMITTEE.—

''(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

''(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall be experts in their scientific field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

''(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research by, not later than 18 months after the establishment of the Institute, directly or through subcontract, developing and periodically updating the following:

''(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to

the design of research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

''(ii) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific research question.

''(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—The methodology committee may consult and contract with the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise to carry out activities described in subparagraph (C) and may consult with relevant stakeholders to carry out such activities.

''(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee's performance of the functions described in subparagraph (C). Reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

''(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

''(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

''(i) evidence from such primary research shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

''(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

''(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

''(C) USE OF EXISTING PROCESSES.—

''(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

''(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

''(8) RELEASE OF RESEARCH FINDINGS.—

''(A) IN GENERAL.—The Institute shall, not later than 90 days after the conduct or receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

''(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

''(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

''(iii) include limitations of the research and what further research may be needed as appropriate;

''(iv) not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations; and

''(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

''(B) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term 'research findings' means the results of a study or assessment.

''(9) ADOPTION.—Subject to subsection (h)(1), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i), and any peer-review process provided under paragraph (7) by majority vote. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

''(10) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

''(A) a description of the activities conducted under this section, research priorities identified under paragraph (1)(A) and methodological standards developed and updated by the methodology committee under paragraph (6)(C)(i) that are adopted under paragraph (9) during the preceding year;

''(B) the research project agenda and budget of the Institute for the following year;

''(C) any administrative activities conducted by the Institute during the preceding year;

''(D) the names of individuals contributing to any peer-review process under paragraph (7), without identifying them with a particular research project; and

''(E) any other relevant information (including information on the membership of the Board, expert advisory panels, methodology committee, and the executive staff of the Institute, any conflicts of interest with respect to these individuals, and any bylaws adopted by the Board during the preceding year).

''(e) ADMINISTRATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

''(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(9) are nondelegable.

''(f) BOARD OF GOVERNORS.—

''(1) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of the following members:

''(A) The Director of Agency for Healthcare Research and Quality (or the Director's designee).

''(B) The Director of the National Institutes of Health (or the Director's designee).

''(C) Fourteen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

''(i) 3 members representing patients and health care consumers.

''(ii) 5 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

''(iii) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

''(iv) 1 member representing quality improvement or independent health service researchers.

''(v) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

''(2) QUALIFICATIONS.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest in accordance with subsection (h)(4)(B). Members of the Board shall be recused from relevant Institute activities in the case where the member (or an immediate family member of such member) has a real conflict of interest directly related to the research project or the matter that could affect or be affected by such participation.

''(3) TERMS; VACANCIES.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered evenly over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made.

''(4) CHAIRPERSON AND VICE-CHAIRPERSON.—The Comptroller General of the United States shall designate a Chairperson and Vice Chairperson of the Board from among the members of the Board. Such members shall serve as Chairperson or Vice Chairperson for a period of 3 years.

''(5) COMPENSATION.—Each member of the Board who is not an officer or employee of the Federal Government shall be entitled to compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing the duties of the Board. An officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.

''(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

''(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

''(g) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

''(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

''(2) REVIEW AND ANNUAL REPORTS.—

''(A) REVIEW.—The Comptroller General of the United States shall review the following:

''(i) Not less frequently than on an annual basis, the financial audits conducted under paragraph (1).

''(ii) Not less frequently than every 5 years, the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

''(B) ANNUAL REPORTS.—Not later than April 1 of each year, the Comptroller General of the United States shall submit to Congress a report containing the results of the review conducted under subparagraph (A) with respect to the preceding year (or years, if applicable), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

''(h) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

''(1) PUBLIC COMMENT PERIODS.—The Institute shall provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption under subsection (d)(9) of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed and updated by the methodology committee under subsection (d)(6)(C)(i), and the peer-review process provided under paragraph (7), and after the release of draft findings with respect to systematic reviews of existing research and evidence.

''(2) ADDITIONAL FORUMS.—The Institute shall support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate.

''(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute the following:

''(A) Information contained in research findings as specified in subsection (d)(9).

''(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducing such research and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research protocols, including measures taken, methods of research and analysis, research results, and such other information the Institute determines appropriate) concurrent with the release of research findings.

''(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

''(D) Subsequent comments received during each of the public comment periods.

''(E) In accordance with applicable laws and processes and as the Institute determines appropriate, proceedings of the Institute.

''(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

''(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

''(i) By the Institute in appointing members to an expert advisory panel under subsection (d)(4), in selecting individuals to contribute to any peer-review process under subsection (d)(7), and for employment as executive staff of the Institute.

''(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

''(iii) By the Institute in the annual report under subsection (d)(10), except that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

''(B) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subparagraph (A) as soon as practicable on the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists.

''(i) RULES.—The Institute, its Board or staff, shall be prohibited from accepting gifts, bequeaths, or donations of services or property. In addition, the Institute shall be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

Subtitle F—Elder Justice Act

SEC. 5401. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Elder Justice Act of 2009''.

SEC. 5402. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 5503(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 5403. ELDER JUSTICE.

(a) ELDER JUSTICE.—

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting ''**AND ELDER JUSTICE**'' after ''**SOCIAL SERVICES**'';

(B) by inserting before section 2001 the following:

''Subtitle A—Block Grants to States for Social Services'';

and

(C) by adding at the end the following:

''Subtitle B—Elder Justice

''SEC. 2011. DEFINITIONS.

''In this subtitle:

''(1) ABUSE.—The term 'abuse' means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

''(2) ADULT PROTECTIVE SERVICES.—The term 'adult protective services' means such services provided to adults as the Secretary may specify and includes services such as—

''(A) receiving reports of adult abuse, neglect, or exploitation;

''(B) investigating the reports described in subparagraph (A);

''(C) case planning, monitoring, evaluation, and other case work and services; and

''(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

''(3) CAREGIVER.—The term 'caregiver' means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

''(4) DIRECT CARE.—The term 'direct care' means care by an employee or contractor who provides assistance or long-term care services to a recipient.

''(5) ELDER.—The term 'elder' means an individual age 60 or older.

''(6) ELDER JUSTICE.—The term 'elder justice' means—

''(A) from a societal perspective, efforts to—

''(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

''(ii) protect elders with diminished capacity while maximizing their autonomy; and

''(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

''(7) ELIGIBLE ENTITY.—The term 'eligible entity' means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

''(8) EXPLOITATION.—The term 'exploitation' means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

''(9) FIDUCIARY.—The term 'fiduciary'—

''(A) means a person or entity with the legal responsibility—

''(i) to make decisions on behalf of and for the benefit of another person; and

''(ii) to act in good faith and with fairness; and

''(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

''(10) GRANT.—The term 'grant' includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

''(11) GUARDIANSHIP.—The term 'guardianship' means—

''(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

''(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

''(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

''(12) INDIAN TRIBE.—

''(A) IN GENERAL.—The term 'Indian tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

''(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term 'Indian tribe' includes any Pueblo or Rancheria.

''(13) LAW ENFORCEMENT.—The term 'law enforcement' means the full range of potential responders to elder abuse, neglect, and exploitation including—

''(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

''(B) prosecutors;

''(C) medical examiners;

''(D) investigators; and

''(E) coroners.

''(14) LONG-TERM CARE.—

''(A) IN GENERAL.—The term 'long-term care' means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

''(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term 'loss of capacity for self-care' means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one's financial affairs, and other activities the Secretary determines appropriate.

''(15) LONG-TERM CARE FACILITY.—The term 'long-term care facility' means a residential care provider that arranges for, or directly provides, long-term care.

''(16) NEGLECT.—The term 'neglect' means—

''(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

''(B) self-neglect.

''(17) NURSING FACILITY.—

''(A) IN GENERAL.—The term 'nursing facility' has the meaning given such term under section 1919(a).

''(B) INCLUSION OF SKILLED NURSING FACILITY.—The term 'nursing facility' includes a skilled nursing facility (as defined in section 1819(a)).

''(18) SELF-NEGLECT.—The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

''(A) obtaining essential food, clothing, shelter, and medical care;

''(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

''(C) managing one's own financial affairs.

''(19) SERIOUS BODILY INJURY.—

''(A) IN GENERAL.—The term 'serious bodily injury' means an injury—

''(i) involving extreme physical pain;

''(ii) involving substantial risk of death;

''(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

''(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

''(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

''(20) SOCIAL.—The term 'social', when used with respect to a service, includes adult protective services.

''(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term 'State legal assistance developer' means an individual described in section 731 of the Older Americans Act of 1965.

''(22) STATE LONG-TERM CARE OMBUDSMAN.—The term 'State Long-Term Care Ombudsman' means the State Long-Term Care Ombudsman described in section 712(a)(2) of the Older Americans Act of 1965.

''SEC. 2012. GENERAL PROVISIONS.

''(a) PROTECTION OF PRIVACY.—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

''(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice—

''(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

''(2) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or

''(3) may be unambiguously deduced from the elder's life history.

''PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

''Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

''SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.

''(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the 'Council').

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The Council shall be composed of the following members:

''(A) The Secretary (or the Secretary's designee).

''(B) The Attorney General (or the Attorney General's designee).

''(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

''(2) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

''(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

''(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

''(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

''(f) DUTIES.—

''(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

''(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

''(A) describes the activities and accomplishments of, and challenges faced by—

''(i) the Council; and

''(ii) the entities represented on the Council; and

''(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

''(g) POWERS OF THE COUNCIL.—

''(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

''(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

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

''SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

''(a) ESTABLISHMENT.—There is established a board to be known as the 'Advisory Board on Elder Abuse, Neglect, and Exploitation' (in this section referred to as the 'Advisory Board') to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

''(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

''(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

''(d) TERMS.—

''(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

''(A) 9 shall be appointed for a term of 3 years;

''(B) 9 shall be appointed for a term of 2 years; and

''(C) 9 shall be appointed for a term of 1 year.

''(2) VACANCIES.—

''(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

''(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

''(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

''(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

''(f) DUTIES.—

''(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT,

AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

''(2) COLLABORATIVE EFFORTS TO DEVELOP CONSENSUS AROUND THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

''(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

''(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

''(3) REPORT.—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

''(A) information on the status of Federal, State, and local public and private elder justice activities;

''(B) recommendations (including recommended priorities) regarding—

''(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

''(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

''(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

''(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

''(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

''(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

''(g) POWERS OF THE ADVISORY BOARD.—

''(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

''(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act, any data, reports, or recommendations generated in connection with such activities.

''(3) POSTAL SERVICES.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT ADVISORY COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

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

''SEC. 2023. RESEARCH PROTECTIONS.

''(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

''(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term 'legally authorized representative' means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

''SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this subpart—

''(1) for fiscal year 2011, $6,500,000; and

''(2) for each of fiscal years 2012 through 2014, $7,000,000.

''Subpart B—Elder Abuse, Neglect, and Exploitation Forensic Centers

''SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

''(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

''(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

''(c) MOBILE CENTERS.—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

''(d) AUTHORIZED ACTIVITIES.—

''(1) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that receives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

''(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

''(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

''(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

''(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

''(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $4,000,000;

''(2) for fiscal year 2012, $6,000,000; and

''(3) for each of fiscal years 2013 and 2014, $8,000,000.

''PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

''SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

''(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

''(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individuals to train for, seek, and maintain employment providing direct care in long-term care.

''(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

''(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

''(B) CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

''(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

''(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing direct care; and

''(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

''(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to

the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

''(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

''(3) SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.—

''(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

''(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

''(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

''(ii) the establishment of motivational and thoughtful work organization practices;

''(iii) the creation of a workplace culture that respects and values caregivers and their needs;

''(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

''(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

''(C) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

''(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this paragraph.

''(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

''(5) DEFINITIONS.—In this subsection:

''(A) COMMUNITY-BASED LONG-TERM CARE.—The term 'community-based long-term care' has the meaning given such term by the Secretary.

''(B) ELIGIBLE ENTITY.—The term 'eligible entity' means the following:

''(i) A long-term care facility.

''(ii) A community-based long-term care entity (as defined by the Secretary).

''(b) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.—

''(1) GRANTS AUTHORIZED.—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR technology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(2) USE OF GRANT FUNDS.—Funds provided under grants under this subsection may be used for any of the following:

''(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

''(B) Making improvements to existing computer software and hardware.

''(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

''(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

''(3) APPLICATION.—

''(A) IN GENERAL.—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

''(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

''(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(c) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.—

''(1) STANDARDS AND COMPATIBILITY.—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

''(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

''(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

''(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

''(3) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $20,000,000;

''(2) for fiscal year 2012, $17,500,000; and

''(3) for each of fiscal years 2013 and 2014, $15,000,000.

''SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

''(a) SECRETARIAL RESPONSIBILITIES.—

''(1) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services—

''(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

''(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

''(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

''(D) conducts research related to the provision of adult protective services; and

''(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $3,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 through 2014.

''(b) GRANTS TO ENHANCE THE PROVISION OF ADULT PROTECTIVE SERVICES.—

''(1) ESTABLISHMENT.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

''(B) GUARANTEED MINIMUM PAYMENT AMOUNT.—

''(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

''(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to '0.75' were a reference to '0.1'.

''(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

''(3) AUTHORIZED ACTIVITIES.—

''(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

''(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

''(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds

expended to provide adult protective services in the State.

''(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

''(c) STATE DEMONSTRATION PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

''(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be used by States and local units of government to conduct demonstration programs that test—

''(A) training modules developed for the purpose of detecting or preventing elder abuse;

''(B) methods to detect or prevent financial exploitation of elders;

''(C) methods to detect elder abuse;

''(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

''(E) other matters relating to the detection or prevention of elder abuse.

''(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $25,000,000 for each of fiscal years 2011 through 2014.

''SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

''(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—

''(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

''(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

''(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

''(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

''(A) for fiscal year 2011, $5,000,000;

''(B) for fiscal year 2012, $7,500,000; and

''(C) for each of fiscal years 2013 and 2014, $10,000,000.

''(b) OMBUDSMAN TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.

''SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

''(a) PROVISION OF INFORMATION.—To be eligible to receive a grant under this part, an applicant shall agree—

''(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the eligible entity may require in order to conduct such evaluation; or

''(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

''(b) USE OF ELIGIBLE ENTITIES TO CONDUCT EVALUATIONS.—

''(1) EVALUATIONS REQUIRED.—Except as provided in paragraph (2), the Secretary shall—

''(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

''(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

''(2) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

''(3) AUTHORIZED ACTIVITIES.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

''(4) APPLICATIONS.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

''(5) REPORTS.—Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

''(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

''(1) EVALUATIONS.—The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 2041(b). Such evaluation shall include an evaluation of whether the funding provided under the grant is expended only for the purposes for which it is made.

''(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

''SEC. 2045. REPORT.

''Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

''(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

''(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

''SEC. 2046. RULE OF CONSTRUCTION.

''Nothing in this subtitle shall be construed as—

''(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

''(2) creating a private cause of action for a violation of this subtitle.''.

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

''(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

''(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

''(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel,

and, if so, shall include an overview of such assistance.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(b) PROTECTING RESIDENTS OF LONG-TERM CARE FACILITIES.—

(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under a State health security program.

(B) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Federal and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a

week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395r).

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 5005, is amended by inserting after section 1150A the following new section:

''REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

''SEC. 1150B. (a) DETERMINATION AND NOTIFICATION.—

''(1) DETERMINATION.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine whether the facility received at least $10,000 in such Federal funds during the preceding year.

''(2) NOTIFICATION.—If the owner or operator determines under paragraph (1) that the facility received at least $10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

''(3) COVERED INDIVIDUAL DEFINED.—In this section, the term 'covered individual' means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

''(b) REPORTING REQUIREMENTS.—

''(1) IN GENERAL.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

''(2) TIMING.—If the events that cause the suspicion—

''(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

''(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

''(c) PENALTIES.—

''(1) IN GENERAL.—If a covered individual violates subsection (b)—

''(A) the covered individual shall be subject to a civil money penalty of not more than $200,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(2) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

''(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(3) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

''(4) EXTENUATING CIRCUMSTANCES.—

''(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

''(B) UNDERSERVED POPULATION DEFINED.—In this paragraph, the term 'underserved population' means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

''(i) areas or groups that are geographically isolated (such as isolated in a rural area);

''(ii) racial and ethnic minority populations; and

''(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

''(d) ADDITIONAL PENALTIES FOR RETALIATION.—

''(1) IN GENERAL.—A long-term care facility may not—

''(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

''(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

''(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

''(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

''(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(f) DEFINITIONS.—In this section, the terms 'elder justice', 'long-term care facility', and 'law enforcement' have the meanings given those terms in section 2011.''.

(c) NATIONAL NURSE AIDE REGISTRY.—

(1) DEFINITION OF NURSE AIDE.—In this subsection, the term ''nurse aide'' has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

(2) STUDY AND REPORT.—

(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.

(B) AREAS EVALUATED.—The study conducted under this subsection shall include an evaluation of—

(i) who should be included in the registry;

(ii) how such a registry would comply with Federal and State privacy laws and regulations;

(iii) how data would be collected for the registry;

(iv) what entities and individuals would have access to the data collected;

(v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;

(vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers under section 4301; and

(vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)) would be provided as part of a national nurse aide registry.

(C) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into consideration the findings and conclusions of relevant reports and other relevant resources, including the following:

(i) The Department of Health and Human Services Office of Inspector General Report,

Nurse Aide Registries: State Compliance and Practices (February 2005).

(ii) The General Accounting Office (now known as the Government Accountability Office) Report, Nursing Homes: More Can Be Done to Protect Residents from Abuse (March 2002).

(iii) The Department of Health and Human Services Office of the Inspector General Report, Nurse Aide Registries: Long-Term Care Facility Compliance and Practices (July 2005).

(iv) The Department of Health and Human Services Health Resources and Services Administration Report, Nursing Aides, Home Health Aides, and Related Health Care Occupations—National and Local Workforce Shortages and Associated Data Needs (2004) (in particular with respect to chapter 7 and appendix F).

(v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries.

(vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)).

(D) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021 of the Social Security Act, as added by section 1805(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed $500,000.

(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

(d) CONFORMING AMENDMENTS.—

(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 5503(a), is amended—

(A) in the heading of section 2001, by striking ''TITLE'' and inserting ''SUBTITLE''; and

(B) in subtitle 1, by striking ''this title'' each place it appears and inserting ''this subtitle''.

(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 404(d)—

(i) in paragraphs (1)(A), (2)(A), and (3)(B), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears;

(ii) in the heading of paragraph (2), by inserting ''SUBTITLE OF'' before ''TITLE XX''; and

(iii) in the heading of paragraph (3)(B), by inserting ''SUBTITLE OF'' before ''TITLE XX''; and

(B) in sections 422(b), 471(a)(4), 472(h)(1), and 473(b)(2), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears.

(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting ''subtitle 1 of'' before ''title XX''; and

(ii) by striking ''such title'' and inserting ''such subtitle''; and

(B) in section 1128A(i)(1), by inserting ''subtitle 1 of'' before ''title XX''.

Subtitle G—Sense of the Senate Regarding Medical Malpractice

SEC. 5501. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VI—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

SEC. 6001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the ''Biologics Price Competition and Innovation Act of 2009''.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway balancing innovation and consumer interests should be established.

SEC. 6002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting ''under this subsection or subsection (k)'' after ''biologics license''; and

(2) by adding at the end the following:

''(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

''(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

''(2) CONTENT.—

''(A) IN GENERAL.—

''(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

''(I) the biological product is biosimilar to a reference product based upon data derived from—

''(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

''(bb) animal studies (including the assessment of toxicity); and

''(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics) that are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which licensure is sought for the biological product;

''(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product;

''(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

''(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

''(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent.

''(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary's discretion, that an element described in clause (i)(I) is unnecessary in an application submitted under this subsection.

''(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

''(I) shall include publicly-available information regarding the Secretary's previous determination that the reference product is safe, pure, and potent; and

''(II) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

''(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (4).

''(3) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

''(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

''(i) is biosimilar to the reference product; or

''(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

''(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

''(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

''(A) the biological product—

''(i) is biosimilar to the reference product; and

''(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

''(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

''(5) GENERAL RULES.—

''(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

''(B) REVIEW.—An application submitted under this subsection shall be reviewed by

the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

''(C) RISK EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

''(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use until the earlier of—

''(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product to be approved as interchangeable for that reference product;

''(B) 18 months after—

''(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

''(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6) and such litigation is still ongoing within such 42-month period; or

''(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(6).

For purposes of this paragraph, the term 'final court decision' means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

''(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

''(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

''(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

''(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

''(i) a supplement for the biological product that is the reference product; or

''(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

''(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

''(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

''(8) GUIDANCE DOCUMENTS.—

''(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

''(B) PUBLIC COMMENT.—

''(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

''(ii) INPUT REGARDING MOST VALUABLE GUIDANCE.—The Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

''(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

''(D) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

''(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

''(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (4).

''(E) CERTAIN PRODUCT CLASSES.—

''(i) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license as provided under this subsection for such product or product class.

''(ii) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subparagraph (A) to modify or reverse a guidance document under clause (i).

''(iii) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not indicated in a guidance document that the science and experience, as described in clause (i), does not allow approval of such an application.

''(l) PATENTS.—

''(1) CONFIDENTIAL ACCESS TO SUBSECTION (k) APPLICATION.—

''(A) APPLICATION OF PARAGRAPH.—Unless otherwise agreed to by a person that submits an application under subsection (k) (referred to in this subsection as the 'subsection (k) applicant') and the sponsor of the application for the reference product (referred to in this subsection as the 'reference product sponsor'), the provisions of this paragraph shall apply to the exchange of information described in this subsection.

''(B) IN GENERAL.—

''(i) PROVISION OF CONFIDENTIAL INFORMATION.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in clause (ii), subject to the terms of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that the subsection (k) applicant determines, in its sole discretion, to be appropriate (referred to in this subsection as the 'confidential information').

''(ii) RECIPIENTS OF INFORMATION.—The persons described in this clause are the following:

''(I) OUTSIDE COUNSEL.—One or more attorneys designated by the reference product sponsor who are employees of an entity other than the reference product sponsor (referred to in this paragraph as the 'outside counsel'), provided that such attorneys do not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(II) IN-HOUSE COUNSEL.—One attorney that represents the reference product sponsor who is an employee of the reference product sponsor, provided that such attorney does not engage, formally or informally, in patent prosecution relevant or related to the reference product.

''(iii) PATENT OWNER ACCESS.—A representative of the owner of a patent exclusively licensed to a reference product sponsor with respect to the reference product and who has retained a right to assert the patent or participate in litigation concerning the patent may be provided the confidential information, provided that the representative informs the reference product sponsor and the subsection (k) applicant of his or her agreement to be subject to the confidentiality provisions set forth in this paragraph, including those under clause (ii).

''(C) LIMITATION ON DISCLOSURE.—No person that receives confidential information pursuant to subparagraph (B) shall disclose any confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the reference product sponsor, without the prior written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

''(D) USE OF CONFIDENTIAL INFORMATION.—Confidential information shall be used for the sole and exclusive purpose of determining, with respect to each patent assigned to or exclusively licensed by the reference product sponsor, whether a claim of patent infringement could reasonably be asserted if the subsection (k) applicant engaged in the manufacture, use, offering for sale, sale, or importation into the United States of the biological product that is the subject of the application under subsection (k).

''(E) OWNERSHIP OF CONFIDENTIAL INFORMATION.—The confidential information disclosed under this paragraph is, and shall remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

''(F) EFFECT OF INFRINGEMENT ACTION.—In the event that the reference product sponsor files a patent infringement suit, the use of confidential information shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of such order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that order. No confidential information shall be included in any publicly-available complaint or other pleading. In the event that the reference product sponsor does not file an infringement action by the date specified in paragraph (6), the reference product sponsor shall return or destroy all confidential information received under this paragraph, provided that if the reference product sponsor opts to destroy such information, it will confirm destruction in writing to the subsection (k) applicant.

''(G) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) as an admission by the subsection (k) applicant regarding the validity, enforceability, or infringement of any patent; or

''(ii) as an agreement or admission by the subsection (k) applicant with respect to the competency, relevance, or materiality of any confidential information.

''(H) EFFECT OF VIOLATION.—The disclosure of any confidential information in violation of this paragraph shall be deemed to cause the subsection (k) applicant to suffer irreparable harm for which there is no adequate legal remedy and the court shall consider immediate injunctive relief to be an appropriate and necessary remedy for any violation or threatened violation of this paragraph.

''(2) SUBSECTION (k) APPLICATION INFORMATION.—Not later than 20 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant—

''(A) shall provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application; and

''(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor.

''(3) LIST AND DESCRIPTION OF PATENTS.—

''(A) LIST BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

''(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or by a patent owner that has granted an exclusive license to the reference product sponsor with respect to the reference product, if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application; and

''(ii) an identification of the patents on such list that the reference product sponsor would be prepared to license to the subsection (k) applicant.

''(B) LIST AND DESCRIPTION BY SUBSECTION (k) APPLICANT.—Not later than 60 days after receipt of the list under subparagraph (A), the subsection (k) applicant—

''(i) may provide to the reference product sponsor a list of patents to which the subsection (k) applicant believes a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application;

''(ii) shall provide to the reference product sponsor, with respect to each patent listed by the reference product sponsor under subparagraph (A) or listed by the subsection (k) applicant under clause (i)—

''(I) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

''(II) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product before the date that such patent expires; and

''(iii) shall provide to the reference product sponsor a response regarding each patent identified by the reference product sponsor under subparagraph (A)(ii).

''(C) DESCRIPTION BY REFERENCE PRODUCT SPONSOR.—Not later than 60 days after receipt of the list and statement under subparagraph (B), the reference product sponsor shall provide to the subsection (k) applicant a detailed statement that describes, with respect to each patent described in subparagraph (B)(ii)(I), on a claim by claim basis, the factual and legal basis of the opinion of the reference product sponsor that such patent will be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application and a response to the statement concerning validity and enforceability provided under subparagraph (B)(ii)(I).

''(4) PATENT RESOLUTION NEGOTIATIONS.—

''(A) IN GENERAL.—After receipt by the subsection (k) applicant of the statement under paragraph (3)(C), the reference product sponsor and the subsection (k) applicant shall engage in good faith negotiations to agree on which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6).

''(B) FAILURE TO REACH AGREEMENT.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

''(5) PATENT RESOLUTION IF NO AGREEMENT.—

''(A) NUMBER OF PATENTS.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that such applicant will provide to the reference product sponsor under subparagraph (B)(i)(I).

''(B) EXCHANGE OF PATENT LISTS.—

''(i) IN GENERAL.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor under subparagraph (A), the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

''(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

''(II) the list of patents, in accordance with clause (ii), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

''(ii) NUMBER OF PATENTS LISTED BY REFERENCE PRODUCT SPONSOR.—

''(I) IN GENERAL.—Subject to subclause (II), the number of patents listed by the reference product sponsor under clause (i)(II) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I).

''(II) EXCEPTION.—If a subsection (k) applicant does not list any patent under clause (i)(I), the reference product sponsor may list 1 patent under clause (i)(II).

''(6) IMMEDIATE PATENT INFRINGEMENT ACTION.—

''(A) ACTION IF AGREEMENT ON PATENT LIST.—If the subsection (k) applicant and the reference product sponsor agree on patents as described in paragraph (4), not later than 30 days after such agreement, the reference product sponsor shall bring an action for patent infringement with respect to each such patent.

''(B) ACTION IF NO AGREEMENT ON PATENT LIST.—If the provisions of paragraph (5) apply to the parties as described in paragraph (4)(B), not later than 30 days after the exchange of lists under paragraph (5)(B), the reference product sponsor shall bring an action for patent infringement with respect to each patent that is included on such lists.

''(C) NOTIFICATION AND PUBLICATION OF COMPLAINT.—

''(i) NOTIFICATION TO SECRETARY.—Not later than 30 days after a complaint is served to a subsection (k) applicant in an action for patent infringement described under this paragraph, the subsection (k) applicant shall provide the Secretary with notice and a copy of such complaint.

''(ii) PUBLICATION BY SECRETARY.—The Secretary shall publish in the Federal Register notice of a complaint received under clause (i).

''(7) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

''(A) is issued to, or exclusively licensed by, the reference product sponsor after the date that the reference product sponsor provided the list to the subsection (k) applicant under paragraph (3)(A); and

''(B) the reference product sponsor reasonably believes that, due to the issuance of such patent, a claim of patent infringement could reasonably be asserted by the reference product sponsor if a person not licensed by the reference product sponsor engaged in the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application,

not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a supplement to the list provided by the reference product sponsor under paragraph (3)(A) that includes such patent, not later than 30 days after such supplement is provided, the subsection (k) applicant shall provide a statement to the reference product sponsor in accordance with paragraph (3)(B), and such patent shall be subject to paragraph (8).

''(8) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

''(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant shall provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of the biological product licensed under subsection (k).

''(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforcement, and infringement with respect to any patent that is—

''(i) included in the list provided by the reference product sponsor under paragraph (3)(A) or in the list provided by the subsection (k) applicant under paragraph (3)(B); and

''(ii) not included, as applicable, on—

''(I) the list of patents described in paragraph (4); or

''(II) the lists of patents described in paragraph (5)(B).

''(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor and the subsection (k) applicant shall reasonably cooperate to expedite such further discovery as is needed

in connection with the preliminary injunction motion.

''(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

''(A) SUBSECTION (k) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (ii) of paragraph (8)(B).

''(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (k) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under paragraph (3)(B)(ii), paragraph (5), paragraph (6)(C)(i), paragraph (7), or paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

''(C) SUBSECTION (k) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (2)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that claims the biological product or a use of the biological product.''.

(b) DEFINITIONS.—Section 351(i) of the Public Health Service Act (42 U.S.C. 262(i)) is amended—

(1) by striking ''In this section, the term 'biological product' means'' and inserting the following: ''In this section:

''(1) The term 'biological product' means'';

(2) in paragraph (1), as so designated, by inserting ''protein (except any chemically synthesized polypeptide),'' after ''allergenic product,''; and

(3) by adding at the end the following:

''(2) The term 'biosimilar' or 'biosimilarity', in reference to a biological product that is the subject of an application under subsection (k), means—

''(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

''(B) there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

''(3) The term 'interchangeable' or 'interchangeability', in reference to a biological product that is shown to meet the standards described in subsection (k)(4), means that the biological product may be substituted for the reference product without the intervention of the health care provider who prescribed the reference product.

''(4) The term 'reference product' means the single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).''.

(c) CONFORMING AMENDMENTS RELATING TO PATENTS.—

(1) PATENTS.—Section 271(e) of title 35, United States Code, is amended—

(A) in paragraph (2)—

(i) in subparagraph (A), by striking ''or'' at the end;

(ii) in subparagraph (B), by adding ''or'' at the end; and

(iii) by inserting after subparagraph (B) the following:

''(C)(i) with respect to a patent that is identified in the list of patents described in section 351(l)(3) of the Public Health Service Act (including as provided under section 351(l)(7) of such Act), an application seeking approval of a biological product, or

''(ii) if the applicant for the application fails to provide the application and information required under section 351(l)(2)(A) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(l)(3)(A)(i) of such Act,''; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product'';

(B) in paragraph (4)—

(i) in subparagraph (B), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking ''and'' at the end;

(ii) in subparagraph (C), by—

(I) striking ''or veterinary biological product'' and inserting '', veterinary biological product, or biological product''; and

(II) striking the period and inserting '', and'';

(iii) by inserting after subparagraph (C) the following:

''(D) the court shall order a permanent injunction prohibiting any infringement of the patent by the biological product involved in the infringement until a date which is not earlier than the date of the expiration of the patent that has been infringed under paragraph (2)(C), provided the patent is the subject of a final court decision, as defined in section 351(k)(6) of the Public Health Service Act, in an action for infringement of the patent under section 351(l)(6) of such Act, and the biological product has not yet been approved because of section 351(k)(7) of such Act.''; and

(iv) in the matter following subparagraph (D) (as added by clause (iii)), by striking ''and (C)'' and inserting ''(C), and (D)''; and

(C) by adding at the end the following:

''(6)(A) Subparagraph (B) applies, in lieu of paragraph (4), in the case of a patent—

''(i) that is identified, as applicable, in the list of patents described in section 351(l)(4) of the Public Health Service Act or the lists of patents described in section 351(l)(5)(B) of such Act with respect to a biological product; and

''(ii) for which an action for infringement of the patent with respect to the biological product—

''(I) was brought after the expiration of the 30-day period described in subparagraph (A) or (B), as applicable, of section 351(l)(6) of such Act; or

''(II) was brought before the expiration of the 30-day period described in subclause (I), but which was dismissed without prejudice or was not prosecuted to judgment in good faith.

''(B) In an action for infringement of a patent described in subparagraph (A), the sole and exclusive remedy that may be granted by a court, upon a finding that the making, using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

''(C) The owner of a patent that should have been included in the list described in section 351(l)(3)(A) of the Public Health Service Act, including as provided under section 351(l)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product.''.

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: '', or section 351 of the Public Health Service Act''.

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: ''or, with respect to an applicant for approval of a biological product under section 351(k) of the Public Health Service Act, any necessary clinical study or studies''.

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following:

''(n) NEW ACTIVE INGREDIENT.—

''(1) NON-INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that the Secretary has not determined to meet the standards described in subsection (k)(4) of such section for interchangeability with the reference product, shall be considered to have a new active ingredient under this section.

''(2) INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section.''.

(e) PRODUCTS PREVIOUSLY APPROVED UNDER SECTION 505.—

(1) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) EXCEPTION.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subtitle as the ''Secretary'') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term ''biological product'' has the meaning given such term under section

351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(f) FOLLOW-ON BIOLOGICS USER FEES.—

(1) DEVELOPMENT OF USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) IN GENERAL.—Beginning not later than October 1, 2010, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with—

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care professionals;

(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(i) present the recommendations developed under subparagraph (A) to the Congressional committees specified in such subparagraph;

(ii) publish such recommendations in the Federal Register;

(iii) provide for a period of 30 days for the public to provide written comments on such recommendations;

(iv) hold a meeting at which the public may present its views on such recommendations; and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Secretary shall transmit to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made to the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applications under section 351(k) of the Public Health Service Act (as added by this Act).

(3) TRANSITIONAL PROVISIONS FOR USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.—Section 735(1)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379g(1)(B)) is amended by striking ''section 351'' and inserting ''subsection (a) or (k) of section 351''.

(B) EVALUATION OF COSTS OF REVIEWING BIOSIMILAR BIOLOGICAL PRODUCT APPLICATIONS.—During the period beginning on the date of enactment of this Act and ending on October 1, 2010, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(C) AUDIT.—

(i) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall perform an audit of the costs of reviewing such applications under such section 351(k). Such an audit shall compare—

(I) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(II)(aa) such ratio determined under subclause (I); to

(bb) the ratio of the costs of reviewing applications for biological products under section 351(a) of such Act (as amended by this Act) to the amount of the user fee applicable to such applications under such section 351(a).

(ii) ALTERATION OF USER FEE.—If the audit performed under clause (i) indicates that the ratios compared under subclause (II) of such clause differ by more than 5 percent, then the Secretary shall alter the user fee applicable to applications submitted under such section 351(k) to more appropriately account for the costs of reviewing such applications.

(iii) ACCOUNTING STANDARDS.—The Secretary shall perform an audit under clause (i) in conformance with the accounting principles, standards, and requirements prescribed by the Comptroller General of the United States under section 3511 of title 31, United State Code, to ensure the validity of any potential variability.

(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2012.

(g) PEDIATRIC STUDIES OF BIOLOGICAL PRODUCTS.—

(1) IN GENERAL.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following:

''(m) PEDIATRIC STUDIES.—

''(1) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (a), (d), (e), (f), (i), (j), (k), (l), (p), and (q) of section 505A of the Federal Food, Drug, and Cosmetic Act shall apply with respect to the extension of a period under paragraphs (2) and (3) to the same extent and in the same manner as such provisions apply with respect to the extension of a period under subsection (b) or (c) of section 505A of the Federal Food, Drug, and Cosmetic Act.

''(2) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(3) MARKET EXCLUSIVITY FOR ALREADY-MARKETED BIOLOGICAL PRODUCTS.—If the Secretary determines that information relating to the use of a licensed biological product in the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under subsection (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each age group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

''(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years; and

''(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

''(4) EXCEPTION.—The Secretary shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made later than 9 months prior to the expiration of such period.''.

(2) STUDIES REGARDING PEDIATRIC RESEARCH.—

(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting '', biological products,'' after ''including drugs''.

(B) INSTITUTE OF MEDICINE STUDY.—Section 505A(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

''(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Biologics Price Competition and Innovation Act of 2009 and the importance for children, health care providers, parents, and others of labeling changes made as a result of such testing;

''(5) review and assess the number, importance, and prioritization of any biological products that are not being tested for pediatric use; and

''(6) offer recommendations for ensuring pediatric testing of biological products, including consideration of any incentives, such as those provided under this section or section 351(m) of the Public Health Service Act.''.

(h) ORPHAN PRODUCTS.—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar to, or interchangeable with, such reference product may be licensed by the Secretary only after the expiration for such reference product of the later of—

(1) the 7-year period described in section 527(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360cc(a)); and

(2) the 12-year period described in subsection (k)(7) of such section 351.

SEC. 6003. SAVINGS.

(a) DETERMINATION.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall for each fiscal year determine the amount of savings to the Federal Government as a result of the enactment of this subtitle.

(b) USE.—Notwithstanding any other provision of this subtitle (or an amendment made by this subtitle), the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for deficit reduction.

Subtitle B—More Affordable Medicines for Children and Underserved Communities

SEC. 6101. EXPANDED PARTICIPATION IN 340B PROGRAM.

(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

''(M) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act), and that meets the requirements of subparagraph (L)(i).

''(N) An entity that is a rural referral center, as defined by section 1886(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1886(d)(5)(C)(iii) of such Act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.''.

(b) EXTENSION OF DISCOUNT TO INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking ''outpatient'' each place it appears; and

(2) in subsection (b)—

(A) by striking ''OTHER DEFINITION'' and all that follows through ''In this section'' and inserting the following: ''OTHER DEFINITIONS.—

''(1) IN GENERAL.—In this section''; and

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

''(2) COVERED DRUG.—In this section, the term 'covered drug'—

''(A) means a covered outpatient drug (as defined in section 1927(k)(2) of the Social Security Act); and

''(B) includes, notwithstanding paragraph (3)(A) of section 1927(k) of such Act, a drug used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), or (N) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.''.

(c) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (4)(L)—

(A) in clause (i), by adding ''and'' at the end;

(B) in clause (ii), by striking ''; and'' and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (5), as amended by subsection (b)—

(A) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E); respectively; and

(B) by inserting after subparagraph (B), the following:

''(C) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—

''(i) IN GENERAL.—A hospital described in subparagraph (L), (M), or (N) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, except as permitted or provided for pursuant to clauses (ii) or (iii).

''(ii) INPATIENT DRUGS.—Clause (i) shall not apply to drugs purchased for inpatient use.

''(iii) EXCEPTIONS.—The Secretary shall establish reasonable exceptions to clause (i)—

''(I) with respect to a covered outpatient drug that is unavailable to be purchased through the program under this section due to a drug shortage problem, manufacturer noncompliance, or any other circumstance beyond the hospital's control;

''(II) to facilitate generic substitution when a generic covered outpatient drug is available at a lower price; or

''(III) to reduce in other ways the administrative burdens of managing both inventories of drugs subject to this section and inventories of drugs that are not subject to this section, so long as the exceptions do not create a duplicate discount problem in violation of subparagraph (A) or a diversion problem in violation of subparagraph (B).

''(iv) PURCHASING ARRANGEMENTS FOR INPATIENT DRUGS.—The Secretary shall ensure that a hospital described in subparagraph (L), (M), or (N) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section shall have multiple options for purchasing covered drugs for inpatients, including by utilizing a group purchasing organization or other group purchasing arrangement, establishing and utilizing its own group purchasing program, purchasing directly from a manufacturer, and any other purchasing arrangements that the Secretary determines is appropriate to ensure access to drug discount pricing under this section for inpatient drugs taking into account the particular needs of small and rural hospitals.''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section and section 6102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

(2) EFFECTIVENESS.—The amendments made by this section and section 6102 shall be effective and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), notwithstanding any other provision of law.

SEC. 6102. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) INTEGRITY IMPROVEMENTS.—Subsection (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended to read as follows:

''(d) IMPROVEMENTS IN PROGRAM INTEGRITY.—

''(1) MANUFACTURER COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, which shall include the following:

''(I) Developing and publishing through an appropriate policy or regulatory issuance, precisely defined standards and methodology for the calculation of ceiling prices under such subsection.

''(II) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

''(III) Performing spot checks of sales transactions by covered entities.

''(IV) Inquiring into the cause of any pricing discrepancies that may be identified and either taking, or requiring manufacturers to take, such corrective action as is appropriate in response to such price discrepancies.

''(ii) The establishment of procedures for manufacturers to issue refunds to covered entities in the event that there is an overcharge by the manufacturers, including the following:

''(I) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

''(II) Oversight by the Secretary to ensure that the refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment to relevant pricing data and exceptional circumstances such as erroneous or intentional overcharging for covered drugs.

''(iii) The provision of access through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in accordance with this section, in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of privileged pricing data from unauthorized re-disclosure.

''(iv) The development of a mechanism by which—

''(I) rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

''(II) appropriate credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

''(v) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

''(vi) The imposition of sanctions in the form of civil monetary penalties, which—

''(I) shall be assessed according to standards established in regulations to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act;

''(II) shall not exceed $5,000 for each instance of overcharging a covered entity that may have occurred; and

''(III) shall apply to any manufacturer with an agreement under this section that knowingly and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).

''(2) COVERED ENTITY COMPLIANCE.—

''(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements specified under subsection (a)(5).

''(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

''(i) The development of procedures to enable and require covered entities to regularly update (at least annually) the information on the Internet website of the Department of Health and Human Services relating to this section.

''(ii) The development of a system for the Secretary to verify the accuracy of information regarding covered entities that is listed on the website described in clause (i).

''(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing covered drugs to State health security programs in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

''(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under

this section, including the processing of chargebacks for such drugs.

''(v) The imposition of sanctions, in appropriate cases as determined by the Secretary, additional to those to which covered entities are subject under subsection (a)(5)(E), through one or more of the following actions:

''(I) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or manufacturers in the form of interest on sums for which the covered entity is found liable under subsection (a)(5)(E), such interest to be compounded monthly and equal to the current short term interest rate as determined by the Federal Reserve for the time period for which the covered entity is liable.

''(II) Where the Secretary determines a violation of subsection (a)(5)(B) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and disqualifying the entity from re-entry into such program for a reasonable period of time to be determined by the Secretary.

''(III) Referring matters to appropriate Federal authorities within the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal statutes, such as the Prescription Drug Marketing Act (21 U.S.C. 353).

''(3) ADMINISTRATIVE DISPUTE RESOLUTION PROCESS.—

''(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under this section, and claims by manufacturers, after the conduct of audits as authorized by subsection (a)(5)(D), of violations of subsections (a)(5)(A) or (a)(5)(B), including appropriate procedures for the provision of remedies and enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

''(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

''(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that they have been charged prices for covered drugs in excess of the ceiling price described in subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(A) or (a)(5)(B) have occurred;

''(ii) establish such deadlines and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously;

''(iii) establish procedures by which a covered entity may discover and obtain such information and documents from manufacturers and third parties as may be relevant to demonstrate the merits of a claim that charges for a manufacturer's product have exceeded the applicable ceiling price under this section, and may submit such documents and information to the administrative official or body responsible for adjudicating such claim;

''(iv) require that a manufacturer conduct an audit of a covered entity pursuant to subsection (a)(5)(D) as a prerequisite to initiating administrative dispute resolution proceedings against a covered entity;

''(v) permit the official or body designated under clause (i), at the request of a manufacturer or manufacturers, to consolidate claims brought by more than one manufacturer against the same covered entity where, in the judgment of such official or body, consolidation is appropriate and consistent with the goals of fairness and economy of resources; and

''(vi) include provisions and procedures to permit multiple covered entities to jointly assert claims of overcharges by the same manufacturer for the same drug or drugs in one administrative proceeding, and permit such claims to be asserted on behalf of covered entities by associations or organizations representing the interests of such covered entities and of which the covered entities are members.

''(C) FINALITY OF ADMINISTRATIVE RESOLUTION.—The administrative resolution of a claim or claims under the regulations promulgated under subparagraph (A) shall be a final agency decision and shall be binding upon the parties involved, unless invalidated by an order of a court of competent jurisdiction.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2010 and each succeeding fiscal year.''.

(b) CONFORMING AMENDMENTS.—Section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: ''Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the 'ceiling price'), and shall require that the manufacturer offer each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchaser at any price.''; and

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 6101(c), by inserting ''after audit as described in subparagraph (D) and'' after ''finds,''.

SEC. 6103. GAO STUDY TO MAKE RECOMMENDATIONS ON IMPROVING THE 340B PROGRAM.

(a) 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 that examines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) (referred to in this section as the ''340B program'') are receiving optimal health care services.

(b) RECOMMENDATIONS.—The report under subsection (a) shall include recommendations on the following:

(1) Whether the 340B program should be expanded since it is anticipated that the 47,000,000 individuals who are uninsured as of the date of enactment of this Act will have health care coverage once this Act is implemented.

(2) Whether mandatory sales of certain products by the 340B program could hinder patients access to those therapies through any provider.

(3) Whether income from the 340B program is being used by the covered entities under the program to further the program objectives.

SA 2838. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 11 on page 183, and insert the following:

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title, health

Beginning on page 187, strike line 17 and all that follows through line 8 on page 188, and insert the following:

(6) REIMBURSEMENT RATES.—

(A) RATES ESTABLISHED BY SECRETARY.—

(i) IN GENERAL.—The Secretary shall establish payment rates for the community health insurance option for services and health care providers consistent with this section and may change such payment rates.

(ii) INITIAL PAYMENT RULES.—

(I) IN GENERAL.—Except as provided in subclause (II), during the first 3 years in which the community health insurance option if offered, the Secretary shall base the payment rates under this section for services and providers described in subparagraph (A) on the payment rates for similar services and providers under parts A and B of Medicare under title XVIII of the Social Security Act.

(II) EXCEPTIONS.—

(aa) PAYMENT RATES FOR PRACTITIONERS SERVICES.—Payment rates for practitioners services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.

(bb) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this section.

(iii) FOR NEW SERVICES.—The Secretary shall modify payment rates described in clause (ii) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(iv) PRESCRIPTION DRUGS.—Payment rates under this paragraph for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(B) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(i) INITIAL INCENTIVE PERIOD.—

(I) IN GENERAL.—The Secretary shall provide, in the case of services described in subclause (II) furnished during the first 3 years in which a community health insurance option is offered, for payment rates that are 5 percent greater than the rates established under subparagraph (A).

(II) SERVICES DESCRIBED.—The services described in this subclause are items and professional services, under the community health insurance option by a physician or other health care practitioner who participates in both Medicare and the community health insurance option.

(III) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by

the Secretary) shall also be eligible for the increased payment rates under subclause (I).

(ii) SUBSEQUENT PERIODS.—Beginning with the fourth year in which the community health insurance option is offered, and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordability and the efficient delivery of medical care. Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subparagraph (A)(ii) and clause (i) of this subparagraph were continued.

(iii) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the community health insurance option unless they opt out in a process established by the Secretary.

(C) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this paragraph but not to the specific methodology for establishing such rates or the calculation of such rates.

(D) CONSTRUCTION.—Nothing in this subtitle shall be construed—

(i) as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the amounts paid for similar health care providers and services under other Exchange-participating qualified health plans.

(ii) as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services.

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this paragraph.

SA 2839. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 8 on page 188, and insert the following:

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title, health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.

(2) COMMUNITY HEALTH INSURANCE OPTION.—In this section, the term ''community health insurance option'' means health insurance coverage that—

(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;

(B) provides high value for the premium charged;

(C) reduces administrative costs and promotes administrative simplification for beneficiaries;

(D) promotes high quality clinical care;

(E) provides high quality customer service to beneficiaries;

(F) offers a sufficient choice of providers; and

(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).

(3) ESSENTIAL HEALTH BENEFITS.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).

(B) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.

(C) CREDITS.—

(i) IN GENERAL.—An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner as an individual who is enrolled in a qualified health plan.

(ii) NO ADDITIONAL FEDERAL COST.—A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.

(D) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).

(E) ENSURING ACCESS TO ALL SERVICES.—Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out-of-pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.

(F) PROTECTING ACCESS TO END OF LIFE CARE.—A community health insurance option offered under this section shall be prohibited from limiting access to end of life care.

(4) COST SHARING.—A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).

(5) PREMIUMS.—

(A) PREMIUMS SUFFICIENT TO COVER COSTS.—The Secretary shall establish geographically adjusted premium rates in an amount sufficient to cover expected costs (including claims and administrative costs) using methods in general use by qualified health plans.

(B) APPLICABLE RULES.—The provisions of title XXVII of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.

(C) COLLECTION OF DATA.—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).

(D) NATIONAL POOLING.—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.

(E) CONTINGENCY MARGIN.—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.

(6) REIMBURSEMENT RATES.—

(A) RATES ESTABLISHED BY SECRETARY.—

(i) IN GENERAL.—The Secretary shall establish payment rates for the community health insurance option for services and health care providers consistent with this section and may change such payment rates.

(ii) INITIAL PAYMENT RULES.—

(I) IN GENERAL.—Except as provided in subclause (II), during the first 3 years in which the community health insurance option if offered, the Secretary shall base the payment rates under this section for services and providers described in subparagraph (A) on the payment rates for similar services and providers under parts A and B of Medicare under title XVIII of the Social Security Act.

(II) EXCEPTIONS.—

(aa) PAYMENT RATES FOR PRACTITIONERS SERVICES.—Payment rates for practitioners services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.

(bb) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this section.

(iii) FOR NEW SERVICES.—The Secretary shall modify payment rates described in clause (ii) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(iv) PRESCRIPTION DRUGS.—Payment rates under this paragraph for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(B) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(i) INITIAL INCENTIVE PERIOD.—

(I) IN GENERAL.—The Secretary shall provide, in the case of services described in subclause (II) furnished during the first 3 years in which a community health insurance option is offered, for payment rates that are 5 percent greater than the rates established under subparagraph (A).

(II) SERVICES DESCRIBED.—The services described in this subclause are items and professional services, under the community health insurance option by a physician or other health care practitioner who participates in both Medicare and the community health insurance option.

(III) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subclause (I).

(ii) SUBSEQUENT PERIODS.—Beginning with the fourth year in which the community health insurance option is offered, and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordablility and the efficient delivery of medical care. Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subparagraph (A)(ii) and clause (i) of this subparagraph were continued.

(iii) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the community health insurance option

unless they opt out in a process established by the Secretary.

(C) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this paragraph but not to the specific methodology for establishing such rates or the calculation of such rates.

(D) CONSTRUCTION.—Nothing in this subtitle shall be construed—

(i) as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the amounts paid for similar health care providers and services under other Exchange-participating qualified health plans.

(ii) as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services.

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this paragraph.

SA 2840. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 11 on page 183, and insert the following:

(b) ESTABLISHMENT OF COMMUNITY HEALTH INSURANCE OPTION.—

(1) ESTABLISHMENT.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title, health

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SA 2841. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 187, strike line 17 and all that follows through line 8 on page 188, and insert the following:

(6) REIMBURSEMENT RATES.—

(A) RATES ESTABLISHED BY SECRETARY.—

(i) IN GENERAL.—The Secretary shall establish payment rates for the community health insurance option for services and health care providers consistent with this section and may change such payment rates.

(ii) INITIAL PAYMENT RULES.—

(I) IN GENERAL.—Except as provided in subclause (II), during the first 3 years in which the community health insurance option if offered, the Secretary shall base the payment rates under this section for services and providers described in subparagraph (A) on the payment rates for similar services and providers under parts A and B of Medicare under title XVIII of the Social Security Act.

(II) EXCEPTIONS.—

(aa) PAYMENT RATES FOR PRACTITIONERS SERVICES.—Payment rates for practitioners services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this subparagraph shall be not less than 1 percent.

(bb) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this section.

(iii) FOR NEW SERVICES.—The Secretary shall modify payment rates described in clause (ii) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(iv) PRESCRIPTION DRUGS.—Payment rates under this paragraph for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(B) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(i) INITIAL INCENTIVE PERIOD.—

(I) IN GENERAL.—The Secretary shall provide, in the case of services described in subclause (II) furnished during the first 3 years in which a community health insurance option is offered, for payment rates that are 5 percent greater than the rates established under subparagraph (A).

(II) SERVICES DESCRIBED.—The services described in this subclause are items and professional services, under the community health insurance option by a physician or other health care practitioner who participates in both Medicare and the community health insurance option.

(III) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subclause (I).

(ii) SUBSEQUENT PERIODS.—Beginning with the fourth year in which the community health insurance option is offered, and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to ensure adequate beneficiary access to providers, and to promote affordablility and the efficient delivery of medical care. Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subparagraph (A)(ii) and clause (i) of this subparagraph were continued.

(iii) ESTABLISHMENT OF A PROVIDER NETWORK.—Health care providers participating under Medicare are participating providers in the community health insurance option unless they opt out in a process established by the Secretary.

(C) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this paragraph but not to the specific methodology for establishing such rates or the calculation of such rates.

(D) CONSTRUCTION.—Nothing in this subtitle shall be construed—

(i) as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the amounts paid for similar health care providers and services under other Exchange-participating qualified health plans.

(ii) as affecting the authority of the Secretary to establish payment rates, including payments to provide for the more efficient delivery of services.

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this paragraph.

SA 2842. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 249, strike lines 3 through 12, and insert the following:

(ii) COVERAGE MUST PROVIDE MINIMUM VALUE AND ESSENTIAL BENEFITS.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and—

(I) the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, or

(II) the plan does not provide coverage for at least the essential health benefits required to be provided by a qualified health plan under section 1302(b) of the Patient Protection and Affordable Care Act.

SA 2843. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 268, after line 19, insert the following:

SEC. 1403. EMPLOYEES ELIGIBLE FOR CREDIT AND REDUCTIONS IF EMPLOYER'S PLAN DOESN'T COVER ESSENTIAL HEALTH BENEFITS.

(a) IN GENERAL.—Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986, as added by section 1401, is amended to read as follows:

''(ii) COVERAGE MUST PROVIDE MINIMUM VALUE AND ESSENTIAL BENEFITS.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and—

''(I) the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, or

''(II) the plan does not provide coverage for at least the essential health benefits required to be provided by a qualified health plan under section 1302(b) of the Patient Protection and Affordable Care Act.''.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—

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

''PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

''SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4

percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(3) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2010.

SA 2844. Mr. SANDERS (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1979, line 20, strike all through page 1996, line 3, and insert the following:

SEC. 9001. SURCHARGE ON HIGH INCOME INDIVIDUALS.

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

''PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

''SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SA 2845. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 212, line 18, strike ''2017'' and insert ''2014''.

On page 214, line 12, insert '', except that the Secretary shall determine such amount on the basis of reasonable estimates until such time as data regarding the experiences of other States become available and if such estimates are determined to be incorrect on the basis of such data, the Secretary shall adjust subsequent payments to correct errors in earlier payments that were based on such estimates'' after ''States''.

On page 219, strike lines 12 through 20, and insert:

(e) TERM OF WAIVER.—

(1) IN GENERAL.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver and such request is granted by the Secretary under paragraph (2).

(2) APPROVAL OF REQUEST.—A request under paragraph (1) shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. The Secretary may deny such a request only if the Secretary—

(A) determines that the State plan under the waiver to be continued did not meet the requirements under subsection (b);

(B) notifies the State in writing of the requirements under subsection (b) that the State plan did not meet and provides to the State the information used by the Secretary in making that determination; and

(C) provides the State with an opportunity to appeal such determination and provide information as to how such requirements were met.

The Secretary shall consider any information provided under subparagraph (C) and reconsider its determination under subparagraph (A). The Secretary shall grant the request if the Secretary determines upon reconsideration that the State plan met such requirements.

SA 2846. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 1332 and insert the following:

SEC. 1332. WAIVER FOR STATE INNOVATION.

(a) APPLICATION.—

(1) IN GENERAL.—A State may apply to the Secretary for the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning on or after January 1, 2014. Such application shall—

(A) be filed at such time and in such manner as the Secretary may require;

(B) contain such information as the Secretary may require, including—

(i) a comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under this section; and

(ii) a 10-year budget plan for such plan that is budget neutral for the Federal Government; and

(C) provide an assurance that the State has enacted the law described in subsection (b)(2).

(2) REQUIREMENTS.—The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows:

(A) Part I of subtitle D.

(B) Part II of subtitle D.

(C) Section 1402.

(D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.

(3) PASS THROUGH OF FUNDING.—With respect to a State waiver under paragraph (1), under which, due to the structure of the State plan, individuals and small employers in the State would not qualify for the premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E for which they would otherwise be eligible, the Secretary shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges established under this title had the State not received such waiver, shall be paid to the State for purposes of implementing the State plan under the waiver. Such amount shall be determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States, except that the Secretary shall determine such amount on the basis of reasonable estimates until such time as data regarding the experiences of other States become available and if such estimates are determined to be incorrect on the basis of such data, the Secretary shall adjust subsequent payments to correct errors in earlier payments that were based on such estimates.

(4) WAIVER CONSIDERATION AND TRANSPARENCY.—

(A) IN GENERAL.—An application for a waiver under this section shall be considered by the Secretary in accordance with the regulations described in subparagraph (B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved seeks to waive; and

(II) the specific plans of the State to ensure that the waiver will be in compliance with subsection (b);

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(5) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law relating to the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(6) DEFINITION.—In this section, the term ''Secretary'' means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

(b) GRANTING OF WAIVERS.—

(1) IN GENERAL.—The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(D) will not increase the Federal deficit.

(2) REQUIREMENT TO ENACT A LAW.—

(A) IN GENERAL.—A law described in this paragraph is a State law that provides for State actions under a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and terminate the authority provided under the waiver with respect to the State.

(c) SCOPE OF WAIVER.—

(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) DETERMINATIONS BY SECRETARY.—

(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) EFFECT OF DETERMINATION.—

(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) TERM OF WAIVER.—

(1) IN GENERAL.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver and such request is granted by the Secretary under paragraph (2).

(2) APPROVAL OF REQUEST.—A request under paragraph (1) shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. The Secretary may deny such a request only if the Secretary—

(A) determines that the State plan under the waiver to be continued did not meet the requirements under subsection (b);

(B) notifies the State in writing of the requirements under subsection (b) that the State plan did not meet and provides to the State the information used by the Secretary in making that determination; and

(C) provides the State with an opportunity to appeal such determination and provide information as to how such requirements were met.

The Secretary shall consider any information provided under subparagraph (C) and reconsider its determination under subparagraph (A). The Secretary shall grant the request if the Secretary determines upon reconsideration that the State plan met such requirements.

SA 2847. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 212, line 18, strike ''2017'' and insert ''2014''.

SA 2848. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 214, line 12, insert '', except that the Secretary shall determine such amount on the basis of reasonable estimates until such time as data regarding the experiences of other States become available and if such estimates are determined to be incorrect on the basis of such data, the Secretary shall adjust subsequent payments to correct errors in earlier payments that were based on such estimates'' after ''States''.

SA 2849. Mr. SANDERS (for himself and Mr. WYDEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 219, strike lines 12 through 20, and insert:

(e) TERM OF WAIVER.—

(1) IN GENERAL.—No waiver under this section may extend over a period of longer than 5 years unless the State requests continuation of such waiver and such request is granted by the Secretary under paragraph (2).

(2) APPROVAL OF REQUEST.—A request under paragraph (1) shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. The Secretary may deny such a request only if the Secretary—

(A) determines that the State plan under the waiver to be continued did not meet the requirements under subsection (b);

(B) notifies the State in writing of the requirements under subsection (b) that the State plan did not meet and provides to the State the information used by the Secretary in making that determination; and

(C) provides the State with an opportunity to appeal such determination and provide information as to how such requirements were met.

The Secretary shall consider any information provided under subparagraph (C) and reconsider its determination under subparagraph (A). The Secretary shall grant the request if the Secretary determines upon reconsideration that the State plan met such requirements.

SA 2850. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, add the following:

SEC. ___. REVISION OF EFFECTIVE DATES.

(a) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act shall be implemented by substituting ''2012'' for ''2014'' in each of the following:

(1) Section 2794 of the Public Health Service Act (as added by section 1003.

(2) Section 1001.

(3) Section 1101.

(4) Section 1002.

(5) Section 1253.

(6) Section 1302.

(7) Section 1311.

(8) Section 1321.

(9) Section 1322.

(10) Section 1332.

(11) Section 1341.

(12) Section 36B of the Internal Revenue Code of 1986 (as added by section 1401).

(13) Section 45R of the Internal Revenue Code of 1986 (as added by section 1421).

(14) Section 5000A of the Internal Revenue Code of 1986 (as added by section 1501(b)).

(15) Section 4980H of the Internal Revenue Code of 1986 (as added by section 1513.

(16) The provisions of title II including the amendments made by such title.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—

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

''PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

''SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(3) SECTION 15 NOT TO APPLY.—The amendment made by paragraph (1) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2010.

SA 2851. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title I, add the following:

SEC. ___. REVISION OF EFFECTIVE DATES.

Notwithstanding any other provision of this Act (or an amendment made by this Act), this Act shall be implemented by substituting ''2012'' for ''2014'' in each of the following:

(1) Section 2794 of the Public Health Service Act (as added by section 1003.

(2) Section 1001.

(3) Section 1101.

(4) Section 1002.

(5) Section 1253.

(6) Section 1302.

(7) Section 1311.

(8) Section 1321.

(9) Section 1322.

(10) Section 1332.

(11) Section 1341.

(12) Section 36B of the Internal Revenue Code of 1986 (as added by section 1401).

(13) Section 45R of the Internal Revenue Code of 1986 (as added by section 1421).

(14) Section 5000A of the Internal Revenue Code of 1986 (as added by section 1501(b)).

(15) Section 4980H of the Internal Revenue Code of 1986 (as added by section 1513.

(16) The provisions of title II including the amendments made by such title.

SA 2852. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2001 and insert the following:

SEC. 2001. MEDICAID ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.

(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(1) FULL MEDICAID BENEFITS FOR NON-MEDICARE ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

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

''(VIII) who are under 65 years of age, who are not described in a previous subclause of this clause, who are not entitled to hospital insurance benefits under part A of title XVIII, and whose family income (determined using methodologies and procedures specified by the Secretary) does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(2) MEDICARE COST SHARING ASSISTANCE FOR MEDICARE-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(E) of such Act (42 U.S.C. 1396b(a)(10)(E)) is amended—

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

(B) in clause (iv), by adding ''and'' at the end; and

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

''(v) for making medical assistance available for medicare cost-sharing described in

subparagraphs (B) and (C) of section 1905(p)(3), for individuals under 65 years of age who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 150 percent of the official poverty line (referred to in such section) for a family of the size involved; and''.

(3) INCREASED FMAP FOR NON-TRADITIONAL FULL MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(A) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods before 2015 and 91 percent for periods beginning with 2015) with respect to amounts described in subsection (y)''; and

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

''(y) ADDITIONAL EXPENDITURES SUBJECT TO INCREASED FMAP.—For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1) Amounts expended for medical assistance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).''.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VIII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraphs (1) and (2), or an increased FMAP under the amendments made by paragraph (3), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(5) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''; and

(ii) by inserting ''1902(a)(10)(E)(v),'' before ''1905(p)(1)''.

(B) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), is amended, in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xii);

(ii) by adding ''or'' at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL .—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)), as amended by subsection (a), is amended—

(A) by striking ''or'' at the end of subclause (VII); and

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

''(IX) who are over 18, and under 65 years of age, who would be eligible for medical assistance under the State plan under subclause (I) or section 1931 (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

''(X) beginning with 2014, who are under 19, years of age, who would be eligible for medical assistance under the State plan under subclause (I), (IV) (insofar as it relates to subsection (l)(1)(B)), (VI), or (VII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or''.

(2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

(A) INCREASED FMAP FOR ADULTS.—Section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting ''or (IX)'' after ''(VIII)''.

(B) ENHANCED FMAP FOR CHILDREN.—Section 1905(b)(4) of such Act is amended by inserting ''1902(a)(10)(A)(i)(X), or'' after ''on the basis of section''.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subclause (IX) or (X) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1), or an increased or enhanced FMAP under the amendments made by paragraph (2), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) CONFORMING AMENDMENT.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended by inserting ''1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(i)(X),'' after ''1902(a)(10)(A)(i)(VIII),''.

(c) NETWORK ADEQUACY.—Section 1932(a)(2) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)) is amended by adding at the end the following new subparagraph:

''(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual described in section 1902(a)(10)(A)(i)(VIII) unless the State demonstrates, to the satisfaction of the Secretary, that the entity, through its provider network and other arrangements, has the capacity to meet the health, mental health, and substance abuse needs of such individuals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2013, and shall apply with respect to items and services furnished on or after such date.

(e) DEFINITIONS.—In this section:

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

(2) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''traditional Medicaid eligible individual'' means a Medicaid eligible individual other than an individual who is—

(A) a Medicaid eligible individual by realson of the application of subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act; or

(B) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

(3) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''non-traditional Medicaid eligible individual'' means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

SA 2853. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 2001 and insert the following:

SEC. 2001. MEDICAID ELIGIBILITY FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.

(a) ELIGIBILITY FOR NON-TRADITIONAL INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—

(1) FULL MEDICAID BENEFITS FOR NON-MEDICARE ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

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

''(VIII) who are under 65 years of age, who are not described in a previous subclause of this clause, who are not entitled to hospital insurance benefits under part A of title XVIII, and whose family income (determined using methodologies and procedures specified by the Secretary) does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved;''.

(2) MEDICARE COST SHARING ASSISTANCE FOR MEDICARE-ELIGIBLE INDIVIDUALS.—Section 1902(a)(10)(E) of such Act (42 U.S.C. 1396b(a)(10)(E)) is amended—

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

(B) in clause (iv), by adding ''and'' at the end; and

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

''(v) for making medical assistance available for medicare cost-sharing described in subparagraphs (B) and (C) of section 1905(p)(3), for individuals under 65 years of age who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 150 percent of the official poverty line (referred to in such section) for a family of the size involved; and''.

(3) INCREASED FMAP FOR NON-TRADITIONAL FULL MEDICAID ELIGIBLE INDIVIDUALS.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(A) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods before 2015 and 91 percent for periods beginning with 2015) with respect to amounts described in subsection (y)''; and

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

''(y) ADDITIONAL EXPENDITURES SUBJECT TO INCREASED FMAP.—For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1) Amounts expended for medical assistance for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i).''.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VIII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraphs (1) and

(2), or an increased FMAP under the amendments made by paragraph (3), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(5) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''; and

(ii) by inserting ''1902(a)(10)(E)(v),'' before ''1905(p)(1)''.

(B) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), is amended, in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xii);

(ii) by adding ''or'' at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL .—

(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)), as amended by subsection (a), is amended—

(A) by striking ''or'' at the end of subclause (VII); and

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

''(IX) who are over 18, and under 65 years of age, who would be eligible for medical assistance under the State plan under subclause (I) or section 1931 (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

''(X) beginning with 2014, who are under 19, years of age, who would be eligible for medical assistance under the State plan under subclause (I), (IV) (insofar as it relates to subsection (l)(1)(B)), (VI), or (VII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or''.

(2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—

(A) INCREASED FMAP FOR ADULTS.—Section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting ''or (IX)'' after ''(VIII)''.

(B) ENHANCED FMAP FOR CHILDREN.—Section 1905(b)(4) of such Act is amended by inserting ''1902(a)(10)(A)(i)(X), or'' after ''on the basis of section''.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subclause (IX) or (X) of section 1902(a)(10)(A)(i) of the Social Security Act, as added by paragraph (1), or an increased or enhanced FMAP under the amendments made by paragraph (2), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(4) CONFORMING AMENDMENT.—Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by subsection (a)(4), is amended by inserting ''1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(i)(X),'' after ''1902(a)(10)(A)(i)(VIII),''.

(c) NETWORK ADEQUACY.—Section 1932(a)(2) of the Social Security Act (42 U.S.C. 1396u–2(a)(2)) is amended by adding at the end the following new subparagraph:

''(D) ENROLLMENT OF NON-TRADITIONAL MEDICAID ELIGIBLES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual described in section 1902(a)(10)(A)(i)(VIII) unless the State demonstrates, to the satisfaction of the Secretary, that the entity, through its provider network and other arrangements, has the capacity to meet the health, mental health, and substance abuse needs of such individuals.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2013, and shall apply with respect to items and services furnished on or after such date.

(e) DEFINITIONS.—In this section:

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

(2) TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''traditional Medicaid eligible individual'' means a Medicaid eligible individual other than an individual who is—

(A) a Medicaid eligible individual by realson of the application of subclause (VIII) of section 1902(a)(10)(A)(i) of the Social Security Act; or

(B) a childless adult not described in section 1902(a)(10)(A) or (C) of such Act (as in effect as of the day before the date of the enactment of this Act).

(3) NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ''non-traditional Medicaid eligible individual'' means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

SEC. 2001A. SURCHARGE ON HIGH INCOME INDIVIDUALS.

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

''PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

''SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(c) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SA 2854. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 103, line 10, insert before the period the following: '', including oral and vision care''.

SA 2855. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

SEC. ____. ORAL AND VISION CARE.

(a) TECHNICAL AMENDMENT.—Section 1302(b)(1)(A) of this Act is amended by inserting '', including oral and vision care'' before the period.

(b) SURCHARGE ON HIGH INCOME INDIVIDUALS.—

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

''PART VIII—SURCHARGE ON HIGH INCOME INDIVIDUALS

''Sec. 59B. Surcharge on high income individuals.

"SEC. 59B. SURCHARGE ON HIGH INCOME INDIVIDUALS.

''(a) GENERAL RULE.—In the case of a taxpayer other than a corporation, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax equal to 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.

''(b) TAXPAYERS NOT MAKING A JOINT RETURN.—In the case of any taxpayer other than a taxpayer making a joint return under section 6013 or a surviving spouse (as defined in section 2(a)), subsection (a) shall be applied by substituting '$500,000' for '$1,000,000'.

''(c) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income reduced by any deduction (not taken into account in determining adjusted gross income) allowed for investment interest (as defined in section 163(d)). In the case of an estate or trust, adjusted gross income shall be determined as provided in section 67(e).

''(d) SPECIAL RULES.—

''(1) NONRESIDENT ALIEN.—In the case of a nonresident alien individual, only amounts taken into account in connection with the tax imposed under section 871(b) shall be taken into account under this section.

''(2) CITIZENS AND RESIDENTS LIVING ABROAD.—The dollar amount in effect under subsection (a) (after the application of subsection (b)) shall be decreased by the excess of—

''(A) the amounts excluded from the taxpayer's gross income under section 911, over

''(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) with respect to the amounts described in subparagraph (A).

''(3) CHARITABLE TRUSTS.—Subsection (a) shall not apply to a trust all the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B).

''(4) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.''.

(2) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''PART VIII. SURCHARGE ON HIGH INCOME INDIVIDUALS.''.

(3) SECTION 15 NOT TO APPLY.—The amendment made by paragraph (1) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2010.

SA 2856. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 97, between lines 6 and 7, insert the following:

SEC. 2709. APPLICATION OF PREMIUM AND COVERAGE RULES TO GRANDFATHERED GROUP PLANS AND OTHER LARGE GROUP PLANS.

Notwithstanding section 2701 or 2707, or section 1251 of the Patient Protection and Affordable Care Act, in the case of plan years beginning after December 31, 2014, sections 2701 and 2707 shall apply to a group health plan, and a health insurance issuer offering group health insurance coverage, which is—

(1) a grandfathered health plan (as defined in section 1251(e) of such Act); or

(2) health insurance coverage offered in the large group market.

SA 2857. Mr. SANDERS submitted an amendment intended t be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 162, after line 25, add the following:

(7) CAP ON PRIVATE INSURANCE COMPANY EXECUTIVE COMPENSATION.—

(A) LIMITS ON COMPENSATION FOR EXECUTIVES OF PRIVATE INSURANCE COMPANIES PARTICIPATING IN AN EXCHANGE.—

(i) IN GENERAL.—Notwithstanding any other provision of law or agreement to the contrary, no employee or executive of a private health insurance issuer that offers coverage through an Exchange may receive aggregate annual compensation, in any form, from the issuer in an amount in excess of $1,000,000.

(ii) DEFINITION.—For purposes of this paragraph, the term ''aggregate annual compensation'' includes bonuses, deferred compensation, stock options, securities, or any other form of compensation provided to an employee or executive.

(B) BAR FROM PARTICIPATION IN EXCHANGE.—If a private health insurance issuer offering coverage through an Exchange fails to comply with the requirement of subparagraph (A), such issuer shall be prohibited from offering coverage through the Exchange.

SA 2858. Mr. SANDERS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for Mr. BAUCUS. Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1925, between lines 14 and 15, insert the following:

Subtitle C—Ethical Pathway for Pharmaceutical Products

SEC. 7201. ETHICAL PATHWAY FOR THE APPROVAL AND LICENSURE OF GENERIC PHARMACEUTICAL PRODUCTS.

(a) DEFINITIONS.—In this section—

(1) the term ''abbreviated new drug application'' means an abbreviated application for a new drug submitted under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j);

(2) the term ''Commissioner'' means the Commissioner of Food and Drugs; and

(3) the term ''Secretary'' means the Secretary of Health and Human Services.

(b) ETHICAL PATHWAY.—As soon as practicable after the date of enactment of this Act, the Secretary, acting through the Commissioner, shall establish a mechanism by which the filer of an abbreviated new drug application for approval of a drug or an application for licensure of a biological product under section 351(k) of the Public Health Service Act may request a cost-sharing arrangement described in subsection (c). Such a filer may request such an arrangement if, but for the arrangement, such filer would be required to conduct clinical investigations involving human subjects that violate Article 20 of the Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects in order to obtain such approval or licensure from the Secretary.

(c) COST-SHARING ARRANGEMENT.—The cost-sharing arrangement described in this subsection is an arrangement in which—

(1) the filer of the abbreviated new drug application or the application under section 351(k) of the Public Health Service Act pays a fee to the Commissioner;

(2) notwithstanding any other provision of law, the Commissioner provides such reports to such filer;

(3) such filer may, notwithstanding any provision of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) or of the Public Health Service Act (42 U.S.C. 301 et seq.), rely in such application on reports of investigations, conducted by a holder of an approved application under section 505(b) of the Federal Food, Drug, and Cosmetic Act or a holder of a license under section 351(a) of the Public Health Service Act, which have been made to show whether or not such drug or biological product is safe for use and whether such drug or biological product is effective in use; and

(4) the Commissioner remits the amount of such fee to the holder of the approved application under such section 505(b) or of the license under such section 351(a), as appropriate.

SA 2859. Ms. SNOWE (for herself, Ms. LANDRIEU, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 223, strike lines 6 through 10.

On page 224, line 2, insert after ''Act'' the following: '', including the rating requirements of such part A (except that the State may subsequent to the date of enactment of this Act enact more restrictive rating requirements),''.

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on Public Lands and Forests.

The hearing will be held on Thursday, December 17, 2009, at 2:30 p.m. in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on the following bills:

S. 1470, to sustain the economic development and recreational use of National Forest System land and other public land in the State of Montana, to add certain land to the National Wilderness Preservation System, to release certain wilderness study areas, to designate new areas for recreation, and for other purposes;

S. 1719, to provide for the conveyance of certain parcels of land to the town of Alta, Utah;

S. 1787, to reauthorize the Federal Land Transaction Facilitation Act, and for other purposes;

H.R. 762, to validate final patent number 27–2005–0081, and for other purposes; and

H.R. 934, to convey certain submerged lands to the Commonwealth of the Northern Mariana Islands in order to give that territory the same benefits in its submerged lands as Guam, the Virgin Islands, and American Samoa have in their submerged lands.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send it to the Committee on Energy and Natural Resources, United States Senate, Washington, DC 20510–6150, or by e-mail to allison_seyferth@energy.senate.gov.

For further information, please contact Scott Miller or Allison Seyferth.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on December 2, 2009, at 9:30 a.m. in room 216 of the Hart Senate Office Building.

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

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Wednesday, December 2, 2009, at 9 a.m.

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

COMMITTEE ON COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 2, 2009, at 10 a.m. in room 253 of the Russell Senate Office Building.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate to conduct a hearing on December 2, 2009, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS AND THE SUBCOMMITTEE ON SUPERFUND, TOXICS, AND ENVIRONMENTAL HEALTH

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works and the Subcommittee on Superfund, Toxics, and Environmental Health be authorized to meet during the session of the Senate on December 2, 2009, at 2:30 p.m. in Room 406 of the Dirksen Senate Office Building.

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

COMMITTEE ON THE JUDICIARY

Mr. DURIBN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 2, 2009, at 10 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Has the Supreme Court Limited Americans' Access to Courts?''

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

AD HOC SUBCOMMITTEE ON DISASTER RECOVERY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Ad Hoc Subcommittee on Disaster Recovery of the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 2, 2009, at 2:30 p.m. to conduct a hearing entitled, ''Disaster Case Management: Developing a Comprehensive National Program Focused on Outcomes.''

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

EXTENDING CONDOLENCES TO SLAIN WASHINGTON OFFICERS' FAMILIES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 366, submitted earlier today.

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

The clerk will report.

The bill clerk read as follows:

A resolution (S. Res. 366) extending condolences to the families of Sergeant Mark Rennigner, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DURBIN. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to the resolution be printed in the RECORD.

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

The resolution (S. Res. 366) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 366

Whereas on the morning of November 29, 2009, 4 members of the Lakewood Police Department were slain by gunfire in a senseless act of violence while preparing for their shift in Lakewood, Washington;

Whereas the 4 officers have been members of the Lakewood Police Department since its founding 5 years ago, were valuable members of the community, and were deeply respected for their service;

Whereas Sergeant Mark Renninger, who served 13 years in law enforcement, first with the Tukwila Police Department and most recently with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas Officer Tina Griswold, who served 14 years in law enforcement, first with the Lacey Police Department and most recently with the Lakewood Police Department, is survived by her husband and 2 children;

Whereas Officer Ronald Owens, who served 12 years in law enforcement, first with the Washington State Patrol and most recently with the Lakewood Police Department, is survived by his daughter;

Whereas Officer Greg Richards, who served 8 years in law enforcement, first with the Kent Police Department and most recently with the Lakewood Police Department, is survived by his wife and 3 children;

Whereas the senseless violence against and murder of law enforcement officers, who are sworn to serve, protect, and preserve the peace of the communities, is a particularly heinous crime; and

Whereas in the face of this senseless tragedy, the people of the City of Lakewood, the surrounding communities, and the State of Washington have come together in support of the law enforcement community and the families of the victims: Now, therefore, be it

Resolved, That the Senate—

(1) extends its condolences to the families of Sergeant Mark Renninger, Officer Tina Griswold, Officer Ronald Owens, and Officer Greg Richards; and

(2) stands with the people of Lakewood, Washington, the men and women of the Lakewood Police Department, and members of the law enforcement community as they celebrate the lives and mourn the loss of these 4 dedicated public servants and law enforcement heroes.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. DURBIN. Mr. President, I ask unanimous consent that the previous order with respect to H.R. 3590 be modified to provide that the time until 11:45 a.m. be equally divided between Senator MIKULSKI and the minority leader or their designees.

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

ORDERS FOR THURSDAY, DECEMBER 3, 2009

Mr. DURBIN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m. tomorrow, Thursday, December 3; that following the prayer and the pledge, the Journal of

proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, as provided for under the previous order.

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

PROGRAM

Mr. DURBIN. Mr. President, under a previous order, at 11:45 a.m., there will be a series of two rollcall votes and two more votes at 2:40 p.m. Those votes will be in relation to the Mikulski amendment, as amended, the Murkowski amendment, the Bennet of Colorado amendment, and the McCain motion to commit.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. DURBIN. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate adjourn under the previous order.

There being no objection, the Senate, at 8:31 p.m., adjourned until Thursday, December 3, 2009, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF COMMERCE

DAVID W. MILLS, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE DARRYL W. JACKSON, RESIGNED.

INTERNATIONAL MONETARY FUND

DOUGLAS A. REDIKER, OF MASSACHUSETTS, TO BE UNITED STATES ALTERNATE EXECUTIVE DIRECTOR OF THE INTERNATIONAL MONETARY FUND FOR A TERM OF TWO YEARS, VICE DANIEL D. HEATH, TERM EXPIRED.

FEDERAL MARITIME COMMISSION

MICHAEL A. KHOURI, OF KENTUCKY, TO BE A FEDERAL MARITIME COMMISSIONER FOR A TERM EXPIRING JUNE 30, 2011, VICE STEVEN ROBERT BLUST, RESIGNED.

IN THE COAST GUARD

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE UNITED STATES COAST GUARD TO THE GRADE INDICATED UNDER SECTION 271, TITLE 14, U.S.C.:

To be rear admiral

REAR ADM. (LH) JOSEPH R. CASTILLO
REAR ADM. (LH) DANIEL R. MAY
REAR ADM. (LH) ROY A. NASH
REAR ADM. (LH) PETER F. NEFFENGER
REAR ADM. (LH) CHARLES W. RAY
REAR ADM. (LH) KEITH A. TAYLOR

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE AND AS PERMANENT PROFESSOR AT THE UNITED STATES AIR FORCE ACADEMY, UNDER TITLE 10, U.S.C., SECTIONS 9333(B) AND 9336(A):

To be colonel

JOSEPH E. SANDERS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be lieutenant colonel

CHINMOY MISHRA

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

CHARLES F. KIMBALL

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES AIR FORCE UNDER TITLE 10, U.S.C., SECTION 624:

To be major

MINH THU NGOC LE
ROBERT C. POPE

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

MATTHEW S. FLEMMING