Mr. DODD, and Mr. HARKIN to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3058. Mr. ENSIGN 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 3059. Mr. ENSIGN 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 3060. Mr. ENSIGN 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 3061. 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, supra; which was ordered to lie on the table.

SA 3062. Mr. ENSIGN 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 3063. Mr. AKAKA (for himself and 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, supra; which was ordered to lie on the table.

SA 3064. Mr. CASEY 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 3065. Mr. CARDIN (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 3066. Mrs. BOXER 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 3067. Mr. ENSIGN (for himself, Mrs. BOXER, and Mr. ROCKEFELLER) 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 3068. Mr. KYL (for himself, Mr. ROY, ERTS, Mr. GRASSLEY, Mr. CUBAN, Mr. COBURN, Mr. BARRASSO, and Mr. JOHANNIS) 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 3069. Mr. KOHL 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 3070. Mrs. HAGAN 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 3071. Mrs. HAGAN 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 3072. Mrs. HAGAN 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 3073. Mr. SANDERSON submitted an amendment intended to be proposed by her to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3074. Mr. ENSIGN 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 3075. Mr. DURBIN 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 3076. Mr. DURBIN (for himself and Mr. SANDERSON) 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 3077. Mr. DURBIN 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 3078. Ms. KLOBUCHAR (for herself and Ms. SOWE) 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 3079. Mr. DURBIN 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 3080. Mrs. HAGAN 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 3081. Mrs. HAGAN 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 974, between lines 9 and 10, insert the following:

SEC. 3316. IMPROVEMENT IN PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS.

(a) In General.—Section 18610(f)(4)(C) of the Social Security Act (42 U.S.C. 1395w-104(c)(2)) is amended—

(1) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (E), (F), and (G), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraph (C):

‘‘(C) REQUIRED INTERVENTIONS.—For plan years beginning on or after the date that is 2 years after the date of the enactment of this Act, prescription drug sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under paragraph (A)(ii), in the medication therapy management program required under this subsection; and

(ii) permit such beneficiaries to opt-out of enrollment in such program.’’.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.
On page 1722, after line 24, insert the following:

“(C) USE OF TECHNOLOGY.—The Secretary shall incorporate the use of technologies, including predictive modeling techniques; and

“(d) PROHIBITION.—The advisory group established under subsection (a) shall examine and make recommendations of best practices of employee wellness and disease management programs administered by employers, including:

(1) provide public and private sector entities with improved information in assessing the role of employee wellness and disease management programs in saving money and improving quality of life for patients with chronic illnesses; and

(2) encourage the adoption of effective employee wellness and disease management programs.

(c) REPORT.—Not later than 1 year after the date of the enactment of this Act, the advisory group established under subsection (a) shall submit to the Secretary the results of the examination under subsection (b)(1).

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle such sums as may be necessary.

SA 3004. Mrs. HAGAN (for herself and Mr. BENNET) 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 32, after line 24, add the following:

“(4) CLEAR TRANSPARENCY OF HEALTH CARE CHARGES.—

“(1) PUBLIC DISCLOSURE OF REIMBURSEMENT AMOUNTS.—A health insurance covering group or individual health insurance coverage shall report at least once a year to the Secretary the current allowable reimbursement amounts that the issuer would reimburse for such charges.

“(2) ACCESSIBILITY.—Information submitted to the Secretary under paragraph (1) shall be maintained in a manner that ensures that such information is readily accessible by the public.

“(3) REGULATIONS.—Not later than one year after the date of the enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to implement the requirements of this subsection.”.

SA 3005. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) 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 150, line 5, strike “small business development centers” and insert “resource partners of the Small Business Administration”.

SEC. 1. SHORT TITLE.

This subtitle may be cited as the “Catalyst to Better Diabetes Care Act of 2009”.

SEC. 2. DIABETES SCREENING COLLABORATION AND OUTREACH PROGRAM.

(a) ESTABLISHMENT.—With respect to diabetes screening tests and for the purposes of reducing the number of undiagnosed seniors with diabetes or prediabetes, the Secretary of Health and Human Services (referred to in this section as the “Secretary”), in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”), shall—

(1) review uptake and utilization of diabetes screening benefits to identify and address any existing problems with regard to uptake and utilization of diabetes screening tests and for the purpose of—

(2) entities with an interest in diabetes, including analytics and predictive modeling techniques that minimize investigations that result in false positive outcomes.

(b) DUTIES.—The advisory group established under subsection (a) shall examine and make recommendations of best practices of employee wellness and disease management programs administered by employers, including:

(1) provide public and private sector entities with improved information in assessing the role of employee wellness and disease management programs in saving money and improving quality of life for patients with chronic illnesses; and

(2) encourage the adoption of effective employee wellness and disease management programs.

(c) REPORT.—Not later than 1 year after the date of the enactment of this Act, the advisory group established under subsection (a) shall submit to the Secretary the results of the examination under subsection (b)(1).

SEC. 3. NATIONAL DIABETES REPORT CARD.

(a) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Secretary”), shall prepare on a biennial basis a national diabetes report card (referred to in this section as a “Report Card”) and, to the extent possible, for each State, for the purpose of—

(1) aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes including—

(A) preventative care practices and quality of care;

(B) risk factors; and

(C) outcomes.

(2) UPDATED REPORTS.—Each Report Card that is prepared after the initial Report Card shall include indicators and other data that is readily accessible by the public.

(b) CONTENTS.—

(1) IN GENERAL.—Each Report Card shall include—

(A) tracking progress in meeting established national goals and objectives for improving diabetes care, costs, and prevalence (including Healthy People 2010); and

(B) informing policy and program development.

(c) AVAILABILITY.—The Secretary, in collaboration with the Director, shall make each report card available on the Internet by posting the Report Card on the Internet.

SEC. 5. IMPROVEMENT OF VITAL STATISTICS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(1) promote the education and training of physicians on the importance of birth and death certificate data and how to properly complete these documents, including the collection of such data for diabetes and other chronic diseases;

(2) encourage State adoption of the latest standard revisions of birth and death certificates; and

(3) work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(b) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—In carrying out this section, the Secretary may promote improvements to the collection of diabetes mortality data, including the addition of a question for the individual certifying the cause of death regarding whether the deceased had diabetes.
SA 3006. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) 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 272, between lines 18 and 19, insert the following:

(VIII) small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)) and self-employed individuals; and

SA 3007. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) 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 163, between lines 21 and 22, insert the following:

(4) a survey of the cost and affordability of health care insurance provided under the Exchange for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and

SA 3008. Ms. LANDRIEU (for herself, Ms. SNOWE, 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 2074, after line 25, add the following:

SEC. 9024. SMALL BUSINESS PROCUREMENT.

Part 19 of the Federal Acquisition Regulation, section 15 of the Small Business Act (15 U.S.C. 644), and any other applicable laws or regulations, or procuring or a required procurement or required requirements relating to small business concerns (as defined in section 3 of the Small Business Act (15 U.S.C. 632)) may not be waived with respect to any contract awarded under any program or other authority under this Act or an amendment made by this Act.

SA 3009. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) 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 54, between lines 16 and 17, insert the following:

(1) ALLOCATION OF FUNDING FOR SMALL BUSINESSES.—Of the amount appropriated under subsection (e), a reasonable amount, as determined by the Secretary, shall be used to provide for the establishment of small businesses that would not have received a small business grant or loan under section 3 of the Small Business Act (15 U.S.C. 632), and self-employed individuals; and

SA 3013. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) 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 274, after line 25, add the following:

SA 3012. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. STABENOW) 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 274, after line 25, add the following:

SEC. 9024. EXTENSION OF SMALL BUSINESS TAX CREDIT TO 5 YEARS.

(a) In General.—Section 45R(b)(2) of the Internal Revenue Code of 1986, as added by section 1421(a), is amended by striking “2—consecutive-taxable-year” and inserting “5—consecutive-taxable-year”.

(b) Conforming Amendment.—Section 45R(i) of the Internal Revenue Code of 1986, as so added, is amended by striking “2—year” and inserting “5—year”.

(c) Effective Date.—The amendments made by this section shall take effect as if included in the enactment of section 1421.

SA 3013. Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. STABENOW) 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 274, after line 25, add the following:

SEC. 9024. EXTENSION OF SMALL BUSINESS TAX CREDIT TO 2010.

(a) In General.—Paragraph (4) of section 162(1) of the Internal Revenue Code of 1986 is amended to read as follows:

“(4) REDUCED DEDUCTION FOR SELF-EMPLOYMENT TAX PURPOSES.—In determining an individual’s net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2, the deduction allowable by reason of section 1421 shall be reduced by an amount equal to 50 percent of the amount which would otherwise be allowable (determined without regard to this paragraph).”;

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.
SA 3015. Mr. ENSIGN 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. 2. PROTECTION OF ACCESS TO QUALITY HEALTH CARE THROUGH THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.

(a) HEALTH CARE THROUGH DEPARTMENT OF VETERANS AFFAIRS. Nothing in this Act shall be construed to prohibit, limit, or otherwise penalize veterans and dependents eligible for health care through the Department of Veterans Affairs under the laws administered by the Secretary of Veterans Affairs from receiving timely access to quality health care in any facility of the Department or from a non-Department health care provider through which the Secretary provides health care.

(b) HEALTH CARE THROUGH DEPARTMENT OF DEFENSE.

(1) IN GENERAL.—Nothing in this Act shall be construed to prohibit, limit, or otherwise penalize eligible beneficiaries from receiving timely access to quality health care in any facility of the Department or from any non-Department health care provider through which the Secretary provides health care.

SEC. 3. PROVIDING FEDERAL EMPLOYEE HEALTH BENEFITS PLANS.

(a) IN GENERAL.—Notwithstanding section 8902 of title 5, United States Code, that take effect with respect to calendar years that begin more than 1 year after that date.

(b) EFFECTIVE DATE.—This subsection shall take effect on the date of enactment of this Act.

(c) EFFECTIVE DATE.—The amendments made by this Act, shall be treated in the same manner as an individual retirement account described in section 408 of such Code, or on whose behalf such an election is made, shall be treated as an applicable tax-free retirement plan, or, if made, shall be treated as an applicable tax-free retirement plan.

SA 3017. Mr. ENSIGN 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. 7. APPOINTMENT OF HEALTH CARE CZARS.

Notwithstanding any other provision of this Act, any individual appointed by the President as a czar to address health care issues shall be subject to Senate confirmation.

SA 3019. Mr. ENSIGN 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 106, line 16, insert “or” or meets the requirements for a high deductible health plan under section 223(c)(2) of the Internal Revenue Code of 1986” after “section 1902(a)”.

SA 3020. Mr. ENSIGN 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. 10. EQUIVALENT BANKRUPTCY PROTECTIONS FOR HEALTH SAVINGS ACCOUNTS AS RETIREMENT FUNDS.

(a) IN GENERAL.—Section 522 of title 11, United States Code, is amended by adding at the end the following new subsection:

(“TREATMENT OF HEALTH SAVINGS ACCOUNTS.—For purposes of this section, any health savings account (as described in section 225 of the Internal Revenue Code of 1986) shall be treated in the same manner as an individual retirement account described in section 401 of such Code.”)

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to cases commencing under title 11, United States Code, after the date of the enactment of this Act.

SA 3021. Mr. ENSIGN 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 816, after line 20, insert the following:

SEC. 3115. ENSURING THAT AN INDIVIDUAL WHO ELECTS TO OPT-OUT OF MEDICARE PART A BENEFITS IS NOT ALSO REQUIRED TO OPT-OUT OF SOCIAL SECURITY BENEFITS.

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to opt-out of

amendment made by that Act, any taxpayer who—

(1) is a citizen or national of the United States; and

(2) has a household income which is not greater than 133 percent of an amount equal to the poverty line for a family of the size involved.

may elect to enroll in a qualified health plan through the Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act instead of enrolling in the State Medicaid plan under title XIX of the Social Security Act, or under a waiver of such plan.

SEC. 3116. APPOINTMENT OF HEALTH CARE CZARS.

Notwithstanding any other provision of this Act, any individual appointed by the President as a czar to address health care issues shall be subject to Senate confirmation.

On page 816, after line 20, insert the following:

SEC. 3115. ENSURING THAT AN INDIVIDUAL WHO ELECTS TO OPT-OUT OF MEDICARE PART A BENEFITS IS NOT ALSO REQUIRED TO OPT-OUT OF SOCIAL SECURITY BENEFITS.

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to opt-out of

amendment made by that Act, any taxpayer who—

(1) is a citizen or national of the United States; and

(2) has a household income which is not greater than 133 percent of an amount equal to the poverty line for a family of the size involved.

may elect to enroll in a qualified health plan through the Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act instead of enrolling in the State Medicaid plan under title XIX of the Social Security Act, or under a waiver of such plan.

SEC. 3115. ENSURING THAT AN INDIVIDUAL WHO ELECTS TO OPT-OUT OF MEDICARE PART A BENEFITS IS NOT ALSO REQUIRED TO OPT-OUT OF SOCIAL SECURITY BENEFITS.

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to opt-out of

amendment made by that Act, any taxpayer who—

(1) is a citizen or national of the United States; and

(2) has a household income which is not greater than 133 percent of an amount equal to the poverty line for a family of the size involved.

may elect to enroll in a qualified health plan through the Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act instead of enrolling in the State Medicaid plan under title XIX of the Social Security Act, or under a waiver of such plan.

SEC. 3115. ENSURING THAT AN INDIVIDUAL WHO ELECTS TO OPT-OUT OF MEDICARE PART A BENEFITS IS NOT ALSO REQUIRED TO OPT-OUT OF SOCIAL SECURITY BENEFITS.

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to opt-out of

amendment made by that Act, any taxpayer who—

(1) is a citizen or national of the United States; and

(2) has a household income which is not greater than 133 percent of an amount equal to the poverty line for a family of the size involved.

may elect to enroll in a qualified health plan through the Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act instead of enrolling in the State Medicaid plan under title XIX of the Social Security Act, or under a waiver of such plan.
benefits under title II of such Act as a condition for making such election.

SA 3022. Mr. ENSIGN 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:

SEC. 3. LIMITATION ON IMPLEMENTATION.

Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall not implement the amendments made by and the provisions of this Act for any year unless the Secretary certifies with respect to such year that such amendments and provisions will not result in any individual who would otherwise be enrolled in a Medicare Advantage plan under part C of title XVIII of the Social Security Act as in effect on the date of enactment of this Act being forced away from or losing their enrollment in such plan, as such enrollment was in effect on the day before the date of enactment of this Act.

SA 3023. Mr. ENSIGN 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 1050, between lines 7 and 10, insert the following:

SEC. 3022. STUDY AND REPORT ON MEDICARE COVERAGE FOR MEDICAL EQUIPMENT USED IN THE TREATMENT OF CIRCULATORY DISEASES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on the feasibility and advisability of providing reimbursement under the Medicare program for the use of gradient pumps and compression stockings that are used in the treatment of individuals with lymphedema, chronic venous insufficiency, and other circulatory diseases. Such study shall include an analysis of the following:

(1) The types of gradient pumps and compression stockings that are currently available on the market.

(b) Clinical appropriateness of providing gradient pumps and compression stockings for Medicare beneficiaries who have been diagnosed with lymphedema, chronic venous insufficiency, and other circulatory diseases.

(c) The financial impact on the Medicare program (including a description of any resulting costs or savings) if reimbursement were to be provided for gradient pumps and compression stockings that are used in the treatment of lymphedema, chronic venous insufficiency, and other circulatory diseases.

SA 3024. Mr. ENSIGN 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. 3. PROHIBITION ON USING MEDICARE SAVINGS TO OFFSET PROGRAMS RELATED TO MEDICARE.

Title III of the Congressional Budget Act of 1974 (sec. 306), is amended by adding at the end the following:

"SEC. 316. PROHIBITION ON USING MEDICARE SAVINGS TO OFFSET PROGRAMS UNRELATED TO MEDICARE.

"For purposes of this title and title IV, a reduction in outlays under title XVIII of the Social Security Act may not be counted as an offset to any outlays under any other program or activity of the Federal Government."
SA 3030. Mrs. FEINSTEIN (for herself, Mr. ROCKEFELLER, and Mr. WHITEHOUSE) 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 37, strike line 10 through line 14 and insert the following:

"(b) ELECTRONIC REPORTING.—The process established under subparagraph (A) shall include an electronic reporting system established by the Authority through which health insurance issuers shall report to the Secretary and State insurance commissioners the information requested by the Secretary under this subsection.

On page 37, between lines 24 and 25, insert the following:

"(3) HEALTH INSURANCE RATE AUTHORITY.—

"(A) IN GENERAL.—The Secretary shall establish a Health Insurance Rate Authority (referred to in this paragraph as the ‘Authority’) to be composed of 7 members to be appointed by the Secretary, of which—

"(i) at least 2 members shall be a consumer advocate with expertise in the insurance industry;

"(ii) at least 1 member shall be an individual who is a medical professional;

"(iii) at least 1 member shall be a representative of health insurance issuers; and

"(iv) such remaining members shall be individuals who are recognized for their expertise in health finance and economics, actuarial science, health facility management, health information technology, reimbursement of health facilities, and other related fields, who provide broad geographic representation and a balance between states and other regions.

"(B) ROLE.—In addition to the other duties of the Authority set forth in this subsection, the Authority shall advise and make recommendations to the Secretary concerning—

"(i) the information necessary to undertake the actions described in subparagraph (A), based on the Secretary’s determination that the State has sufficient authority and capability to deny rates, modify rates, provide rebates, or take other corrective actions; and

"(ii) as a condition of receiving a grant under subsection (c)(1); and

"(iii) at least 2 members shall be a consumer advocate with expertise in the insurance industry;

"(B) ROLE.—In addition to the other duties of the Authority set forth in this subsection, the Authority shall advise and make recommendations to the Secretary concerning—

"(i) the information necessary to undertake the actions described in subparagraph (A), based on the Secretary’s determination that the State has sufficient authority and capability to deny rates, modify rates, provide rebates, or take other corrective actions; and

"(ii) as a condition of receiving a grant under subsection (c)(1); and

"(iii) at least 2 members shall be a consumer advocate with expertise in the insurance industry;

"(B) ROLE.—In addition to the other duties of the Authority set forth in this subsection, the Authority shall advise and make recommendations to the Secretary concerning—

"(i) the information necessary to undertake the actions described in subparagraph (A), based on the Secretary’s determination that the State has sufficient authority and capability to deny rates, modify rates, provide rebates, or take other corrective actions; and

"(ii) as a condition of receiving a grant under subsection (c)(1); and

"(iii) at least 2 members shall be a consumer advocate with expertise in the insurance industry;

"(B) ROLE.—In addition to the other duties of the Authority set forth in this subsection, the Authority shall advise and make recommendations to the Secretary concerning—

"(i) the information necessary to undertake the actions described in subparagraph (A), based on the Secretary’s determination that the State has sufficient authority and capability to deny rates, modify rates, provide rebates, or take other corrective actions; and

"(ii) as a condition of receiving a grant under subsection (c)(1); and

"(iii) at least 2 members shall be a consumer advocate with expertise in the insurance industry;

"(B) ROLE.—In addition to the other duties of the Authority set forth in this subsection, the Authority shall advise and make recommendations to the Secretary concerning—

"(i) the information necessary to undertake the actions described in subparagraph (A), based on the Secretary’s determination that the State has sufficient authority and capability to deny rates, modify rates, provide rebates, or take other corrective actions; and

"(ii) as a condition of receiving a grant under subsection (c)(1); and

"(iii) at least 2 members shall be a consumer advocate with expertise in the insurance industry;
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term in section 1886(h)(5)(C) of the Social Security Act; 'approved medical residency program'; and

(3) ANNUAL REPORTING REQUIRED.—The provisions of subsection (b)(3) of section 304E shall apply to women's hospitals under this section in the same manner as such provisions apply to women's hospitals under such section 304E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (c) and (d) of section 3040 shall apply to women's hospitals under this section in the same manner as such provisions apply to hospitals under such section 3040. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

(d) MAKING OF PAYMENTS.—(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year involved for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and shall subject to pari passu claims the payments for the number of residents reported in the hospital's most recently filed Medicare cost report prior to the application date for the Federal fiscal year for which the interim payments are to be made for a hospital under this section, the fiscal year involved for which payments may be made for a hospital under this section, $12,000,000 for fiscal year 2007 were Medicare discharges of individuals who, as of the date of discharge—

(i) were enrolled in the original Medicare fee-for-service program under part A of title XVIII of the Social Security Act; and

(ii) were not women.

(2) ROUTING.—(I) A Medicare Advantage plan under part C of title XVIII of that Act; and

(II) an eligible organization under section 1876 of that Act; or

(III) a PACE program under section 1894 of that Act.

SA 3032. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, 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 36, strike line 23 and insert the following: "be necessary to carry out this section."

SEC. 279A. IMPROVING OVERSIGHT OF INSURER SERVICE TO BENEFICIARIES.

(a) DEFINITIONS.—In this section—

(1) the term 'database' means the database established under subsection (b); and

(2) the term 'NAIC' means the National Association of State Insurance Commissioners.

(b) MONITORING INSURER HANDLING OF REQUESTS FOR COVERAGE OF MEDICAL CARE.—

(1) ESTABLISHMENT.—The Secretary shall, in consultation with the NAIC, establish and maintain a nationally consistent database that, using standardized definitions, tracks claims handling performance by—

(A) all group health insurance providers; and

(B) providers offering group health insurance coverage in connection with a group health plan.

(2) CONTENT.—The database shall include information on the nature, timing, final disposition, and other relevant details (as determined by the Secretary) of claims, appeals, reviews, and requests for or denials of treatment by the entities described in paragraph (1). The Secretary may limit the content of the database to those claims that are materially significant, as determined by the Secretary.

(c) COLLECTION OF DATA.—The Secretary shall have the authority to collect and audit data from entities described in paragraph (1) necessary to implement the database, except that, in the case of such entities subject to the Employee Retirement Income Security Act of 1974, such data shall be collected by the Secretary of Labor for use by the Secretary of Labor. At the discretion of the Secretary, such data collection authority may be delegated to State insurance regulators.

(d) DISSEMINATION.—The Secretary shall make the database available to the Secretary of Health and Human Services, and to any other Federal official as determined by the Secretary, in a format that, at a minimum, includes the following:

(1) the identity of the insurer,

(2) the code identifying the group health plan,

(e) IMPLEMENTATION.—The Secretary shall implement the database no later than 2 years after the date of enactment of this section.

(d) DISSEMINATION.—The Secretary shall make the database available to State insurance regulators, health exchanges, and certain other entities as the Secretary determines necessary to ensure the confidentiality and privacy of medical records and comply with all existing privacy laws, and shall update the database on a quarterly basis.

(e) REPORTING.—Not later than January 1, 2013, and on an annual basis thereafter, the Secretary shall issue a report assessing the performance of the plans and issuers described in subsection (b)(1)(A) regarding claims handling, appeals, and reviews. Such report shall assess any evidence of a pattern of denial or delay of medically necessary claims or appeals.

SA 3033. Mr. CASEY (for himself and Mr. SPECTER) 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 1133, between lines 22 and 23, insert the following:

SEC. 3511. CONSISTENT QUALITY ACCREDITATION REQUIREMENTS FOR PROVIDERS CONTRACTING WITH MEDICARE ADVANTAGE PLANS AND STATE MEDICAID PROGRAMS.

(a) MEDICARE ADVANTAGE.—Section 188(a)(5)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)(B)(ii)) is amended—

(1) by striking 'In order to' and inserting the following:

(aa) IN GENERAL.—In order to;

and (bb) QUALITY ASSURANCE.—An MA organization shall not prohibit a particular hospital, physician or other entity within a category of healthcare providers from eligibility to contract with the MA organization because of a separate policy of the MA organization that does not recognize an approved Medicare program accreditation organization with the appropriate 'deeming authority' from the Secretary.

(b) STATE MEDICAID PLAN REQUIREMENT.—Section 1902(a)(3) of title XIX of the Social Security Act (42 U.S.C. 1396a(a)(3)) is amended by inserting "and (C) the State plan and a primary
care case-management system (described in section 1916(b)(1)), a Medicaid managed care organization, or a similar entity shall not prohibit a particular hospital, physician or other entity to which Medicare providers from being qualified to perform a service or services because of a separate policy of the State plan, system, organization, or entity that does not recognize or do not meet recognized accreditation organization with the appropriate "deeming authority" from the Secretary after subsection 1915.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of enactment of this Act and, in the case of MA only, on the date that the Secretary shall have determined that the Health Care Safety Net Enhancement Act of 1986, is amended by adding at the end the following:

"(c) DEFINITION.—In this section—

"(1) the term "medically underserved individual" means an individual who does not have health care coverage under the Medicare program under title XVIII of the Social Security Act, does not have health insurance coverage, or any other health care coverage program; and

"(2) the term "rural census tract of a metropolitan area" means a census tract that is defined as such a census tract on the most recent modification of the Census "Urbanized area or was provided to an individual being treated; and

"(3) to an act or omission by a health care professional that constitutes willful or criminal misconduct, gross negligence, recklessness, misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by such professional.

(c) REQUIREMENTS.—Subsection (a) shall not apply—

(1) to any act or omission by a health care professional that is outside the scope of the practice or care rendered, for which such professional is deemed to be licensed or certified to provide, unless such act or omission can reasonably be determined to be necessary to prevent serious bodily harm or preserve the life of the individual being treated; and

(2) if the services on which the medical malpractice claim is based did not arise out of the rendering of voluntary care for a medically underserved or indigent individual; or

(3) to an act or omission by a health care professional that constitutes willful or criminal misconduct, gross negligence, recklessness, misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by such professional.
SA 3037. Mr. JOHNSON (for himself, Mr. FRANKEN, Mr. BURRUS, and Mr. WARREN) proposed 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:

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SA 3038. Mr. ROCKEFELLER 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. MANAGED CARE ORGANIZATIONS.

(a) MINIMUM MEDICAL LOSS RATIO.—

(1) MEDICAID.—Section 1902(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) by striking “and” at the end of clause (xi); and

(B) by striking the period at the end of clause (xii) and inserting “; and”;

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

“(xii) such contract has a medical loss ratio, as determined in accordance with a methodology specified by the Secretary, that is a percentage (not less than 85 percent) specified by the Secretary.”;

(2) CHIP.—Section 1937(c)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 3331(d)(2), 2101(e), and 4401(c), is amended—

(A) by redesignating subparagraphs (B)(i) through (O) as subparagraphs (I) through (P); and

(B) by inserting after subparagraph (G) the following new subparagraph:

“(H) Section 1963(m)(2)(A)(xviv) (relating to application of minimum loss ratios, with respect to comparable contracts under this title).”;

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into or renewed on or after July 1, 2010.

(b) PATIENT ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting “and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary” after “patients”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SA 3040. Mr. ROCKEFELLER 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. AUTOMATIC INCREASE IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE DURING PERIODS OF NATIONAL ECONOMIC DOWNTURN.

(a) NATIONAL ECONOMIC DOWNTURN ASSISTANCE FMAP.—

(1) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396a), as amended by sections 2001(a)(3), 2006, 4106(b), and 4107, is amended—

(A) in subsection (b), in the first sentence—

(i) by striking “and” (5) and inserting “(5)”; and

(ii) by inserting “and” (with respect to each fiscal year quarter for which the Secretary determines that less than 23 States have a rolling average unemployment rate for that quarter has increased by at least 10 percent over the corresponding quarter for the most recent preceding 12-month period for which data are available (in this subsection referred to as the ‘‘trigger quarter’’) and “(B) ends with the first succeeding fiscal year quarter for which the Secretary determines that less than 23 States have a rolling average unemployment rate for that quarter with an increase of at least 10 percent over the corresponding quarter for the most recent preceding 12-month period for which data are available.

(2) ELIGIBLE STATE.—A State described in this paragraph is a State for which the Secretary determines that the rolling average unemployment rate for the State for any quarter occurring during a national economic downturn assistance period described in paragraph (1) has increased over the corresponding quarter for the most recent preceding 12-month period for which data are available.

(3) DETERMINATION OF NATIONAL ECONOMIC DOWNTURN ASSISTANCE FMAP.—

(A) IN GENERAL.—The national economic downturn assistance FMAP for a fiscal year quarter determined with respect to a State under this paragraph is equal to the Federal medical assistance percentage for the State for that quarter increased by the number of percentage points determined by—

(i) dividing—

(I) the Medicaid additional unemployes increased cost amount determined under subparagraph (B) for the quarter; by

(II) the State’s total Medicaid quarterly spending amount determined under subparagraph (C) for the quarter.

(B) MEDICAID ADDITIONAL UNEMPLOYED INCREASED COST AMOUNT.—

(i) IN GENERAL.—The amendment made by paragraph (1) is amended by—

(ii) by inserting after subparagraph (A)(i) the following new subparagraph:

“(B) the amount determined by subtracting the rolling average number of
unemployed individuals in the State for the base unemployment quarter for the State determined under subclause (I) from the rolling average number of unemployed individuals in the State for the quarter described in paragraph (1).

(II) BASE UNEMPLOYMENT QUARTER DEFINED.—

(aa) In general.—For purposes of subclause (I), except as provided in item (bb), the base quarter for a State is the quarter with the lowest rolling average number of unemployed individuals in the State in the 12-month period preceding the trigger quarter for a national economic downturn assistance period described in paragraph (1). The rolling average number of unemployed individuals in the State for the base quarter determined under item (aa), that quarter shall be treated as the base quarter for the State for such national economic downturn assistance period.

(bb) the rolling average number of unemployed individuals in a State for a quarter occurring during a national economic downturn assistance period described in paragraph (1) is less than the rolling average number of unemployed individuals in the State for the base quarter determined under item (aa), that quarter shall be treated as the base quarter for the State for such national economic downturn assistance period.

(ii) NATIONAL AVERAGE AMOUNT OF ADDITIONAL MEDICAID SPENDING PER NONDISABLED, NONELDERLY ADULTS AND CHILDREN MEDICAID SPENDING INDEX.—In the case of—

(I) a calendar quarter occurring in fiscal year 2012, $350; and

(II) a calendar quarter occurring in any succeeding fiscal year, the amount applicable under this clause for calendar quarters occurring in fiscal years preceding fiscal year 2012, increased by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average), as rounded up in an appropriate manner.

(iii) STATE NONDISABLED, NONELDERLY ADULTS AND CHILDREN MEDICAID SPENDING INDEX.—

(A) IN GENERAL.—With respect to a State, the quotient (not to exceed 1.00) of—

(aa) the State expenditure per person in poverty amount determined under subclause (II); divided by

(bb) the National expenditure per person in poverty amount determined under subclause (III).

(B) STATE EXPENDITURE PER PERSON IN POVERTY AMOUNT.—For purposes of subclause (I(aa), the National expenditure per person in poverty amount is the quotient of—

(aa) the total amount of annual expenditures for providing medical assistance under the State plan to nonelderly, nonelderly adults and children; divided by

(bb) the total number of nonelderly adults and children who reside in the State, as determined under paragraph (4)(A).

(C) NATIONAL EXPENDITURE PER PERSON IN POVERTY AMOUNT.—For purposes of subclause (I(bb), the National expenditure per person in poverty amount is the quotient of—

(aa) the sum of the total amounts determined under subclause (II)(aa) for all States; divided by

(bb) the sum of the total amounts determined under subclause (II)(bb) for all States.

(D) STATE'S TOTAL MEDICAID QUARTERLY SPENDING AMOUNT.—For purposes of subparagraph (A)(ii), the State's total Medicaid quarterly spending amount determined under this subparagraph with respect to a State and a quarter is the amount equal to—

(i) the total amount of expenditures by the State for providing medical assistance under its plan to all individuals, including those enrolled in the plan, for all fiscal years occurring in the most recent fiscal year for which data is available; divided by

(ii) 4.

(E) DATA.—In making the determinations required under this subsection, the Secretary shall use, in addition to the most recent available data from the Bureau of Labor Statistics Local Area Unemployment Statistics for each State referred to in paragraph (5), the most recently available—

(i) the monthly seasonally adjusted number of unemployed individuals for the State, as determined by the Bureau of Labor Statistics using the most available data from the Bureau of Labor Statistics Local Area Unemployment Statistics for each State,

(ii) the monthly seasonally adjusted number of unemployed individuals for the State, as determined by the Bureau of Labor Statistics using the most recent data available from the Bureau of Labor Statistics Local Area Unemployment Statistics for each State,

(iii) the average of the 12 most recent months of seasonally adjusted unemployment rates for the State, determined using the monthly seasonally adjusted unemployment rates published in the Bureau of Labor Statistics' "Unemployment Report" and "State Unemployment Report" series; and

(iv) the average of the 12 most recent months of seasonally adjusted unemployment rates for the State, determined using the Bureau of Labor Statistics' "Unemployment Report" series.

(F) DEFINITION OF 'ROLLING AVERAGE NUMBER OF UNEMPLOYED INDIVIDUALS', 'ROLLING AVERAGE UNEMPLOYMENT RATE'.—In this subsection, the term—

(A) rolling average number of unemployed individuals means, with respect to a calendar quarter and a State, the average of the 12 months preceding that calendar quarter for which data is available; divided by the monthly seasonally adjusted number of unemployed individuals for the State; and

(B) monthly unemployment rate means, with respect to a State, the quotient of—

(i) the monthly seasonally adjusted number of unemployed individuals for the State; divided by

(ii) the monthly seasonally adjusted number of the labor force for the State; and

(iii) the monthly unemployment rate for the State; and

(iv) the unemployment rate for the States, using the methodology prescribed in paragraph (2) for the quarter.

(G) SCHEME OF APPLICATION.—The national economic downturn assistance FMAP shall apply for purposes of payments under section 1903 for a quarter and shall not apply with respect to—

(A) disproportionate share hospital payments determined under section 1924; or

(B) payments under title IV or XXI; or

(C) any payments under title X that are based on the enhanced FMAP described in paragraph (1)(A) that are based on the enhanced FMAP described in section 1919(b).

(H) ADDITIONAL REQUIREMENT FOR CERTAIN STATES.—In the case of a State described in paragraph (2) that requires political subdivisions other than the Federal share of expenditures required under section 1902(a)(2), the State shall not require that such political subdivisions other than the Federal share of expenditures required under such section 1902(a)(2) shall be transported to the Federal share of payments under section 1902(a)(2) to the extent that such political subdivisions other than the Federal share of expenditures required under such section 1902(a)(2) exceed the Federal share of payments under such section 1902(a)(2) by the same amount.
Not later than December 31, 2010, and annually thereafter, the Inspector General of the Department of Justice shall prepare and submit to Congress a report that evaluates the adequacy of efforts by States to provide appropriate home and community-based services to individuals with disabilities in accordance with the requirements under Olmstead v. L.C., 527 U.S. 581 (1999).

SEC. 3043. Mr. ROCKEFELLER 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 397, strike line 15 and all that follows through page 398, line 25.

SEC. 3044. Mr. ROCKEFELLER 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:

Beginning on page 397, strike line 15 and all that follows through page 398, line 25.

SEC. . PAYMENT OF MEDICARE LIABILITY TO STATES AS A RESULT OF THE SPECIAL DISABILITY WORKLOAD PROJECT.

(a) IN GENERAL.—The Secretary, in consultation with the Commissioner, shall work with each State to reach an agreement, not later than 6 months after the date of enactment of this Act, on the amount of a payment to be paid by the Secretary to States, from the amounts appropriated under paragraph (2), which will then be paid to States, determined appropriate.

(b) CONDITIONS FOR PAYMENTS.—(1) AMOUNT OF PAYMENTS.—A State shall not receive a payment under this section unless the Secretary determined appropriate.

(2) CONDITIONS FOR PAYMENTS.—A State shall not receive a payment under this section unless the Secretary determined appropriate.

(3) NO INDIVIDUAL STATE CLAIMS DATA REQUIRED.—No State shall be required to submit any individual State claims data under the Medicare program as a condition for receiving a payment under this section.

(4) INELIGIBLE STATES.—No State that is a party to a compact between the United States and any Federal or State court in which relief is sought shall be eligible for payments under this subsection.

(d) DEFINITIONS.—In this section:

(1) COMMISSIONER.—The term "Commissioner" means the Commissioner of Social Security.

(2) MEDICAID PROGRAM.—The term "Medicaid program" means the program established under section 1902 of the Social Security Act (42 U.S.C. 1396a et seq.) as a result of such project, including payments made under agreements in lieu of payments as a result of such project, and any other payment being made under agreements in lieu of payments as a result of such project.

(3) MEDICAID WORKLOAD PROJECT.—The term "Medicaid Workload project" means the Special Disability Workload project involving an individual determined to have met the requirements under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as a result of such project.

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

(5) SOW CASE.—The term "SOW case" means a case in which the Special Disability Workload project involving an individual determined to have met the requirements under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as a result of such project, and any other payment being made under agreements in lieu of payments as a result of such project.

(6) SPECIAL DISABILITY WORKLOAD PROJECT.—The term "Special Disability Workload project" means the project described in subsection (a) to support the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, H.R. Doc. No. 110–104, 110th Cong., 1st Sess.

(7) STATE.—The term "State" means each of the 50 States and the District of Columbia.

SEC. . REQUIREMENTS FOR MEDICARE PROVIDERS TO ACCEPT IN-NETWORK PAYMENT RATES FOR SERVICES PROVIDED TO MEDICARE MANAGED CARE ENROLLERS.

(a) IN GENERAL.—Section 1932(b) of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following: "(9) ASSURING ACCESS TO SERVICES FURNISHED BY NON-CONTRACT PROVIDERS.—Any provider of items or services for which Medicare provides coverage that has an agreement with the Secretary to States under paragraph (1) except that the Secretary determined appropriate.

(2) AMENDMENT.—The amendment made by subsection (a) takes effect on January 1, 2010.

SEC. 3045. Mr. KERRY (for himself, Mr. KIRK, Mr. SCHUMER, Mrs. GILLIBRAND, Mr. LEAHY, Mr. SANDERS, Mr. CARPER, and Mr. KAUFMAN) 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 402, strike line 15 and all that follows through page 403, line 9, and insert the following:

(a) NEWLY ELIGIBLE.—The term "newly eligible" means an individual described in subclause (VIII) of section 1902(a)(10)(A)(i) who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan for full benefits or for benchmark coverage described in section 1907(b)(1) or benchmark equivalent coverage described in section 1907(b)(2), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

SEC. 3046. Mr. KERRY (for himself, Ms. STABENOW, Ms. COLLINS, Ms. SNOWE, Mr. WYDEN, Mrs. LINCOLN, Mr. JOHN-SON, Mr. SHERIDAN, and Mrs. GILLIBRAND) 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 983, strike line 11 and all that follows through page 984, line 3, and insert the following:

“(v) HOME HEALTH MORTGAGE ADJUSTMENT.—After determining the home health mortgage market percentage increase under clause (iii), and after application of clause (v), the Secretary shall submit an amendment for 2015 and each subsequent year, by the productivity adjustment described in section 1866(b)(3)(B)(ix)(II). The application of the preceding sentence may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system being set for a year being less than such payment rates for the preceding year.”.

SA 3047. Mr. KERRY (for himself, Mr. WYDEN, Mr. WHITEHOUSE, Mr. REED) 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. 3107. MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT.

(a) Establishment.—The Secretary shall establish and implement a demonstration project under title XVIII of the Social Security Act to evaluate the benefits of providing payment for intravenous immune globin for the treatment of primary immune deficiency diseases.

(b) Duration and Scope.—

(1) DURATION.—Beginning not later than January 1, 2011, the Secretary shall conduct the demonstration project for a period of 3 years.

(2) SCOPE.—The Secretary shall enroll not greater than 4,000 Medicare beneficiaries who have been diagnosed with primary immune deficiency disease for participation in the demonstration project. A Medicare beneficiary may participate in the demonstration project on a voluntary basis and may terminate participation at any time.

(c) Reimbursement.—The Secretary shall establish an hourly rate for payment for items and services needed for the administration of intravenous immune globin based on the low-utilization payment adjustment under the prospective payment system for home health services established under section 1861(q) of the Social Security Act (42 U.S.C. 1395q).

(d) Study, Report, and Congress.—

(1) INTERIM EVALUATION AND REPORT.—Not later than 24 months after the date of enactment of this Act, the Secretary shall submit to Congress a report that contains the following:

(A) An interim evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the administration of intravenous immune globin within the home.

(B) An analysis of the appropriateness of implementing a new methodology for payment for intravenous immune globulins in all care settings under part B of title XVIII of the Social Security Act (42 U.S.C. 1395k et seq.).

(C) An analysis of the feasibility of reducing the lag time with respect to data used to determine the average sales price under section 1881A of the Social Security Act (42 U.S.C. 1395s).

(D) An update to the report entitled “Analysis of Supply, Distribution, Demand, and Access Issues Associated with Intravenous Immune Globulins” for the period February 1, 2007, to February 1, 2008, by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

(2) FINAL EVALUATION AND REPORT.—Not later than July 1, 2014, the Secretary shall submit to Congress a report that contains a final evaluation of the impact of the demonstration project for Medicare beneficiaries to items and services needed for the administration of intravenous immune globin within the home.

(e) Offset.—

(1) IN GENERAL.—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by adding at the end the following:

“(2) M ED I C A R E BENEFICIARY.—The term ‘Medicare beneficiary’ means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title.

(3) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.”

SA 3048. Mr. BARRASSO 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 816, after line 20, insert the following:

SEC. 3115. RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1842(r) of the Social Security Act (42 U.S.C. 1395w-3a) is amended—

(A) by striking “in a subsequent year” and adding “2010” after the period contained in subparagraph (B); and

(B) by striking “2010” and inserting “2011” after the period contained in subparagraph (A).

SA 3049. Mr. BARRASSO 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 836, between lines 14 and 15, insert the following:

SEC. 3008. PROTECTION OF MEDICAID WAIVER AUTHORITY.

No provision of this Act or any amendment made by this Act shall limit or otherwise restrict any authority in effect on the date of enactment of this Act which the Secretary of Health and Human Services may exercise under section 1115 of the Social Security Act or otherwise to encourage States to develop innovations programs to provide health insurance to uninsured individuals or to contain health care costs by granting States budget neutral Medicaid waivers Any provision of this Act or an amendment of this Act that is contrary to the preceding sentence is null and void.

SA 3050. Mr. BARRASSO 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 906, strike lines 13 through 24.

SA 3051. Mr. BARRASSO 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 816, after line 20, insert the following:

SEC. 3115. RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1842(r) of the Social Security Act (42 U.S.C. 1395w-3a) is amended—

(A) by striking “in a subsequent year” and adding “2010” after the period contained in subparagraph (B); and

(B) by striking “2010” and inserting “2011” after the period contained in subparagraph (A).

SA 3052. Mr. BARRASSO 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 1266, between lines 17 and 18, insert the following:
SEC. 4403. RURAL HEALTH CLINIC AND COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.

Section 331 of the Public Health Service Act (42 U.S.C. 254b), as amended by section 4206, is amended by adding at the end the following:

"(1) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

"(1) IN GENERAL.—Nothing in this section shall prevent a community health center from contracting with a federally certified rural health clinic (as defined by section 1381(a)(2) of the Social Security Act) to deliver of primary health care services that are available at the rural health clinic to individuals who would otherwise be eligible for free or reduced cost care if they were able to obtain such care at the community health center. Such services may be limited in scope to those primary health care services available in that rural health clinic.

"(2) ASSURANCES.—In order for a rural health clinic to receive funds under this section through a contract with a community health center under paragraph (1), such rural health clinic shall establish policies to ensure—

"(A) nondiscrimination based upon the ability to pay; and

"(B) the establishment of a sliding fee scale for low-income patients.'

SA 3053. Mr. INHOFE 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 2026, strike line 3 and insert the following:

(1) EXCLUSION OF ASSISTIVE DEVICES FOR PEOPLE WITH DISABILITIES.—

(1) IN GENERAL.—The term "medical device sales" shall not include sales of any assistive device for people with disabilities.

(2) REDUCTION OF AGGREGATE FEE AMOUNT.—

The $2,000,000,000 amount in subsection (b)(1) shall be reduced in each calendar year by the amount which bears the same ratio to such $2,000,000,000 amount as the amount of the sales of devices described in paragraph (1) for such calendar year bears to the amount of total medical device sales (without regard to this subsection) for such calendar year, as determined by the Secretary.

SA 3054. Mr. ROBERTS (for himself and Mr. KYL) 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 1703, between lines 4 and 5, insert the following:

(1) PROHIBITION ON THE USE OF COST IN COMPARATIVE EFFECTIVENESS RESEARCH.—

(a) IN GENERAL.—Notwithstanding any other provision of law, in no case may the cost of any medical treatment, item, or service described in subsection (b) be considered a factor in any comparative effectiveness research conducted—

(1) by the Federal Government; or

(2) by any other entity using funding provided by the Federal Government.

(b) MEDICAL TREATMENT, ITEM, OR SERVICE.—The medical services, and items described in this subsection are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals, medical products, and services (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.

(c) INCLUSION.—The comparative effectiveness research described under subsection (a) includes any such research conducted or funded by—

(1) the Patient-Centered Outcomes Research Institute under section 1381 of the Social Security Act (as added by section 6301);

(2) the Department of Health and Human Services, including the Agency for Healthcare Research and Quality and the National Institutes of Health; and


(d) APPLICATION.—This section shall apply to any comparative effectiveness research—

(1) that is ongoing as of the date of enactment of this Act; or

(2) that is conducted after the date of enactment of this Act.

SA 3055. Mr. ENSIGN 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 1983, strike lines 1–11 and insert the following:

(3) 3-YEAR AVERAGE FEBH PROGRAM PREMIUM INCREASE.—For purposes of clause (i)—

(I) IN GENERAL.—The term ‘3-year average FEBH program premium increase’ means, with respect to any calendar year, the average of the FEBH program premium increases for the preceding 3 calendar years.

(II) FEBH PREMIUM INCREASE.—The term ‘FEBH program premium increase’ means, with respect to any calendar year, the average amount of the increases in premiums (if any) for all plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code, which were offered under such program for the preceding calendar year.

SA 3056. Mr. ENSIGN 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. 4. NO FEDERAL TAX INCREASE IMPOSED ON MIDDLE INCOME INDIVIDUALS AND FAMILIES.

(a) IN GENERAL.—Notwithstanding any provision of, or amendment made by this Act, no such provision or amendment which, directly or indirectly, results in a Federal tax increase shall be administered in such manner as to impose such an increase on any middle income taxpayer.

(b) MIDDLE INCOME TAXPAYER.—For purposes of this section, the term ‘middle income taxpayer’ means, for any taxable year,
any taxpayer with adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) of less than $200,000 ($250,000 in the case of a joint return of tax).

SA 3059. Mr. ENSIGN 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 1999, strike lines 1 through 20.

SA 3060. Mr. ENSIGN 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. 2024. TAXES NOT FEES, PENALTIES, OR ASSESSABLE PAYMENTS.

(a) TAXES NOT FEES.—Sections 4375, 4376, 4377, and 9511 of the Internal Revenue Code of 1986 (as added by section 3001(e) and as amended by sections 9008, 9009, and 9101) are each amended by striking "fee" or "fees" each place they appear and inserting "tax" or "taxes", respectively.

(b) TAXES NOT PENALTIES.—Section 5000A of the Internal Revenue Code of 1986 (as added by section 151(b)) is amended by striking "penalty" each place it appears (other than the second place in paragraphs (1) and (2)(A) of subsection (g) thereof) and inserting "tax".

(c) TAXES NOT ASSESSABLE PAYMENTS.—Section 4980H of the Internal Revenue Code of 1986 (as added by section 151(c)(1) and section 151(c)(2)) is each amended by striking "assessable payment" or "assessable payments" each place they appear and inserting "tax" or "taxes", respectively.

SA 3062. Mr. ENSIGN 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 357, strike line 15 and insert the following:

(d) Report on Impact of Penalties.—Not later than 180 days after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the assessable payments imposed under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The report submitted under this subsection shall include a detailed analysis of the impact of assessable penalty on—

(1) employer profits,

(2) Federal revenues, including any decrease in tax revenues due to any decrease in employer profits as a result of such assessable penalties;

(3) the level of wages and benefits of employees;

(4) the hours worked by employees, including whether employees are classified as part-time or full-time employees, and

(5) the termination of employees.

(e) Effective Date.—The amendments made by

SA 3063. Mr. AKAKA (for himself and 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:

On page 515 of the amendment, between lines 11 and 12, insert the following:

SEC. 2552. ESTABLISHMENT OF PERMANENT MEDICARE DSH ALLOTMENT FOR HAWAII.

(a) In General.—Section 1923(c)(6) of the Social Security Act (42 U.S.C. 1396r–4(f)(6)) is amended—

(1) by striking the paragraph heading and inserting the following: "ALLOTMENT ADJUSTMENTS FOR TENNESSEE AND HAWAII"; and

(2) in subparagraph (B), by adding at the end the following:

"(iii) Allocation for 2d, 3rd, and 4th Quarter of Fiscal Year 2012, Fiscal Year 2013, and Succeeding Fiscal Years.—Notwithstanding the table set forth in paragraph (2) or paragraph (7):"

"(I) 2d, 3rd, and 4th Quarter of Fiscal Year 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be $300,000.

"(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEARS 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clauses (I) and (II) of paragraph (5)(B)."

"(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments under this section do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project."

(b) CONFORMING AMENDMENT.—Effective October 1, 2011, paragraph (7) of section 1923(f) of such Act (42 U.S.C. 1396r–4(f)), as added by section 2551, is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking "paragraph (7)" and inserting "paragraphs (7) and (8)"; and

(2) by adding at the end the following:

"(G) NONAPPLI CATION.—The preceding provisions of this paragraph shall not apply to the DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (6)."

SA 3064. Mr. CASEY 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 124, between lines 16 and 17, insert the following:

(4) Nondiscrimination on Abortion and Respect for Rights of Conscience.—

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

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

(ii) require any health plan created or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination, on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

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

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

SA 3065. Mr. CARDIN (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:

On page 396, between lines 8 and 9, insert the following:
Title I—Improving Managed Care
Subpart A—Utilization Review; Claims

SEC. 1601. UTILIZATION REVIEW ACTIVITIES.
(a) Compliance With Requirements.—
(1) A group health plan, or a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, or retrospective review.

(b) Use of Written Criteria.—
(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.
(2) USE OF WRITTEN CRITERIA.—
(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed and periodically reviewed by a qualified health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably required to assess whether the services under review are medically necessary or appropriate training in the conduct of such activities.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilizations review activities, in addition to any specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional, or authorized representative (regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involving, in any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits.) and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably required to assess whether the services under review are medically necessary or appropriate training in the conduct of such activities.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilizations review activities, in addition to any specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional, or authorized representative (regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involving, in any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits.) and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably required to assess whether the services under review are medically necessary or appropriate training in the conduct of such activities.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilizations review activities, in addition to any specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional, or authorized representative (regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involving, in any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits.) and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably required to assess whether the services under review are medically necessary or appropriate training in the conduct of such activities.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilizations review activities, in addition to any specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional, or authorized representative (regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involving, in any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits.) and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably required to assess whether the services under review are medically necessary or appropriate training in the conduct of such activities.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—A group health plan, or health insurance issuer offering health insurance coverage, shall select qualified personnel to conduct utilization review activities with respect to any plan or issuer to comply with the requirements of subparagraph (A). Such personnel shall be health care professionals, or specific health care professionals, as determined by the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilizations review activities, in addition to any specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional, or authorized representative (regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involving, in any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits.) and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably required to assess whether the services under review are medically necessary or appropriate training in the conduct of such activities.
possible, but not later than 30 days after the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the claim, or, if earlier, 30 days after the date of receipt of the claim for benefits.

(c) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination described in paragraph (B) or (C) of subsection (b)(1), within the 72-hour or applicable period referred to in such subparagraph.

(d) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination of both the plan or issuer and the treating health care professional, if any, in clear and understandable language, and

(2) procedures for obtaining additional information concerning the determination.

(e) DEFINITIONS.—For purposes of this part:

(1) AUTHORIZED REPRESENTATIVE.—The term ‘authorized representative’ has the meaning given in section 1857(c)(2) of the Social Security Act.

(2) CLAIM FOR BENEFITS.—The term ‘claim for benefits’ means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(f) DENIAL OF CLAIM FOR BENEFITS.—The term ‘denial’ means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this part.

(g) TREATING HEALTH CARE PROFESSIONAL.—The term ‘treating health care professional’ has the meaning given in section 1861(s)(2) of such Act and as defined in paragraph (3) of subsection (a)(1) of section 1861(s)(2) of such Act.

(h) PRIMARY CARE.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides for or covers the medical care or services of a primary care provider, the plan or issuer shall permit each participant, beneficiary, or enrollee to designate any participating provider with prior authorization; and

(i) PRIMARY PROVIDER.—The term ‘primary care provider’ means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual’s consent or without such consent if the individual is medically unable to provide such consent.

(j) CLAIM FOR BENEFITS.—The term ‘claim for benefits’ means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(k) DENIAL OF CLAIM FOR BENEFITS.—The term ‘denial’ means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this part.

(l) TREATING HEALTH CARE PROFESSIONAL.—The term ‘treating health care professional’ has the meaning given in section 1861(s)(2) of such Act.

(m) PRIMARY CARE.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides for or covers the medical care or services of a primary care provider, the plan or issuer shall permit each participant, beneficiary, or enrollee to designate any participating provider with prior authorization; and

(n) PRIMARY PROVIDER.—The term ‘primary care provider’ means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual’s consent or without such consent if the individual is medically unable to provide such consent.

(3) ACCESS TO CERTAIN PROVIDERS.—The term ‘access to providers’ has the meaning given in section 1861(s)(2) of such Act.

SEC. 1611. CHOICE OF HEALTH CARE PROFESSIONAL

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a primary care provider, then the plan or issuer shall permit each participant, beneficiary, or enrollee to designate any participating primary care provider, who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan, or a health insurance policy or certificate of an issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate medical care, pursuant to an appropriate referral procedure, from any qualified participating health care professional who is available to accept such individual.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly explains to each participant, beneficiary, or enrollee, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

(c) NOTICE OF DENIAL OF CLAIM FOR BENEFITS.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

SEC. 1612. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides for emergency medical care, such care shall be provided at no cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would be reasonably expected to pay for such care if provided by a participating health care provider with prior authorization; and

(2) CLAIM FOR BENEFITS.—The term ‘claim for benefits’ means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(b) PRIMARY PROVIDER.—The term ‘primary care provider’ means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual’s consent or without such consent if the individual is medically unable to provide such consent.

(c) DETERMINATION.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination of both the plan or issuer and the treating health care professional, if any, in clear and understandable language, and

(2) procedures for obtaining additional information concerning the determination.

(d) NOTICE OF DETERMINATION.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination of both the plan or issuer and the treating health care professional, if any, in clear and understandable language, and

(2) procedures for obtaining additional information concerning the determination.

(e) CLAIM FOR BENEFITS.—The term ‘claim for benefits’ means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(f) DENIAL OF CLAIM FOR BENEFITS.—The term ‘denial’ means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this part.

(3) ACCESS TO CERTAIN PROVIDERS.—The term ‘access to providers’ has the meaning given in section 1861(s)(2) of such Act.

SEC. 1613. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—

(1) IN GENERAL.—A group health plan or health insurance issuer offering health insurance coverage shall ensure that participants, beneficiaries, and enrollees receive timely access to participating specialists who are appropriate to the condition of, and accessible to, the participant, beneficiary, or enrollee, when such specialty care is a covered benefit under the plan or coverage.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) to require the coverage under a group health plan or health insurance coverage of benefits or services;

(B) to prohibit a plan or issuer from including in the network only to the extent necessary to meet the needs of the plan’s or issuer’s participants, beneficiaries, or enrollees; or

(C) to override any State licensure or scope-of-practice law.

(3) ACCESS TO CERTAIN PROVIDERS.—

(A) IN GENERAL.—With respect to specialty care under this section, if a participating specialist is not available and qualified to provide such care to the participant, beneficiary, or enrollee, the plan or issuer shall provide for coverage of such care by a non-participating specialist.

(B) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a participant, beneficiary, or enrollee receives care from a nonparticipating specialist pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would otherwise pay for such specialty care if provided by a participating specialist.

(1) AUTHORIZATION.—Subject to subsection (a)(1), a group health plan, or health insurance issuer may require an authorization in advance for nonemergency specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time that the plan or issuer determines, in accordance with the requirements of section 1852(d)(2) of the Social Security Act; and
may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

SEC. 1614. ACCESS TO PEDIATRIC CARE.

(a) GENERAL RIGHTS.—For purposes of this section, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, poten-
tially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(b) CONSTRUCTION.—Nothing in subsection (a)(1) shall be construed as prohibiting a plan or issuer from requiring the specialist to provide the plan or issuer with regular updates on the specialty care provided, as well as all other reasonably necessary medical information.

(c) SPECIALIST DEFINED.—For purposes of this section, the term “specialist” means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

SEC. 1615. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

SEC. 1616. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care professional is terminated (as defined in subsection (e)(4)), or

(b) benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such plan or coverage.

(2) REQUIREMENTS.—The plan or issuer shall meet the requirements of paragraph (3) with respect to each continuing care patient described in subsection (a)(4)(B).

(3) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify the continuing care patient involved or have the patient notified pursuant to subsection (d)(2), on a timely basis of the termination described in paragraph (1) (or paragraph (2), if applicable) and the plan's right to provide continued coverage for a serious and complex condition from the provider at the time the plan or issuer receives or provides notice of provider, benefit, or coverage changes.

(2) INSTITUTIONAL OR INPATIENT CARE.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(D) shall extend until the later of—

(A) the expiration of the 90-day period beginning on the date on which the notice subsection (a)(3)(A) is provided; or

(B) the date of discharge of the patient from such care or the termination of the period of institutionalization, or, if later, the date of completion of reasonable follow-up care.

(3) SCHEDULED NON-ELECTIVE SURGERY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(C) shall extend until the completion of the scheduled post-surgical follow-up care relating to the surgery and occurring within 90 days after the date of the surgery.

(4) PREGNANCY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(D) shall extend through the provision of post-partum care directly related to the delivery.

(5) TERMINAL ILLNESS.—The transitional period under this subsection for a continuing care patient involved in paragraph (1) (or paragraph (2), if applicable) shall begin on the date that the plan or issuer is determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of such notice, but only with respect to the provision of post-partum care directly related to the delivery if the plan or issuer is determined to be terminally ill before the date of such notice.

CONSTRUCTION.—Nothing in subsection (b)(2) shall be construed as prohibiting a plan or issuer from requiring the specialist to provide the plan or issuer with regular updates on the specialty care provided, as well as all other reasonably necessary medical information.

(d) SPECIALIST DEFINED.—For purposes of this section, the term “specialist” means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

SEC. 1616. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care professional is terminated (as defined in subsection (e)(4)), or

(b) benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such plan or coverage.

(2) REQUIREMENTS.—The plan or issuer shall meet the requirements of paragraph (3) with respect to each continuing care patient described in subsection (a)(4)(B).

(3) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify the continuing care patient involved or have the patient notified pursuant to subsection (d)(2), on a timely basis of the termination described in paragraph (1) (or paragraph (2), if applicable) and the plan's right to provide continued coverage for a serious and complex condition from the provider at the time the plan or issuer receives or provides notice of provider, benefit, or coverage changes.

(B) provide the patient with an opportunity to notify the plan or issuer of the patient's need for transitional care; and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with respect to the course of treatment by such provider with the provider's consent during a transitional period (as provided for under subsection (b)).

(2) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, poten-
tially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(2) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, poten-
tially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(2) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, poten-
tially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(2) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, poten-
tially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(2) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, poten-
tially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(2) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, poten-
tially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(2) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term “ongoing special condition” means a condition or disease that—

(i) is life-threatening, degenerative, poten-
tentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.
an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) If a health care plan or health insurance issuer agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide the necessary information related to the care provided.

(3) The treating health care provider agrees otherwise to adhere to such a contract or agreement, a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from providing health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(8) PARTICIPATING.—The term "participating" means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(9) PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.—This subtitle shall be interpreted so as not to preclude any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of any requirement of this part.

(10) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—In general.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (4)), such State law shall not be treated as superseding under subsection (a); and

(B) The State law shall not apply instead of the patient protection requirement otherwise applicable with respect to such health insurance coverage and non-Federal governmental plans.
PATIENT PROTECTION REQUIREMENT.—The term "patient protection requirement" means a requirement under this part, and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this part.

B. SUBSTANTIALLY COMPLIANT.—The terms "substantially compliant", substantially complying with, or substantially included in a patient protection requirement with respect to a State law, mean that the State law has the same or similar features as the patient protection requirements and has a similar effect.

c. DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

1. CERTIFICATION BY STATES.—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially compliant with one or more patient protection requirements. Such certification shall be accompanied by such additional information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

2. APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary that the specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination described in subparagraph (A) unless—

(i) the State fails to provide sufficient information in a timely manner to the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that are substantially compliant with the patient protection requirement (or requirements) to which the law relates.

3. APPROVAL.—

(A) IN GENERAL.—The Secretary shall approve a certification under paragraph (1) unless—

(i) the State fails to provide sufficient information in a timely manner to the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that are substantially compliant with the patient protection requirement (or requirements) to which the law relates.

(B) STATE CHALLENGE.—A State that has a certification disapproved by the Secretary under subparagraph (A) may challenge such disapproval in the appropriate United States district court.

(C) PROTECTIONS TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State’s interpretation of the State law involved in determining compliance of the law with a patient protection requirement.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

(i) provide a State with a notice of the determination to approve or disapprove a certification under this paragraph;

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

(iii) promptly publish in the Federal Register a notice that the requirement described in clause (i) with respect to the State; and

(iv) annually publish the status of all States with respect to certifications.

4. CONSENT TO SUIT.—

(a) APPLICABILITY.—Clauses (i) through (iv) of subparagraph (d) shall be construed as applying only with respect to the health insurance issuer offering group health insurance coverage under part I of the Patient Protection and Affordable Care Act if such coverage is being reviewed by a Federal or State court under section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting “(other than section 2720)” after “requirements of such subparagraph.”

5. PETITIONS.—

(A) P ERMITTED PROCESS.—Effective on the date on which the provisions of this subtitle become effective, as provided for in section 1622, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this part.

(B) OPINION.—The Secretary shall issue an advisory opinion with respect to a petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

6. LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

SEC. 1642. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of all or some of the Secretary’s authority under this title to enforce the requirements of title XXVII of the Public Health Service Act (as amended by section 1001, is further amended by adding at the end the following new section:—

SEC. 2754. PATIENT PROTECTION STANDARDS.

Each health insurance issuer shall comply with patient protection requirements under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

SEC. 1643. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of all or some of the Secretary’s authority under this title to enforce the requirements of title XXVII of the Public Health Service Act (as amended by section 1001, is further amended by adding at the end the following new section:—

SEC. 2755. PATIENT PROTECTION STANDARDS.

Each health insurance issuer shall comply with patient protection requirements under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

SEC. 1644. DETERMINATION THROUGH INSURANCE COVERAGE.

Each health insurance issuer offering group health insurance coverage under part I of title XXVII of the Public Health Service Act, and each health insurance issuer offering group health insurance coverage under part I of title XXVII of the Public Health Service Act that is subject to the jurisdiction of such Act, shall comply with the requirements of part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

SEC. 1645. PLAN SATISFACTION OF CERTAIN REQUIREMENTS.

(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of this section (and such requirements shall be deemed to be incorporated into this subsection).

(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.

(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the health insurance coverage through a health insurance issuer, the plan shall be treated as meeting
the following requirements of part I of subsection H of title I of the Patient Protection and Affordable Care Act with respect to such benefits and not be considered as failing to meet such requirements because of a violation of the subsection of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

(a) Section 1612 (relating to choice of health care professional).

(b) Section 1613 (relating to timely access to specialists).

(c) Section 1614 (relating to access to primary care).

(d) Section 1615 (relating to patient access to obstetrical and gynecological care).

(e) Section 1616 (relating to continuity of care), but only insofar as a replacement issuer assumes the obligation for continuity of care.

(2) Application to prohibitions.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of section 1621 of the Patient Protection and Affordable Care Act (relating to prohibition of interference with certain medical communications), the group health plan shall not be liable for such violation unless the plan caused such violation.

(3) Construction.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

(4) Treatment of substantially compliant state laws.—For purposes of applying this subsection, any reference in this subsection to a requirement in a section other provision in subsection H of title I of the Patient Protection and Affordable Care Act with respect to a health insurance issuer is deemed compliance with subsection (a) to a requirement to a reference to a requirement under a State law that substantially complies (as determined under section 1623(c) of such Act) with the requirement in such section or other provisions.

(c) Conforming regulations.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title.

(b) Procedure for ERISA claims procedure requirement.—Section 505 of such Act (29 U.S.C. 1133) is amended by inserting “(a)” after “Sec. 505,” and by adding at the end the following new subsection:

“(b) In the case of any group health plan (as defined in section 733) compliance with the requirements of the part A or part B of title I, part B of title II, or part D of title II of such Act, and compliance with regulations promulgated by the Secretary, in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.”

(c) Conforming amendments.—(1) Section 732(a) of such Act (29 U.S.C. 1183(a)) is amended by striking “section 711” and inserting “sections 711 and 716”.

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

“Sec. 716. Patient protection standards.”

(d) Effect on collective bargaining agreements.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this title, the provisions of this section (and the amendments made by this section) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the covering solely to conform to any requirement added by this section (or amendments) shall not be treated as a termination of such collective bargaining agreement.

SEC. 1652. EFFECTIVE DATE.

This subtitle (and the amendments made by this subtitle) shall take effect in plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

SA 3066. Mrs. BOXER 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. 3. PROHIBITION ON CERTAIN USES OF DATA OBTAINED FROM COMPARATIVE EFFECTIVENESS RESEARCH, ACCOUNTABILITY AND MEASURING MEDICINE AND DIFFERENCES IN PATIENT TREATMENT RESPONSE.

(a) In general.—Nothing in this section shall be construed to affect or modify any other provision of law, a Federal department, office, or representative—

(1) shall not 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) of the Social Security Act (42 U.S.C. 1395w–57(f)), including under plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code), or under private health insurance; and

(2) shall ensure that comparative effectiveness research conducted or supported by the Federal Government accounts for factors contributing to differences in both treatment response and treatment preferences of patients, including patient-reported outcomes, genomics and personalized medicine, the unique needs of health disparity populations, and indirect patient benefits.

(b) Rule of construction.—Nothing in this section shall be construed as affecting the authority of the Secretary of Agriculture under the Federal Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

For the Patient Centered Outcomes Research Institute Board.—Notwithstanding section 1181(c)(1)(A) and (B) of the Social Security Act (as added by section 601), no Federal officer or employee (including Federal elected officials and members of Congress) shall serve on the Board of Governors of the Patient Centered Outcomes Research Institute.

SA 3069. Mr. KOHL submitted an amendment 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:
part 1—elder abuse victims

sec. 31. analysis, report, and recommendations related to elder justice programs.

(a) in general.—subject to the availability of appropriations to carry out this section, the Attorney General, in consultation with the Secretaries of Health and Human Services, shall—

(i) study.—conduct a study of laws and practices relating to elder abuse, neglect, and exploitation, which shall include—

(A) a comprehensive description of State laws and practices relating to elder abuse, neglect, and exploitation;

(B) a comprehensive analysis of the effectiveness of such State laws and practices; and

(c) an examination of State laws and practices relating to specific elder abuse, neglect, and exploitation issues, including—

(i) the definition of—

(A) “elder abuse”;

(B) “neglect”;

(C) “exploitation”;

(ii) mandatory reporting laws, with respect to—

(A) individuals or entities to provide training, technical assistance, multidisciplinary coordination, and other types of support to local prosecutors and courts handling elder justice-related cases, training, technical assistance, and policy development for State prosecutors and courts.

(b) authorization of appropriations.—there are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

sec. 32. victim advocacy grants.

(a) grants authorized.—the Attorney General, after consultation with the Secretaries of Health and Human Services, shall award grants to eligible entities to study the special needs of victims of elder abuse, neglect, and exploitation.

(b) authorized activities.—funds awarded pursuant to subsection (a) shall be used for pilot programs that—

(1) develops programs for and provide training to police, sheriffs, detectives, public safety officers, court personnel, and victim advocates; and

(2) examine special approaches designed to meet the needs of victims of elder abuse, neglect, and exploitation.

(c) authorization of appropriations.—there are authorized to be appropriated to carry out this section $5,000,000 for each of the fiscal years 2010 through 2016.

sec. 33. supporting local prosecutors and courts in elder justice matters.

(a) grants authorized.—subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretaries of Health and Human Services, shall award grants to eligible entities to conduct a validated evaluation of the effectiveness of the activities carried out through the grant program by such recipients.

(b) authorized activities.—funds awarded pursuant to subsection (a) shall be used for—

(i) the creation of a position to coordinate elder justice-related cases, training, technical assistance, multidisciplinary coordination, and other types of support to local prosecutors and courts nationwide for the fiscal years 2010 through 2016.

(c) authorization of appropriations.—there are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

sec. 34. supporting state prosecutors and courts in elder justice matters.

(a) in general.—subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretaries of Health and Human Services, shall—

(i) fund specially designated elder justice positions or units in local prosecutors’ offices and local courts; and

(ii) fund the creation of a Center for the Prosecution of Elder Abuse, Neglect, and Exploitation.

(b) authorization of appropriations.—there are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

sec. 35. supporting law enforcement in elder justice matters.

(a) in general.—subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretaries of Health and Human Services, shall—

(i) fund the creation of a position to coordinate elder justice-related cases, training, technical assistance, and policy development for State prosecutors and courts.

(b) authorization of appropriations.—there are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

sec. 36. evaluations.

(a) grants under this part.—

(1) in general.—in carrying out the grant programs under this part, the Attorney General shall—

(A) require each recipient of a grant to use a portion of the funds made available through the grant to conduct a validated evaluation of the effectiveness of the activities carried out through the grant by such recipient; or

(B) as the Attorney General considers appropriate, use a portion of the funds available under this part for a grant program to provide training, technical assistance, multidisciplinary coordination, and other types of support to local prosecutors and courts handling elder justice-related cases, including—

(i) funding specially designated elder justice positions or units in local prosecutors’ offices and local courts; and

(ii) funding the creation of a Center for the Prosecution of Elder Abuse, Neglect, and Exploitation.

(b) applications.—

(1) submission.—to be eligible to receive a grant under this section, an entity shall submit an application to the Attorney General at such time, in such manner, and containing such information as the Attorney General may require, which shall include—

(A) the methodology described in such information as the Attorney General may require, which shall include—

(i) a description of the objectives, priorities, policies, and a long-term plan developed under paragraph (a)(i) with respect to—

(A) the findings of the study conducted under paragraph (1); and

(B) a description of the objectives, priorities, policies, and a long-term plan developed under paragraph (a)(i) with respect to—

(A) a list, description, and analysis of the best practices used by States to develop, implement, maintain, and improve elder justice systems, based upon such findings;

(b) ga recommendations.—not later than 18 months after the date of enactment of this Act, the Comptroller General shall report to Congress and the Attorney General, after consultation with the Secretaries of Health and Human Services, the findings of a study of the implementation of the Federal criminal justice system relevant to elder justice and shall submit to Congress—

(1) a report on such programs and initiatives; and

(2) any recommendations the Comptroller General determines are appropriate to improve elder justice in the United States.

(c) authorization of appropriations.—there are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

sec. 37.emblement, maintenance, and improvement of elder justice-related cases, training, technical assistance, and policy development for State prosecutors and courts.

(c) authorization of appropriations.—there are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

sec. 35. supporting law enforcement in elder justice matters.

(a) in general.—subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretaries of Health and Human Services, the Postmaster General, and the Chief Postal Inspector for the United States Postal Inspection Service, shall award grants to eligible entities to—

(1) support to police, sheriffs, detectives, public safety officers, corrections, and other first responders who handle elder justice-related matters, to fund specially designated elder justice positions or units designed to support first responders in elder justice matters.

(b) authorization of appropriations.—there are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

sec. 36. evaluations.

(a) grants under this part.—

(1) in general.—in carrying out the grant programs under this part, the Attorney General shall—

(A) require each recipient of a grant to use a portion of the funds made available through the grant to conduct a validated evaluation of the effectiveness of the activities carried out through the grant by such recipient; or

(B) as the Attorney General considers appropriate, use a portion of the funds available under this part for a grant program to—

(i) fund the creation of a position to coordinate elder justice-related cases, training, technical assistance, multidisciplinary coordination, and other types of support to local prosecutors and courts handling elder justice-related cases, including—

(ii) funding specially designated elder justice positions or units in local prosecutors’ offices and local courts; and

(iii) supporting a validated evaluation of the effectiveness of the activities carried out through such grant program by such recipients.

(b) applications.—

(1) submission.—to be eligible to receive a grant under this part, an entity shall submit an application to the Attorney General at such time, in such manner, and containing such information as the Attorney General may require, which shall include—

(A) the proposal for the grant, required to be submitted in accordance with paragraph (1)(A); and

(i) the amount of assistance under paragraph (1)(B) the entity is requesting, if any.

(ii) a proposal for the amount of assistance required to be provided in accordance with paragraph (1)(A); and

burden of appropriations under this section, the Attorney General, after consultation with the Secretaries of Health and Human Services with expertise in evaluation methodology, shall review each application described in subparagraph (A) and determine whether the methodology described in such proposal under subparagraph (A)(i) is adequate to gather meaningful information.

(b) denial.—if the reviewing employee determines the methodology described in such proposal under subparagraph (A)(i) is inadequate for the proposal described in such application, the reviewing employee shall recommend that the Attorney General deny the application for the grant,
or make recommendations for how the application should be amended.

(3) Notice to Applicant.—If the Attorney General denies the application on the basis of such proposal, the Attorney General shall inform the applicant of the reasons the application was denied, and offer assistance to the applicant in modifying the proposal.

(b) Other Measures.—Subject to the availability of appropriations under this section, the Attorney General shall award grants to appropriate entities to conduct validated evaluations of grant activities that are funded by Federal funds not provided under this part, or other funds, to reduce elder abuse, neglect, and exploitation.

(c) Appropriation of Appropriations.—There are authorized to be appropriated to carry out this section $7,000,000 for each of the fiscal years 2010 through 2016.

SEC. 37. DEFINITIONS.

In this part:

(1) ELDER.—The term ‘‘elder’’ means an individual age 60 or older.

(2) 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 maintaining 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.

(3) ELIGIBLE ENTITIES.—The term ‘‘eligible entity’’ means a State or local government agency, Indian tribe or tribal organization, or any nonprofit private entity that is engaged in and has expertise in issues relating to elder justice or a field necessary to promote elder justice efforts.

PART II—ELDER SERVE VICTIM GRANT PROGRAMS

SEC. 41. ESTABLISHMENT OF ELDER SERVE VICTIM GRANT PROGRAMS.

(a) Establishment.—The Attorney General, acting through the Director of the Office of Victims of Crime of the Department of Justice (in this section referred to as the ‘‘Director’’), shall, subject to appropriations, carry out a three-year grant program to be known as the Elder Serve Victim grant program (in this section referred to as the ‘‘Program’’) to provide grants to eligible entities to establish and coordinate programs described in subsection (e) for victims of elder abuse.

(b) Eligibility Requirements for Grantees.—Grantees shall receive a grant under the Program, an entity must meet the following criteria:

(1) ELIGIBLE CRIME VICTIM ASSISTANCE PROGRAM.—The entity is a crime victim assistance program receiving a grant under the Victims of Crime Act of 1984 (42 U.S.C. 1401 et seq.) for the period described in subsection (c)(2) with respect to the grant sought under this section.

(2) Coordination with Local Community Based Agencies and Services.—The entity shall demonstrate to the satisfaction of the Director that such entity has a record of community coordination or established contacts with other county and local services that serve elder individuals.

(3) Ability to Create Effect on Timely Basis.—The entity shall demonstrate to the satisfaction of the Director the ability of the entity to create, not later than 6 months after receiving such grant, an Emergency Crisis Response Team program described in subsection (c)(1) and the programs described in subsection (e)(1) and the programs described in subsection (e)(2).

For purposes of meeting the criteria described in paragraph (2), for each year an entity receives a grant under this section the entity shall provide a report on community coordination or established contacts described in such paragraph through memorandums of understanding, contracts, subcontracts, and other such documentation.

(c) Administrative Provisions.—

(1) Consultative Program Established Pursuant to this Section Shall be Developed and Carried Out in Consultation with the Following Entities, as Appropriate:

(A) Relevant State, local, and tribal public and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elderly individuals.

(B) Local law enforcement including police, sheriffs, detectives, public safety officers, corrections personnel, prosecutors, medical examiners, investigators, and coroners.

(C) Long-term care and nursing facilities.

(2) Grant Period.—Under the Program shall be issued for a three-year period.

(3) Appropriations Authorized.—There is authorized to be appropriated to carry out the Program $20,000,000 for each of the fiscal years 2010 through 2012.

(4) Use of Funds.—The Attorney General shall award grants to eligible entities to carry out a three-year grant program to be known as the Elder Serve Victim grant program (in this section referred to as the ‘‘Program’’) to provide grants to eligible entities to establish and coordinate programs described in subsection (e) for victims of elder abuse.

(5) Use of Funds.—The Attorney General shall award grants to eligible entities to carry out a three-year grant program to be known as the Elder Serve Victim grant program (in this section referred to as the ‘‘Program’’) to provide grants to eligible entities to establish and coordinate programs described in subsection (e) for victims of elder abuse.

(6) Use of Funds.—The Attorney General shall award grants to eligible entities to carry out a three-year grant program to be known as the Elder Serve Victim grant program (in this section referred to as the ‘‘Program’’) to provide grants to eligible entities to establish and coordinate programs described in subsection (e) for victims of elder abuse.

(7) Use of Funds.—The Attorney General shall award grants to eligible entities to carry out a three-year grant program to be known as the Elder Serve Victim grant program (in this section referred to as the ‘‘Program’’) to provide grants to eligible entities to establish and coordinate programs described in subsection (e) for victims of elder abuse.

(d) Technical Assistance.—The Director shall enter into contracts with private entities with experience in elder abuse coordination to provide technical assistance to grantees under this section as the entity determines appropriate.

(e) Reports to Congress.—Not later than 12 months after the commencement of the Program, and annually thereafter, the entity shall submit a report to the Chairman and Ranking Member of the Committee on the Judiciary of the House of Representatives, and the Chairman and Ranking Member of the Special Committee on Aging of the Senate. Each report shall include the following:

(1) A description and assessment of the implementation of the Program.

(2) An assessment of the effectiveness of the Program in providing care, services, and support to seniors, including a comparative assessment of effectiveness for each of the locations designated under subsection (c)(3) of this program.

(3) An assessment of the effectiveness of the coordination for programs described in subsection (e) in contributing toward the effectiveness of the Program.

(4) Such recommendations as the entity considers appropriate for modifications of the Program in order to better provide care, services, and support to seniors.

(f) Definitions.—For purposes of this section:

(1) ELDER ABUSE.—The term ‘‘elder abuse’’ means any type of violence or abuse, whether mental or physical, inflicted upon an elderly individual, and any type of criminal financial exploitation of an elderly individual.

(2) ELDERLY INDIVIDUAL.—The term ‘‘elderly individual’’ means an individual who is age 60 or older.

(3) DEFINITIONS.—There is authorized to be appropriated for the Department of Justice to carry out this section $3,000,000 for each of the fiscal years 2010 through 2012.

Subtitle B—National Silver Alert

SEC. 51. SHORT TITLE.

This subtitle may be cited as the National Silver Alert Act: SEC. 52. DEFINITIONS.

For purposes of this subtitle:

(1) 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, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(2) Missing Senior.—The term ‘‘missing senior’’ refers to any individual who—

(A) is reported to, or identified by, a law enforcement agency as a missing person; and

(B) the report is designated as a missing senior, as determined by the State in which the individual is reported or identified as a missing person.

SEC. 53. SILVER ALERT COMMUNICATIONS NETWORK.

The Attorney General shall, subject to the availability of appropriations under section 57, establish a national Silver Alert communications network within the Department of Justice to provide assistance to regional and local search efforts for missing seniors through the initiation, facilitation, and promotion of local elements of the network.
(known as Silver Alert plans) in coordination with States, units of local government, law enforcement agencies, and other concerned entities with expertise in providing services to seniors.

SEC. 54. SILVER ALERT COORDINATOR.

(a) NATIONAL COORDINATOR WITHIN DEPARTMENT OF JUSTICE.—The Attorney General shall designate an individual of the Department of Justice to act as the national coordinator of the Silver Alert communications network. The individual so designated shall be known as the Silver Alert Coordinator of the Department of Justice (referred to in this subtitle as the “Coordinator”).

(b) COORDINATOR.—In acting as the national coordinator of the Silver Alert communications network, the Coordinator shall—

(1) work with States to encourage the development of additional Silver Alert plans in the network;

(2) establish voluntary guidelines for States to use in developing Silver Alert plans that will promote compatible and integrated Silver Alert plans throughout the United States, including—

(A) a list of the resources necessary to establish a Silver Alert plan;

(B) criteria for evaluating whether a situation involving a Silver Alert taking into consideration the need for the use of such Alerts to be limited in scope because the effectiveness of the Silver Alert communications network may be affected by overuse, including criteria to determine—

(i) whether the mental capacity of a senior who is missing, and the circumstances of his or her disappearance, warrant the issuance of a Silver Alert; and

(ii) whether the individual who reports that a senior is missing is an appropriate and credible source on which to base the issuance of a Silver Alert;

(C) a description of the appropriate uses of the Silver Alert name to readily identify the nature of search efforts for missing seniors; and

(D) recommendations on how to protect the privacy, dignity, independence, and autonomy of any missing senior who may be the subject of a Silver Alert;

(3) develop proposed protocols for efforts to recover missing seniors, and to reduce the number of seniors who are reported missing, including protocols for procedures that are needed from the time of initial notification of a missing senior, taking into consideration that the senior is missing through the time of the return of the senior to family, guardian, or domicile, as appropriate, including—

(A) a public safety communications protocol; (B) case management protocol; (C) command center operations; (D) reunification protocol; and (E) evaluation, debriefing, and public information procedures; and

(4) work with States to ensure appropriate regional coordination of various elements of the network;

(5) establish an advisory group to assist States, units of local government, law enforcement agencies, and other entities involved in the Silver Alert communications network with initiating, facilitating, and promoting Silver Alert plans, which shall include—

(A) to the maximum extent practicable, representation from the various geographic regions of the United States; and

(B) members who are—

(i) representatives of senior citizen advocacy groups, law enforcement agencies, and public safety communications; (ii) broadcasters, first responders, dispatch personnel, and those providing personnel; and (iii) representatives of any other individuals or organizations that the Coordinator determines are necessary to the success of the Silver Alert communications network; and

(6) act as the nationwide point of contact for—

(A) the development of the network; and

(B) regional coordination of alerts for missing seniors through the network.

(c) COORDINATION WITH OTHER AGENCIES.—The Coordinator shall coordinate and consult with the Secretary of Transportation, the Federal Communications Commission, the Assistant Secretary for Aging of the Department of Health and Human Services, the head of the Missing Alzheimer’s Disease Patient Alert Program, and other appropriate offices of the Department of Justice in carrying out activities under this subtitle.

(d) STATE AND LOCAL COORDINATION.—The Coordinator shall consult with local broadcasters and State and local law enforcement agencies in establishing minimum standards under section 55 and in carrying out other activities under this subtitle, as appropriate.

(e) ANNUAL REPORTS.—Not later than one year after the date of enactment of this Act, and annually thereafter, the Coordinator shall submit to Congress a report on the activities of the Coordinator and the effectiveness and status of the Silver Alert plans of each State that request such assistance in the process of establishing such a plan. Each such report shall include—

(1) a list of States that have established Silver Alert plans;

(2) a list of States that are in the process of establishing Silver Alert plans;

(3) for each State that has established such a plan, to the extent the data is available—

(A) the number of Silver Alerts issued;

(B) the number of individuals located successfully;

(C) the average period of time between the issuance of a Silver Alert and the location of the individual for whom such Alert was issued;

(D) the State agency or authority issuing Silver Alerts, and the process by which Silver Alerts are disseminated;

(E) the cost of establishing and operating such a plan; and

(F) the criteria used by the State to determine whether to issue a Silver Alert; and

(G) the extent to which missing individuals for whom Silver Alerts were issued crossed State lines;

(4) actions States have taken to protect the privacy and dignity of the individuals for whom Silver Alerts have been issued;

(5) ways that States have facilitated and improved communication about missing individuals between families, caregivers, law enforcement officials, and other authorities; and

(6) any other information the Coordinator determines is necessary.

SEC. 55. MINIMUM STANDARDS FOR ISSUANCE AND DISSEMINATION OF ALERTS THROUGH SILVER ALERT COMMUNICATIONS NETWORK.

(a) ESTABLISHMENT OF MINIMUM STANDARDS.—Subject to subsection (b), the Coordinator shall establish minimum standards for—

(1) the issuance of alerts through the Silver Alert communications network; and

(2) the extent of the dissemination of alerts issued through the network.

(b) LIMITATIONS.—

(1) VOLUNTARY PARTICIPATION.—The minimum standards established under subsection (a) of this section, and any other guidelines and programs established under section 54, shall be adoptable on a voluntary basis by the States, units of local government, law enforcement agencies, and other concerned entities that are involved in initiating, facilitating, or promoting Silver Alert plans, including broadcasters, first responders, dispatchers, law enforcement personnel, public officials, and other public officials.

(2) DISSEMINATION OF INFORMATION.—The minimum standards shall, to the maximum extent practicable (as determined by the Coordinator in consultation with State and local law enforcement agencies), provide that appropriate information relating to the specific needs of a missing senior (including health care needs) are disseminated to the appropriate law enforcement, public health, and other public officials.

(c) GEOGRAPHIC AREAS.—The minimum standards shall, to the maximum extent practicable (as determined by the Coordinator in consultation with State and local law enforcement agencies), provide that dissemination of an alert through the Silver Alert communications network be limited to the geographic areas which the missing senior reasonably could reach, considering the missing senior’s circumstances and physical and mental condition, the modes of transportation available to the missing senior, and the circumstances of the disappearance.

(d) AGE REQUIREMENTS.—The minimum standards shall not include any specific age requirement for an individual to be classified as a missing senior for purposes of the Silver Alert communication network. Age requirements for determinations of whether an individual is a missing senior shall be determined by each State, and may vary from State to State.

(e) PRIVACY AND CIVIL LIBERTIES PROTECTION.—The minimum standards shall—

(A) ensure that all information that is disseminated through the Silver Alert communications network comply with all applicable Federal, State, and local privacy laws and regulations; and

(B) include standards that specifically provide for the protection of the civil liberties and sensitive medical information of missing seniors.

(f) STATE AND LOCAL VOLUNTARY COORDINATION.—In carrying out the activities under subsection (a), the Coordinator may not interfere with the current system of voluntary coordination among broadcasters and State and local law enforcement agencies for purposes of the Silver Alert communications network.

SEC. 56. TRAINING AND OTHER RESOURCES.

(a) TRAINING AND EDUCATIONAL PROGRAMS.—The Coordinator shall make available training and educational programs to State and local law enforcement agencies, and other concerned entities that are involved in initiating, facilitating, or promoting Silver Alert plans, including broadcasters, first responders, dispatchers, law enforcement personnel, public officials, and other public officials.

(b) COORDINATION.—The Coordinator shall coordinate—

(1) training and educational programs related to the Silver Alert communication network and the capabilities, limitations, and anticipated behaviors of missing seniors, which shall be updated regularly to encourage the use of new tools, technologies, and resources in Silver Alert plans; and

(2) informational materials, including brochures, videos, posters, and websites to support and supplement such training and educational programs.

(c) TACTICAL AND SUPPORT PERSONNEL.—The Coordinator shall coordinate—

(1) with the Assistant Secretary for Aging of the Department of Health and Human Services, the head of the Missing Alzheimer’s Disease Patient Alert Program within the Department of Justice, to determine if any existing material with respect to training programs or educational programs for law enforcement personnel is appropriate and may be used for the programs under subsection (a), and

(2) with the head of the Missing Alzheimer’s Disease Patient Alert Program founded by Section 54 of title 5, United States Code, to determine if any existing material with respect to training programs or educational programs for law enforcement personnel is appropriate and may be used for the programs under subsection (a), and

(3) training and educational programs related to the Silver Alert communication network and the capabilities, limitations, and anticipated behaviors of missing seniors, which shall be updated regularly to encourage the use of new tools, technologies, and resources in Silver Alert plans; and

(4) informational materials, including brochures, videos, posters, and websites to support and supplement such training and educational programs.
SEC. 57. AUTHORIZATION OF APPROPRIATIONS FOR THE SILVER ALERT COMMUNICATIONS NETWORK.
There are authorized to be appropriated to the Department of Justice such sums as may be necessary to carry out the Silver Alert communications network as authorized under subsection (a) on an equitable basis through 2014.

SEC. 58. GRANT PROGRAM FOR SUPPORT OF SILVER ALERT PLANS.
(a) GRANT PROGRAM.—Subject to the availability of appropriations to carry out this section, the Attorney General shall carry out a program to provide grants to States for the development and enhancement of programs to support of Silver Alert plans and the Silver Alert communications network.
(b) ACTIVITIES.—Activities funded by grants under the program under subsection (a) may include—
(1) the development and implementation of education and training programs, and associated materials, relating to Silver Alert plans;
(2) the development and implementation of law enforcement programs, and associated equipment, relating to Silver Alert plans;
(3) the development and implementation of new technologies to improve Silver Alert communications; and
(4) other activities as the Attorney General considers appropriate for supporting the Silver Alert communications network.
(c) FEDERAL SHARE.—The Federal share of the costs of the grants funded by a grant under the program under subsection (a) may not exceed 50 percent.

SEC. 59. SAMMY KIRK VOLUNTARY ELECTRONIC MONITORING PROGRAM.
(a) PROGRAM AUTHORIZED.—The Attorney General, after consultation with the Secretary of Health and Human Services, is authorized to award grants to States and units of local government to carry out programs to provide voluntary electronic monitoring service to eligible individuals to assist in the location of such individuals if such individuals are reported as missing.
(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $2,000,000 for each of the fiscal years 2010 through 2014.
(c) DISINHABITATION.—The grant program authorized under this section shall be referred to as the “Sammy Kirk Voluntary Electronic Monitoring Program”.

Subtitle C—Kristen’s Act Reauthorization

SEC. 61. SHORT TITLE. This subtitle may be cited as “Kristen’s Act Reauthorization of 2009”.

SEC. 62. FINDINGS. Congress finds the following:
(1) Every year thousands of adults become missing adults, due to physical harm and sexual exploitation.
(3) In most cases local law enforcement officials have neither the resources nor the expertise to undertake appropriate search efforts for a missing adult.
(4) The search for a missing adult requires cooperation and coordination among Federal, State, and local law enforcement agencies and assistance from distant communities where the adult may be located.
(5) Federal assistance is urgently needed to help with coordination among such agencies.

SEC. 63. GRANTS FOR THE ASSISTANCE OF ORGANIZATIONS TO FIND MISSING ADULTS.
(a) GRANTS.—
(1) GRANT PROGRAM.—Subject to the availability of appropriations to carry out this section, the Attorney General shall make competitive grants to public agencies or nonprofit private organizations, or combinations thereof, to—
(A) maintain a national resource center and information clearinghouse for missing and unidentified adults;
(B) maintain a national, interconnected database for the purpose of tracking missing adults who are determined by law enforcement to be endangered due to age, diminished mental capacity, or the circumstances of disappearance, when foul play is suspected or when circumstances are unclear;
(C) coordinate public and private programs that locate or recover missing adults or reunite missing adults with their families;
(D) provide assistance and training to law enforcement agencies, State and local governments, elements of the criminal justice system, nonprofit organizations, and individuals who are parents, guardians, or other caregivers of missing adults; and
(E) provide assistance to families in locating and recovering missing adults; and
(2) SPECIAL RULE FOR FY 2010.—In the case of grants under this section by publishing a request for applications in the Federal Register and by posting such a request on the website of the Department of Justice.
(b) OTHER DUTIES.—The Attorney General shall prescribe requirements, including application requirements, for grants under the program under subsection (a).

SEC. 64. AUTHORIZATION OF APPROPRIATIONS.
There are authorized to be appropriated to carry out this subtitle $4,000,000 for each of fiscal years 2010 through 2020.
SEC. 399MM-4. WORKPLACE DISEASE MANAGEMENT AND WELLNESS PUBLIC-PRIVATE PARTNERSHIP.

(a) In General.—The Secretary, in coordination with the Labor Secretary, the Secretary of Commerce, and the Administrator of the Small Business Administration, employers (including small, medium, and large employers), employer organizations, worksite health promotion organizations, State and local health departments, Indian tribes and tribal organizations, and academic institutions, shall provide for the implementation of a national public-private partnership to—

(1) promote the benefits of workplace wellness programs;

(2) understand what types of disease prevention and workplace wellness programs are effective, considering different environments, factors, and circumstances;

(3) establish a system to evaluate implementation of workplace wellness programs, issues relating to employer size and resources, and best practices for the scalable implementation of such programs;

(4) understand what factors influence employees to participate in workplace disease prevention and wellness programs;

(5) emphasize an integrated and coordinated approach to workplace disease management and wellness programs;

(6) share high quality information and best practices through the sharing of high quality information and best practices; and

(7) recommend policies to encourage or stimulate the utilization of worksite disease management and wellness programs, including specific recommendations as to the types of technical and other assistance that may be necessary to fully implement section 399MM.

(b) Report.—Not later than 180 days after the date of enactment of this Act, 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 report containing—

(1) the findings of the public-private partnership implemented under subsection (a); and

(2) recommendations for statutory changes that may be required or useful to implement the findings described in paragraph (1) and to encourage the development of worksite disease management and wellness programs.

(c) Recommendations by CDC.—The Director of the Centers for Disease Control and Prevention shall collect information concerning workplace wellness programs and make recommendations to the Secretary on ways to improve such programs.

SA 3074. Mrs. FEINSTEIN 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 S. 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:

SEC. 2203. PERMITTING LOCAL PUBLIC AGENCIES TO ACT AS MEDICAID ENROLLMENT BROKERS.

Section 1903(b)(4) of the Social Security Act (42 U.S.C. 1396b(4)) is amended by adding at the end the following new subparagraph:

"(C) The Secretary may require a local public agency that is acting as an enrollment broker under a contract or memorandum with a State Medicaid agency, provided the local public agency does not have a direct or indirect financial interest with any Medicaid managed care plan for which it provides enrollment services under this paragraph to establish a separate, transparent, and competitive system with development of a population-based registry of actual occurrences of congenital heart disease, to be known as the National Congenital Heart Disease Registry; or"

"(D) the provision of a grant to one eligible entity to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

"(e) Content.—The Congenital Heart Disease Registry created under paragraph (1) shall contain—

(1) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease;

(2) risk factors associated with the disease;

(3) causation of the disease;

(4) treatment approaches; and

(5) outcome measures, such as analysis of the outcome measures will allow derivation of evidence-based best practices and guidelines for congenital heart disease patients; and

(6) may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease, including infants, young children, adolescents, and adults of all ages.

SEC. 4501. PROGRAMS RELATING TO CONGENITAL HEART DISEASE.

(a) SHORT TITLE.—This subtitle may be cited as the "Congenital Heart Futures Act".

(b) PROGRAMS RELATING TO CONGENITAL HEART DISEASE.—

(1) PUBLIC EDUCATION AND AWARENESS; NATIONAL REGISTRY; ADVISORY COMMITTEE.—
Federal public health infrastructure, including—

‘‘(1) State birth defects surveillance systems;
‘‘(2) the State birth defects tracking systems of the Centers for Disease Control and Prevention;
‘‘(3) the Metropolitan Atlanta Congenital Defects Monitoring Program established by section 246 of the Health Insurance Portability and Accountability Act of 1996.

(g) ELIGIBILITY FOR GRANT.—To be eligible to receive a grant under subsection (a)(2), an entity shall—

‘‘(1) be a public or private nonprofit entity with specialized experience in congenital heart care or—

‘‘(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(h) 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. 399NN-3. ADVISORY COMMITTEE ON CONGENITAL HEART DISEASE.

(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee, to be known as the ‘‘Advisory Committee on Congenital Heart Disease’’ (referred to in this section as the ‘‘Advisory Committee’’).

(b) MEMBERSHIP.—The members of the Advisory Committee may be appointed by the Secretary, acting through the Centers for Disease Control and Prevention, and shall include—

‘‘(1) at least one representative from—

‘‘(A) the National Institutes of Health;

‘‘(B) the Centers for Disease Control and Prevention;

‘‘(C) a national patient advocacy organization with experience advocating on behalf of patients living with congenital heart disease;

‘‘(D) an epidemiologist, who has experience working with data registries;

‘‘(E) a clinician, including—

‘‘(A) at least one with experience diagnosing or treating congenital heart disease; and

‘‘(B) at least one with experience using medical data registries; and

‘‘(4) at least one publicly or privately funded researcher with experience researching congenital heart disease.

(c) ADVISORY COMMITTEE MAY REVIEW INFORMATION AND MAKE RECOMMENDATIONS TO THE SECRETARY CONCERNING—

‘‘(1) the development and maintenance of the National Congenital Heart Disease Registry established under section 399NN-2;

‘‘(2) the type of data to be collected and stored in the National Congenital Heart Disease Registry;

‘‘(3) the manner in which such data is to be collected;

‘‘(4) the use and availability of such data, including guidelines for such use; and

‘‘(5) other matters, as the Secretary determines to be appropriate.

(d) REPORT.—Not later than 180 days after the date on which the Advisory Committee is established and annually thereafter, the Advisory Committee shall submit a report to the Secretary concerning the information described in subsection (c), including recommendations with respect to the results of the Advisory Committee’s review of such information.

(2) CONGENITAL HEART DISEASE RESEARCH.—Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by inserting after the following:

‘‘SEC. 425. CONGENITAL HEART DISEASE.

‘‘(a) IN GENERAL.—The Director of the Institute may expand, intensify, and coordinate research and related activities of the Institute with respect to congenital heart disease, which may include congenital heart disease research with respect to—

‘‘(1) causes of congenital heart disease, including genetic causes;

‘‘(2) long-term outcomes in individuals with congenital heart disease, including infants, children, teenagers, adults, and elderly individuals;

‘‘(3) diagnosis, treatment, and prevention;

‘‘(4) studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes for individuals with congenital heart disease; and

‘‘(5) identifying barriers to life-long care for individuals with congenital heart disease.

‘‘(b) COORDINATION OF RESEARCH ACTIVITIES.—The Director of the Institute may coordinate research efforts related to congenital heart disease among multiple research institutions and may develop research networks.

‘‘(c) MINORITY AND MEDICALLY UNDER -SERVED COMMUNITIES.—In carrying out the activities described in this section, the Director of the Institute shall consider the applicability of such research and other activities to minority and medically underserved communities.

‘‘(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out the amendments made by this section such sums as may be necessary for each of fiscal years 2010 through 2014.

SA 3076. Mr. DURBIN (for himself and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Baucus, Mr. Harkin, Mr. Dodd, and Mr. Hatch) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986, to amend the Estate Tax Relief Act of 2010, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 4107 and insert the following:

SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCORELATION SERVICES IN MEDICAID.

(a) REQUIRING COVERAGE OF COUNSELING AND TREATMENT OF TOBACCO USE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2003, is further amended—

‘‘(1) in subsection (a)(4)—

‘‘(A) by striking ‘‘and’’ before ‘‘(C);’’ and

‘‘(B) by inserting before the semicolon at the end the following: ‘‘and (D) counseling and pharmacotherapy for cessation of tobacco use (as defined in subsection (bb));’’ and

‘‘(2) by adding at the end the following: ‘‘(bb)(1) For purposes of this title, the term ‘counseling and pharmacotherapy for cessation of tobacco use’ means diagnostic, therapeutic, counseling, and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by individuals who use tobacco products or who are being treated for tobacco use that is furnished—

‘‘(A) by or under the supervision of a physician; or

‘‘(B) by any other health care professional who has been—

‘‘(i) is authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

‘‘(ii) is authorized to receive payment for other services under this title or is designated by the State as furnishing such services.

‘‘(2) Subject to paragraph (3), such term is limited to—

‘‘(A) services recommended with respect to individuals in ‘Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline’, published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

‘‘(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use.

‘‘(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.

(d) E F FECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.

SA 3077. Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. Baucus, Mr. Harkin, Mr. Dodd, and Mr. Hatch) 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 816, after line 20, add the following:

SEC. 3115. MEDICARE PASS-THROUGH PAYMENTS FOR CRNA SERVICES.

(a) Treatment of Critical Access Hospitals as Rural in Determining Eligibility for Critical Access Hospital Pass-Through Payments.—Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. 1395k note), as added by section 806(c)(2) of the Family Support Act of 1988 and amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989, is amended by adding at the end the following:

"(3) Any facility that qualifies as a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act) shall be treated as being located in a rural area for purposes of paragraph (1) regardless of any geographic reclassification of the facility, including such a reclassification of the county in which the facility is located as an urban county (also popularly known as a "Lugar county") under section 1886(d)(8)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(8)(B))."

(b) Treatment of Standby and On-Call Costs.—Such section 9320(k), as amended by subsection (a), is further amended by adding at the end the following:

"(4) In determining the reasonable costs incurred by a hospital or critical access hospital for the services of a certified registered nurse anesthetist for the purposes of such subsection, the Secretary shall include standby costs and on-call costs incurred by the hospital or critical access hospital, respectively, with respect to such nurse anesthetist.";

(c) Effective Dates.—

"(1) TREATMENT OF CAHS AS RURAL IN DETERMINING CRNA PASS-THROUGH ELIGIBILITY.—The amendment made by subsection (a) shall apply to calendar years beginning on or after the date of the enactment of this Act (regardless of whether the geographic reclassification of a critical access hospital occurred before, on, or after such date).

"(2) INCLUSION OF STANDBY AND ON-CALL COSTS.—The amendment made by subsection (b) shall apply to costs incurred in cost reporting periods beginning in fiscal years after fiscal year 2003."

SA 3078. Ms. KLOBUCHAR (for herself and Ms. SNOWE) 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 homebuyer 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 IV, insert the following:

SEC. 399H. YOUNG WOMEN'S HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

(a) Public Education Campaign.—

"(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a national evidence-based education campaign to increase awareness among young women of breast cancer's knowledge base.

"(A) breast health in young women of all racial, ethnic, and cultural backgrounds;

"(B) breast awareness and good breast health habits;

"(C) the occurrence of breast cancer and the general and specific risk factors in women who may be at high risk for breast cancer based on familial, racial, ethnic, and cultural backgrounds such as Ashkenazi Jewish populations;

"(D) evidence-based information that would encourage young women and their health care professional to increase early detection of breast cancers; and

"(E) the availability of health information and other resources provided by the Centers for Disease Control and Prevention.

"(2) The availability of health information and other resources provided by the Centers for Disease Control and Prevention shall be treated as being located in a rural area for purposes of paragraph (1) regardless of any geographic reclassification of the facility, including such a reclassification of the county in which the facility is located as an urban county (also popularly known as a "Lugar county") under section 1886(d)(8)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(8)(B))."

"(3) The Secretary shall include in such an advisory committee any organizations and institutions that provide education and awareness services and programs available to address overall health and wellness, and making patient referrals to address tobacco cessation, good nutrition, and physical activity;

"(D) on when to refer patients to a health care provider with genetics expertise;

"(E) in determining the reasonable costs incurred by a hospital or critical access hospital for the services of a certified registered nurse anesthetist under this subsection, the Secretary shall include standby costs and on-call costs incurred by the hospital or critical access hospital, respectively, with respect to such nurse anesthetist.

"(4) MEDIACAMPAIGN.—In conducting the education campaign under paragraph (1), the Secretary shall award grants to entities to establish national multimedia campaigns oriented to young women that may include advertising through television, radio, print media, billboards, posters, all forms of existing and especially emerging social networking media, and any other medium determined appropriate by the Secretary.

"(5) SURVEYS AND EVALUATIONS.—The Secretary shall conduct surveys of health care providers and institutions that provide breast cancer care in high-risk populations; and

"(D) surveys of health care providers and the public regarding knowledge, attitudes, and practices related to breast health and breast cancer prevention and control in high-risk populations; and

"(2) the Director of the National Institutes of Health, shall conduct research to develop and incorporate new screening tests and methods for prevention and early detection of breast cancer in young women.

"(4) SUPPORT FOR YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.—

"(A) of breast health, symptoms, and early diagnosis and treatment of breast cancer in young women, including specific risk factors such as family history of cancer and women who may be at high risk for breast cancer, such as Ashkenazi Jewish population;

"(B) on how to provide counseling to young women about their breast health, including knowledge of their family history and the importance of providing regular clinical breast examinations;

"(C) concerning the importance of discharge planning, and breast health habits, and breast cancer care professionals to increase awareness—"
“(2) PRIORITY.—In making grants under paragraph (1), the Secretary shall give priority to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease.

“(e) NO DUPLICATION OF EFFORT.—In conducting an education campaign or other program under subsections (a), (b), (c), or (d), the Secretary shall avoid duplicating other existing Federal breast cancer education efforts.

“(f) MEASUREMENT; REPORTING.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

“(1) measure—

“(A) young women’s awareness regarding breast health, including knowledge of family cancer history, specific risk factors and early warning signs, and young women’s proactive efforts at early detection;

“(B) the number or percentage of young women utilizing information regarding lifestyle interventions that foster healthy behaviors such as tobacco cessation, nutrition, and physical activity;

“(C) the number or percentage of young women receiving regular clinical breast exams; and

“(D) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this section;

“(2) establish quantitative benchmarks to measure the impact of activities under this section;

“(3) not less than every 3 years, measure the impact of such activities; and

“(4) submit reports to the Congress on the results of such measurements.

“(g) DEFINITIONS.—In this section—

“(1) the term ‘State’ means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, and the Trust Territory of the Pacific Islands; and

“(2) the term ‘young women’ means women 15 to 44 years of age.

“(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out subsections (a), (b), (c)(1), and (d), there are authorized to be appropriated $9,000,000 for each of the fiscal years 2010 through 2014.”.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on December 8, 2009, at 1:30 p.m. The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works be authorized to meet during the session of the Senate on December 8, 2009 at 10 a.m. in room 406 of the Dirksen Senate Office Building. The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 8, 2009, at 2:15 p.m. The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 8, 2009, at 2:30 p.m. The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON ENERGY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Subcommittee on Energy be authorized to meet during the session of the Senate in order to conduct a hearing on December 8, at 2:30 p.m., in room SD-366 of the Dirksen Senate Office Building. The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR WEDNESDAY, DECEMBER 9, 2009

Mr. SANDERS. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m., Wednesday, December 9, that following the prayer and 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; that following any remarks of the chair and ranking member of the Finance Committee, or their designees, for up to 10 minutes each, the next 2 hours be for debate only, with the time equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each; the Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes, with the remaining time equally divided and used in an alternating fashion; further, that no amendments are in order during this time.

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

PROGRAM

Mr. SANDERS. Mr. President, roll-call votes are possible throughout the day tomorrow. Senators will be notified when any votes are scheduled.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. SANDERS. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand adjourned under the previous order.

There being no objection, the Senate, at 8:38 p.m., adjourned until Wednesday, December 9, 2009, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF TRANSPORTATION

MICHAEL PETER HUERTA, OF THE DISTRICT OF COLUMBIA, TO BE DEPUTY ADMINISTRATOR OF THE FEDERAL AVIATION ADMINISTRATION, VICE ROBERT A. STUBBELL, RESIGNED.

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

BRIG. GEN. STEVEN W. SMITH

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

COL. KORY G. CORNUM

BRIG. GEN. STEVEN W. SMITH