TEXT OF AMENDMENTS

SA 3219. Mr. CARDIN 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:

Subtitle H—Patient Protections

PART I—IMPROVING MANAGED CARE

Subpart A—Utilization Review; Claims

SEC. 1601. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall—

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to make with respect to such claim for benefits.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the claim. Such access shall be provided not later than 5 days after the date on which the request for information is received

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such request) shall be treated as the making at that time of a claims for such benefits without regard to whether and when a written confirmation of such request is made.

(b) 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.

(c) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (b) 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 (including a summary of the clinical or scientific evidence used in making the determination); and

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

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

(1) AUTHORIZED REPRESENTATIVE.—The term ''authorized representative'' 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.

(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.

(3) 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.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term ''treating health care professional'' means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

Subpart B—Access to Care

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 participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and 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 and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

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

(3) CONSTRUCTION.—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 or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must

provide reimbursement for maintenance care and post-stabilization care in accordance with the requirements of section 1852(d)(2) of the Social Security Act (42 U.S.C. 1395w–22(d)(2)). Such reimbursement shall be provided in a manner consistent with subsection (a)(1)(C).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term ''emergency ambulance services'' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

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 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 providers in the network only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees;

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

(D) to override the normal community standards, taking into account the geographic location of such community, regarding timely access to specialists.

(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 nonparticipating 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.

(b) REFERRALS.—

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

(A) shall be for an appropriate duration of time or number of referrals, including an authorization for a standing referral where appropriate; and

(B) may not be refused solely because the authorization involves services of a nonparticipating specialist (described in subsection (a)(3)).

(2) REFERRALS FOR ONGOING SPECIAL CONDITIONS.—

(A) IN GENERAL.—Subject to subsection (a)(1), a group health plan or health insurance issuer shall permit a participant, beneficiary, or enrollee who has an ongoing special condition (as defined in subparagraph (B)) to receive a referral to a specialist for the treatment of such condition and such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan (if any) referred to in subsection (c) with respect to the condition, if such specialist agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

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

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

(c) TREATMENT PLANS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may require that the specialty care be provided—

(A) pursuant to a treatment plan, but only if the treatment plan—

(i) is developed by the specialist, in consultation with the case manager or primary care provider, and the participant, beneficiary, or enrollee, and

(ii) is approved by the plan or issuer in a timely manner, if the plan or issuer requires such approval; and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

(2) NOTIFICATION.—Nothing in paragraph (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.

(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. 1614. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

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

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, or health insurance issuer offering health insurance coverage, described in subsection (b) 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. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(2) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in subsection (b) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(b) APPLICATION OF SECTION.—A group health plan, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

(1) provides coverage for obstetric or gynecologic care; and

(2) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(c) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 1616. CONTINUITY OF CARE.

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If—

(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider 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,

the plan or issuer shall meet the requirements of paragraph (3) with respect to each continuing care patient.

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall

apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

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

(A) notify the continuing care patient involved, or arrange to 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 right to elect continued transitional care from the provider under this section;

(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)).

(4) CONTINUING CARE PATIENT.—For purposes of this section, the term ''continuing care patient'' means a participant, beneficiary, or enrollee who—

(A) is undergoing a course of treatment 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 termination described in paragraph (1) (or paragraph (2), if applicable);

(B) is undergoing a course of institutional or inpatient care from the provider at the time of such notice;

(C) is scheduled to undergo non-elective surgery from the provider at the time of such notice;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

(E) is or was 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 a provider that was treating the terminal illness before the date of such notice.

(b) TRANSITIONAL PERIODS.—

(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) shall extend for up to 90 days (as determined by the treating health care professional) from the date of the notice described in subsection (a)(3)(A).

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

(A) the expiration of the 90-day period beginning on the date on which the notice under 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 surgery involved and 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 described in subsection (a)(4)(E) shall extend for the remainder of the patient's life for care that is directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under this section upon the provider agreeing to the following terms and conditions:

(1) The treating health care provider agrees to accept reimbursement from the plan or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient in 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) The treating health care provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The treating health care provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider; or

(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term ''contract'' includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' or ''provider'' means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(3) SERIOUS AND COMPLEX CONDITION.—The term ''serious and complex condition'' means, with respect to a participant, beneficiary, or enrollee under the plan or coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, is an ongoing special condition (as defined in section (b)(2)(B)).

(4) TERMINATED.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Subpart C—Protecting the Doctor-Patient Relationship

SEC. 1621. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

Subpart D—Definitions

SEC. 1631. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this part in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this part under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this part under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this part:

(1) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this part, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(2) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan

under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(6) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(7) NONPARTICIPATING.—The term ''nonparticipating'' 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, 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 insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(9) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

(10) TERMS AND CONDITIONS.—The term ''terms and conditions'' includes, with respect to a group health plan or health insurance coverage, requirements imposed under this part with respect to the plan or coverage.

SEC. 1632. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this part shall not be construed to supersede 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 a requirement of this part.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) CONSTRUCTION.—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this part.

(b) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—

(1) 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 that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this subtitle (except in the case of other substantially compliant requirements), in applying the requirements of this part under section 2720 and 2754 (as applicable) of the Public Health Service Act (as added by part II), subject to subsection (a)(2)—

(A) the State law shall not be treated as being superseded under subsection (a); and

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) 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.

(3) DEFINITIONS.—In this section:

(A) 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 complies'', or ''substantial compliance'' 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 information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.—

(A) IN GENERAL.—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law substantially complies with the patient protection requirement (or requirements) to which the law relates.

(B) 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 under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified additional information is received by the Secretary.

(3) APPROVAL.—

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

(i) the State fails to provide sufficient information to enable 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 substantially comply 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) DEFERENCE 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 and the 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 the notice described in clause (i) with respect to the State; and

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

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this subtitle become effective, as provided for in section 1652, 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.

(d) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 1633. REGULATIONS.

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this part. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this part.

SEC. 1634. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.

The requirements of this part with respect to a group health plan or health insurance coverage are deemed to be incorporated into, and made a part of, such plan or the policy,

certificate, or contract providing such coverage and are enforceable under law as if directly included in the documentation of such plan or such policy, certificate, or contract.

PART II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 1641. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A 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. 2720. PATIENT PROTECTION STANDARDS.

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

(b) CONFORMING AMENDMENT.—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 subparts''.

SEC. 1642. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2753 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.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

''SEC. 2795. 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 some or all of the Secretary's authority under this title to enforce the requirements applicable under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

PART III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 1651. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 1562, is further amended by adding at the end the following new section:

''SEC. 716. PATIENT PROTECTION STANDARDS.

''(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 part I of subtitle H of title I of the Patient Protection and Affordable Care Act (as in effect as of the date of the enactment of such Act), 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 form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of part I of subtitle 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 failure 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 1611 (relating to choice of health care professional).

''(B) Section 1612 (relating to access to emergency care).

''(C) Section 1613 (relating to timely access to specialists).

''(D) Section 1614 (relating to access to pediatric care).

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

''(F) 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 or other provision in subtitle H of title I of the Patient Protection and Affordable Care Act with respect to a health insurance issuer is deemed to include a reference to a requirement under a State law that substantially complies (as determined under section 1632(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) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subpart A of part I of subtitle H of title I of the Patient Protection and Affordable Care 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. 1185(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 coverage which amends the coverage 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 become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

SA 3220. Mr. RISCH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 182, strike line 20 and all that follows through line 4 on page 183, and insert the following:

(3) STATE OPTION TO OPT-OUT OF NEW FEDERAL PROGRAM AND REQUIREMENTS.—

(A) IN GENERAL.—In accordance with this paragraph, a State may elect for the provisions of this Act to not apply within such State to the extent that such provisions violate the protections described in subparagraph (B).

(B) EFFECT OF OPT-OUT.—In the case of a State that makes an election under subparagraph (A)—

(i) the residents of such State shall not be subject to any requirement under this Act, including tax provisions or penalties, that would otherwise require such residents to purchase health insurance;

(ii) the employers located in such State shall not be subject to any requirement under this Act, including tax provisions or penalties, that would otherwise require such employers to provide health insurance to their employees or make contributions relating to health insurance;

(iii) the residents of such State shall not be prohibited under this Act from receiving health care services from any provider of health care services under terms and conditions subject to the laws of such State and mutually acceptable to the patient and the provider;

(iv) the residents of such State shall not be prohibited under this Act from entering into a contract subject to the laws of such State

with any group health plan, health insurance issuer, or other business, for the provision of, or payment to other parties for, health care services;

(v) the eligibility of residents of such State for any program operated by or funded wholly or partly by the Federal Government shall not be adversely affected as a result of having received services in a manner consistent with clauses (iii) and (iv);

(vi) the health care providers within such State shall not be denied participation in or payment from a Federal program for which they would otherwise be eligible as a result of having provided services in a manner consistent with clauses (iii) and (iv); and

(vii) States that elect to opt out shall not be subject to the taxes and fees enumerated in the amendments made by title IX.

(C) PROCESS.—

(i) IN GENERAL.—A State shall be treated as making an election under subparagraph (a) if—

(I) the Governor of such State provides timely and appropriate notice to the Secretary of Health and Human Services notifying the Secretary that the State is making such election; or

(II) such State enacts a law making such election.

Such notice shall be provided at least 180 days before the election is to become effective.

(ii) REVOCATION OF ELECTION.—A State shall be treated as revoking an election made by the State under subparagraph (A) if—

(I) the Governor of such State provides timely and appropriate notice to the Secretary of Health and Human Services of such revocation; or

(II) such State repeals a law described in subparagraph (i)(II).

Such notice of revocation shall be provided at least 180 days before the date the revocation is to become effective. As of such effective date the State and the residents, employers, and health insurance issuers of such State, shall be treated as if the election under subparagraph (A) had not been made.

SA 3221. Mr. WYDEN (for himself and 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, 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 1203, between lines 16 and 17, insert the following:

SEC. 4109. IMPROVING ACCESS TO CLINICAL TRIALS.

(a) FINDINGS.—Congress finds the following:

(1) Advances in medicine depend on clinical trial research conducted at public and private research institutions across the United States.

(2) The challenges associated with enrolling participants in clinical research studies are especially difficult for studies that evaluate treatments for rare diseases and conditions (defined by the Orphan Drug Act as a disease or condition affecting fewer than 200,000 Americans), where the available number of willing and able research participants may be very small.

(3) In accordance with ethical standards established by the National Institutes of Health, sponsors of clinical research may provide payments to trial participants for out-of-pocket costs associated with trial enrollment and for the time and commitment demanded by those who participate in a study. When offering compensation, clinical trial sponsors are required to provide such payments to all participants.

(4) The offer of payment for research participation may pose a barrier to trial enrollment when such payments threaten the eligibility of clinical trial participants for Supplemental Security Income and Medicaid benefits.

(5) With a small number of potential trial participants and the possible loss of Supplemental Security Income and Medicaid benefits for many who wish to participate, clinical trial research for rare diseases and conditions becomes exceptionally difficult and may hinder research on new treatments and potential cures for these rare diseases and conditions.

(b) EXCLUSION FOR COMPENSATION FOR PARTICIPATION IN CLINICAL TRIALS FOR RARE DISEASES OR CONDITIONS.—

(1) EXCLUSION FROM INCOME.—Section 1612(b) of the Social Security Act (42 U.S.C. 1382a(b)) is amended—

(A) by striking ''and'' at the end of paragraph (24);

(B) by striking the period at the end of paragraph (25) and inserting ''; and''; and

(C) by adding at the end the following:

''(26) the first $2,000 received during a calendar year by such individual (or such spouse) as compensation for participation in a clinical trial involving research and testing of treatments for a rare disease or condition (as defined in section 5(b)(2) of the Orphan Drug Act), but only if the clinical trial—

''(A) has been reviewed and approved by an institutional review board that is established—

''(i) to protect the rights and welfare of human subjects participating in scientific research; and

''(ii) in accord with the requirements under part 46 of title 45, Code of Federal Regulations; and

''(B) meets the standards for protection of human subjects as provided under part 46 of title 45, Code of Federal Regulations.''.

(2) EXCLUSION FROM RESOURCES.—Section 1613(a) of the Social Security Act (42 U.S.C. 1382b(a)) is amended—

(A) by striking ''and'' at the end of paragraph (15);

(B) by striking the period at the end of paragraph (16) and inserting ''; and''; and

(C) by inserting after paragraph (16) the following:

''(17) any amount received by such individual (or such spouse) which is excluded from income under section 1612(b)(26) (relating to compensation for participation in a clinical trial involving research and testing of treatments for a rare disease or condition).''.

(3) MEDICAID EXCLUSION.—

(A) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)), as amended by section 2002(a), is amended by adding at the end the following:

''(15) EXCLUSION OF COMPENSATION FOR PARTICIPATION IN A CLINICAL TRIAL FOR TESTING OF TREATMENTS FOR A RARE DISEASE OR CONDITION.—The first $2,000 received by an individual (who has attained 19 years of age) as compensation for participation in a clinical trial meeting the requirements of section 1612(b)(26) shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.''.

(B) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)), as amended by section 2002(b), is amended by inserting ''(e)(15),'' before ''(l)(3)''.

(4) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is the earlier of—

(A) the effective date of final regulations promulgated by the Commissioner of Social Security to carry out this section and such amendments; or

(B) 180 days after the date of enactment of this Act.

(5) SUNSET PROVISION.—This section and the amendments made by this section are repealed on the date that is 5 years after the date of the enactment of this Act.

(c) STUDY AND REPORT.—

(1) STUDY.—Not later than 36 months after the effective date of this section, the Comptroller General of the United States shall conduct a study to evaluate the impact of this section on enrollment of individuals who receive Supplemental Security Income benefits under title XVI of the Social Security Act (referred to in this section as ''SSI beneficiaries'') in clinical trials for rare diseases or conditions. Such study shall include an analysis of the following:

(A) The percentage of enrollees in clinical trials for rare diseases or conditions who were SSI beneficiaries during the 3-year period prior to the effective date of this section as compared to such percentage during the 3-year period after the effective date of this section.

(B) The range and average amount of compensation provided to SSI beneficiaries who participated in clinical trials for rare diseases or conditions.

(C) The overall ability of SSI beneficiaries to participate in clinical trials.

(D) Any additional related matters that the Comptroller General determines appropriate.

(2) REPORT.—Not later than 12 months after completion of the study conducted under paragraph (1), the Comptroller General shall submit to Congress a report containing the results of such study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SA 3222. Mr. FEINGOLD 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 1525, between lines 21 and 22, insert the following:

(iv) USE OF EXISTING DATA AND STATISTICS AND NEW DATA AND METHODOLOGIES.—In carrying out the responsibilities described in subclauses (I) through (III) of clause (iii), the Institute designated under clause (i)(II) shall identify, select, and incorporate existing data and statistics as well as new data and methodologies that would synthesize, expand, augment, improve, and modernize statistical measures to provide more accurate, transparent, coherent, and comprehensive assessments.

SA 3223. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue

Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 553, between lines 14 and 15, insert the following:

SEC. 2721. INCREASED PAYMENTS TO PRIMARY CARE PRACTITIONERS UNDER MEDICAID.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b), as amended by section 2001(b)(2), is amended—

(A) in subsection (a)(13)—

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

(ii) by adding ''and'' at the end of subparagraph (B); and

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

''(C) payment for primary care services (as defined in subsection (hh)(1)) furnished by physicians (or for services furnished by other health care professionals that would be primary care services under such section if furnished by a physician) at a rate not less than 80 percent of the payment rate that would be applicable if the adjustment described in subsection (hh)(2) were to apply to such services and physicians or professionals (as the case may be) under part B of title XVIII for services furnished in 2010, 90 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2011, or 100 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2012 and each subsequent year;''; and

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

''(hh) INCREASED PAYMENT FOR PRIMARY CARE SERVICES.—For purposes of subsection (a)(13)(C):

''(1) PRIMARY CARE SERVICES DEFINED.—The term 'primary care services' means evaluation and management services, without regard to the specialty of the physician furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Health Care Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary).

''(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASED FMAP.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2006 and 4107(a)(2), is amended

(1) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent for periods beginning with 2015 with respect to amounts described in subsection (cc)''; and

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

''(cc) For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of June 16, 2009.

''(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SA 3224. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 510, between lines 9 and 10, insert the following:

SEC. 2504. SUBMISSION OF DATA FOR PHYSICIAN ADMINISTERED DRUGS.

(a) EXTENSION FOR IMPLEMENTATION OF REQUIREMENT FOR HOSPITALS TO SUBMIT UTILIZATION DATA.—Section 1927(a)(7) of the Social Security Act (42 U.S.C. 1396r–8(a)(7)) is amended—

(1) in subparagraph (A), by inserting ''in non-hospital settings and on or after August 1, 2010, in hospitals'' after ''January 1, 2006,'';

(2) in subparagraph (B)(ii), by inserting ''in non-hospital settings and on or after August 1, 2010, in hospitals'' after ''January 1, 2008,''; and

(3) in subparagraph (C), by inserting ''(August 1, 2010, in the case of hospital information),'' after ''January 1, 2007,''.

(b) PROPORTIONAL REBATES FOR DUAL ELIGIBLE CLAIMS.—Section 1927(a)(7) of the Social Security Act (42 U.S.C. 1396r–8)(a)(7)) is amended by adding at the end the following new subparagraph:

''(E) TEMPORARY ADJUSTMENT TO REBATE CALCULATION FOR DUAL ELIGIBLE CLAIMS.—Only with respect to claims for rebates submitted by States to manufacturers during the 2-year period that begins on the date of enactment of this subparagraph, for purposes of calculating the amount of rebate under subsection (c) for a rebate period for a covered outpatient drug for which payment is made under a State plan or waiver under this title and under part B of title XVIII, the total number of units reported by the State of each dosage form and strength of each such drug paid for under the State plan or waiver under this title during such rebate period is deemed to be equal to the product of—

''(i) such total number of units of such drug for which payment is made under the State plan or waiver under this title and under part B of title XVIII; and

''(ii) the proportion (expressed as a percentage) that the amount the State paid for each dosage form and strength of such drug under the State plan or waiver under this title during such rebate period bears to the amount that the State would have paid for each dosage form and strength of such drug under the State plan or waiver under this title during such rebate period if the State were the sole payer for such dosage form and strength of such drug.''.

SA 3225. Mr. LEMIEUX submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title VI, insert the following:

SEC. ___. ESTABLISHMENT OF OFFICE OF DEPUTY SECRETARY FOR HEALTH CARE FRAUD PREVENTION IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; APPOINTMENT AND POWERS OF DEPUTY SECRETARY.

(a) IN GENERAL.—There is hereby established in the Department of Health and Human Services the Office of the Deputy Secretary for Health Care Fraud Prevention (referred to in this section as the ''Office'').

(b) DUTIES OF THE OFFICE.—The Office shall—

(1) direct the appropriate implementation within the Department of Health and Human Services of health care fraud prevention and detection recommendations made by Federal Government and private sector antifraud and oversight entities;

(2) routinely consult with the Office of the Inspector General for the Department of Health and Human Services, the Attorney General, and private sector health care antifraud entities to identify emerging health care fraud issues requiring immediate action by the Office;

(3) through a fixed fee for implementation and maintenance plus results-based contingency fee contract entered into with an entity that has experience in designing and implementing antifraud systems in the financial sector and experience and knowledge of the various service delivery and reimbursement models of Federal health programs, provide for the design, development, and operation of a predictive model antifraud system (in accordance with subsection (d)) to analyze health care claims data in real-time to identify high risk claims activity, develop appropriate rules, processes, and procedures and investigative research approaches, in coordination with the Office of the Inspector General for the Department of Health and Human Services, based on the risk level assigned to claims activity, and develop a comprehensive antifraud database for health care activities carried out or managed by Federal health agencies;

(4) promulgate and enforce regulations relating to the reporting of data claims to the health care antifraud system developed under paragraph (3) by all Federal health agencies;

(5) establish thresholds, in consultation with the Office of the Inspector General of the Department of Health and Human Services and the Department of Justice—

(A) for the amount and extent of claims verified and designated as fraudulent, wasteful, or abusive through the fraud prevention system developed under paragraph (3) for excluding providers or suppliers from participation in Federal health programs; and

(B) for the referral of claims identified through the health care fraud prevention

system developed under paragraph (3) to law enforcement entities (such as the Office of the Inspector General, Medicaid Fraud Control Units, and the Department of Justice); and

(6) share antifraud information and best practices with Federal health agencies, health insurance issuers, health care providers, antifraud organizations, antifraud databases, and Federal, State, and local law enforcement and regulatory agencies.

(c) DEPUTY SECRETARY FOR HEALTH CARE FRAUD PREVENTION.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services the position of Deputy Secretary for Health Care Fraud Prevention (referred to in this section as the ''Deputy Secretary''). The Deputy Secretary shall serve as the head of the Office, shall act as the chief health care fraud prevention and detection officer of the United States, and shall consider and direct the appropriate implementation of recommendations to prevent and detect health care fraud, waste, and abuse activities and initiatives within the Department.

(2) APPOINTMENT.—The Deputy Secretary shall be appointed by the President, by and with the advice and consent of the Senate, and serve for a term of 5 years, unless removed prior to the end of such term for cause by the President.

(3) POWERS.—Subject to oversight by the Secretary, the Deputy Secretary shall exercise all powers necessary to carry out this section, including the hiring of staff, entering into contracts, and the delegation of responsibilities to any employee of the Department of Health and Human Services or the Office appropriately designated for such responsibility.

(4) DUTIES.—

(A) IN GENERAL.—The Deputy Secretary shall—

(i) establish and manage the operation of the predictive modeling system developed under subsection (b)(3) to analyze Federal health claims in real-time to identify high risk claims activity and refer risky claims for appropriate verification and investigative research;

(ii) consider and order the appropriate implementation of fraud prevention and detection activities, such as those recommended by the Office of the Inspector General of the Department of Health and Human Services, the Government Accountability Office, MedPac, and private sector health care antifraud entities;

(iii) not later than 6 months after the date on which he or she is initially appointed, submit to Congress an implementation plan for the health care fraud prevention systems under subsection (d); and

(iv) submit annual performance reports to the Secretary and Congress that, at minimum, shall provide an estimate of the return on investment with respect to the system, for all recommendations made to the Deputy Secretary under this section, a description of whether such recommendations are implemented or not implemented, and contain other relevant performance metrics.

(B) ANALYSIS AND RECOMMENDATIONS.—The Deputy Secretary shall provide required strategies and treatments for claims identified as high risk (including a system of designations for claims, such as ''approve'', ''decline'', ''research'', and ''educate and pay'') to the Centers for Medicare & Medicaid Services, other Federal and State entities responsible for verifying whether claims identified as high risk are payable, should be automatically denied, or require further research and investigation.

(C) LIMITATION.—The Deputy Secretary shall not have any criminal or civil enforcement authority otherwise delegated to the Office of Inspector General of the Department of Health and Human Services or the Attorney General.

(5) REGULATIONS.—The Deputy Secretary shall promulgate and enforce such rules, regulations, orders, and interpretations as the Deputy Secretary determines to be necessary to carry out the purposes of this section. Such authority shall be exercised as provided under section 553 of title 5, United States Code.

(d) HEALTH CARE FRAUD PREVENTION SYSTEM.—

(1) IN GENERAL.—The fraud prevention system established under subsection (b)(3) shall be designed as follows:

(A) IN GENERAL.—The fraud prevention system shall—

(i) be holistic;

(ii) be able to view all provider and patient activities across all Federal health program payers;

(iii) be able to integrate into the existing health care claims flow with minimal effort, time, and cost;

(iv) be modeled after systems used in the Financial Services industry; and

(v) utilize integrated real-time transaction risk scoring and referral strategy capabilities to identify claims that are statistically unusual.

(B) MODULARIZED ARCHITECTURE.—The fraud prevention system shall be designed from an end-to-end modularized perspective to allow for ease of integration into multiple points along a health care claim flow (pre- or post-adjudication), which shall—

(i) utilize a single entity to host, support, manage, and maintain software-based services, predictive models, and solutions from a central location for the customers who access the fraud prevention system;

(ii) allow access through a secure private data connection rather than the installation of software in multiple information technology infrastructures (and data facilities);

(iii) provide access to the best and latest software without the need for upgrades, data security, and costly installations;

(iv) permit modifications to the software and system edits in a rapid and timely manner;

(v) ensure that all technology and decision components reside within the module; and

(vi) ensure that the third party host of the modular solution is not a party, payer, or stakeholder that reports claims data, accesses the results of the fraud prevention systems analysis, or is otherwise required under this section to verify, research, or investigate the risk of claims.

(C) PROCESSING, SCORING, AND STORAGE.—The platform of the fraud prevention system shall be a high volume, rapid, real-time information technology solution, which includes data pooling, data storage, and scoring capabilities to quickly and accurately capture and evaluate data from millions of claims per day. Such platform shall be secure and have (at a minimum) data centers that comply with Federal and State privacy laws.

(D) DATA CONSORTIUM.—The fraud prevention system shall provide for the establishment of a centralized data file (referred to as a ''consortium'') that accumulates data from all government health insurance claims data sources. Notwithstanding any other provision of law, Federal health care payers shall provide to the consortium existing claims data, such as Medicare's ''Common Working File'' and Medicaid claims data, for the purpose of fraud and abuse prevention. Such accumulated data shall be transmitted and stored in an industry standard secure data environment that complies with applicable Federal privacy laws for use in building medical waste, fraud, and abuse prevention predictive models that have a comprehensive view of provider activity across all payers (and markets).

(E) MARKET VIEW.—The fraud prevention system shall ensure that claims data from Federal health programs and all markets flows through a central source so the waste, fraud, and abuse system can look across all markets and geographies in health care to identify fraud and abuse in Medicare, Medicaid, the State Children's Health Program, TRICARE, and the Department of Veterans Affairs, holistically. Such cross-market visibility shall identify unusual provider and patient behavior patterns and fraud and abuse schemes that may not be identified by looking independently at one Federal payer's transactions.

(F) BEHAVIOR ENGINE.—The fraud prevention system shall ensure that the technology used provides real-time ability to identify high-risk behavior patterns across markets, geographies, and specialty group providers to detect waste, fraud, and abuse, and to identify providers that exhibit unusual behavior patterns. Behavior pattern technology that provides the capability to compare a provider's current behavior to their own past behavior and to compare a provider's current behavior to that of other providers in the same specialty group and geographic location shall be used in order to provide a comprehensive waste, fraud, and abuse prevention solution.

(G) PREDICTIVE MODEL.—The fraud prevention system shall involve the implementation of a statistically sound, empirically derived predictive modeling technology that is designed to prevent (versus post-payment detect) waste, fraud, and abuse. Such prevention system shall utilize historical transaction data, from across all Federal health programs and markets, to build and re-develop scoring models, have the capability to incorporate external data and external models from other sources into the health care predictive waste, fraud, and abuse model, and provide for a feedback loop to provide outcome information on verified claims so future system enhancements can be developed based on previous claims experience.

(H) CHANGE CONTROL.—The fraud prevention system platform shall have the infrastructure to implement new models and attributes in a test environment prior to moving into a production environment. Capabilities shall be developed to quickly make changes to models, attributes, or strategies to react to changing patterns in waste, fraud, and abuse.

(I) SCORING ENGINE.—The fraud prevention system shall identify high-risk claims by scoring all such claims on a real-time capacity prior to payment. Such scores shall then be communicated to the fraud management system provided for under subparagraph (J).

(J) FRAUD MANAGEMENT SYSTEM.—The fraud prevention system shall utilize a fraud management system, that contains workflow management and workstation tools to provide the ability to systematically present scores, reason codes, and treatment actions for high-risk scored transactions. The fraud prevention system shall ensure that analysts who review claims have the capability to access, review, and research claims efficiently, as well as decline or approve claims (payments) in an automated manner. Workflow management under this subparagraph shall be combined with the ability to utilize principles of experimental design to compare and measure prevention and detection rates between test and control strategies. Such strategy testing shall allow for continuous improvement and maximum effectiveness in keeping up with ever changing fraud and abuse patterns. Such system shall provide the capability to test different treatments or

actions randomly (typically through use of random digit assignments).

(K) DECISION TECHNOLOGY.—The fraud prevention system shall have the capability to monitor consumer transactions in real-time and monitor provider behavior at different stages within the transaction flow based upon provider, transaction and consumer trends. The fraud prevention system shall provide for the identification of provider and claims excessive usage patterns and trends that differ from similar peer groups, have the capability to trigger on multiple criteria, such as predictive model scores or custom attributes, and be able to segment transaction waste, fraud, and abuse into multiple types for health care categories and business types.

(L) FEEDBACK LOOP.—The fraud prevention system shall have a feedback loop where all Federal health payers provide pre-payment and post-payment information about the eventual status of a claim designated as ''Normal'', ''Waste'', ''Fraud'', ''Abuse'', or ''Education Required''. Such feedback loop shall enable Federal health agencies to measure the actual amount of waste, fraud, and abuse as well as the savings in the system and provide the ability to retrain future, enhanced models. Such feedback loop shall be an industry file that contains information on previous fraud and abuse claims as well as abuse perpetrated by consumers, providers, and fraud rings, to be used to alert other payers, as well as for subsequent fraud and abuse solution development.

(M) TRACKING AND REPORTING.—The fraud prevention system shall ensure that the infrastructure exists to ascertain system, strategy, and predictive model return on investment. Dynamic model validation and strategy validation analysis and reporting shall be made available to ensure a strategy or predictive model has not degraded over time or is no longer effective. Queue reporting shall be established and made available for population estimates of what claims were flagged, what claims received treatment, and ultimately what results occurred. The capability shall exist to complete tracking and reporting for prevention strategies and actions residing farther upstream in the health care payment flow. The fraud prevention system shall establish a reliable metric to measure the dollars that are never paid due to identification of fraud and abuse, as well as a capability to effectively test and estimate the impact from different actions and treatments utilized to detect and prevent fraud and abuse for legitimate claims. Measuring results shall include waste and abuse.

(N) OPERATING TENET.—The fraud prevention system shall not be designed to deny health care services or to negatively impact prompt-pay laws because assessments are late. The database shall be designed to speed up the payment process. The fraud prevention system shall require the implementation of constant and consistent test and control strategies by stakeholders, with results shared with Federal health program leadership on a quarterly basis to validate improving progress in identifying and preventing waste, fraud, and abuse. Under such implementation, Federal health care payers shall use standard industry waste, fraud, and abuse measures of success.

(2) COORDINATION.—The Deputy Secretary shall coordinate the operation of the fraud prevention system with the Department of Justice and other related Federal fraud prevention systems.

(3) OPERATION.—The Deputy Secretary shall phase-in the implementation of the system under this subsection beginning not later than 18 months after the date of enactment of this Act, through the analysis of a limited number of Federal health program claims. Not later than 5 years after such date of enactment, the Deputy Secretary shall ensure that such system is fully phased-in and applicable to all Federal health program claims.

(4) NON-PAYMENT OF CLAIMS.—The Deputy Secretary shall promulgate regulations to prohibit the payment of any health care claim that has been identified as potentially ''fraudulent'', ''wasteful'', or ''abusive'' until such time as the claim has been verified as valid.

(5) APPLICATION.—The system under this section shall only apply to Federal health programs (all such programs), including programs established after the date of enactment of this Act.

(6) REGULATIONS.—The Deputy Secretary shall promulgate regulations providing the maximum appropriate protection of personal privacy consistent with carrying out the Office's responsibilities under this section.

(e) PROTECTING PARTICIPATION IN HEALTH CARE ANTIFRAUD PROGRAMS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, no person providing information to the Secretary under this section shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew, or had reason to believe, that such information was false.

(2) CONFIDENTIALITY.—The Office shall, through the promulgation of regulations, establish standards for—

(A) the protection of confidential information submitted or obtained with regard to suspected or actual health care fraud;

(B) the protection of the ability of representatives the Office to testify in private civil actions concerning any such information; and

(C) the sharing by the Office of any such information related to the medical antifraud programs established under this section.

(f) PROTECTING LEGITIMATE PROVIDERS AND SUPPLIERS.—

(1) INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish procedures for the implementation of fraud and abuse detection methods under all Federal health programs (including the programs under titles XVIII, XIX, and XXI of the Social Security Act) with respect to items and services furnished by providers of services and suppliers that includes the following:

(A) In the case of a new applicant to be such a provider or supplier, a background check, and in the case of a supplier a site visit prior to approval of participation in the program and random unannounced site visits after such approval.

(B) Not less than 5 years after the date of enactment of this Act, in the case of a provider or supplier who is not a new applicant, re-enrollment under the program, including a new background check and, in the case of a supplier, a site-visit as part of the application process for such re-enrollment, and random unannounced site visits after such re-enrollment.

(2) REQUIREMENT FOR PARTICIPATION.—In no case may a provider of services or supplier who does not meet the requirements under paragraph (1) participate in any Federal health program.

(3) BACKGROUND CHECKS.—The Secretary shall determine the extent of the background check conducted under paragraph (1), including whether—

(A) a fingerprint check is necessary;

(B) a background check shall be conducted with respect to additional employees, board members, contractors or other interested parties of the provider or supplier; and

(C) any additional national background checks regarding exclusion from participation in Federal health programs (such as the program under titles XVIII, XIX, or XXI of the Social Security Act), including conviction of any felony, crime that involves an act of fraud or false statement, adverse actions taken by State licensing boards, bankruptcies, outstanding taxes, or other indications identified by the Inspector General of the Department of Health and Human Services are necessary.

(4) LIMITATION.—No payment may be made to a provider of services or supplier under any Federal health program if such provider or supplier fails to obtain a satisfactory background check under this subsection.

(5) FEDERAL HEALTH PROGRAM.—In this subsection, the term ''Federal health program'' means any program that provides Federal payments or reimbursements to providers of health-related items or services, or suppliers of such items, for the provision of such items or services to an individual patient.

(g) USE OF SAVINGS.—Notwithstanding any other provision on law, amounts remaining at the end of a fiscal year in the account for any Federal health program to which this section applies that the Secretary of Health and Human Services determines are remaining as a result of the fraud prevention activities applied under this section shall remain in such account and be used for such program for the next fiscal year.

(h) DEFINITION.—The term ''Federal health agency'' means the Department of Health and Human Services, the Department of Veterans Affairs, and any Federal agency with oversight or authority regarding the provision of any medical benefit, item, or service for which payment may be made under a Federal health care plan or contract.

SA 3226. 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:

Beginning on page 2027, strike line 20 and all that follows through page 2029, line 4, and insert the following:

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) NET PREMIUMS WRITTEN.—

(i) IN GENERAL.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be the sum of—

(I) the net premiums written with respect to Medicaid business that are taken into account during the calendar year, plus

(II) the net premiums written with respect to non-Medicaid business that are taken into account during the calendar year.

(ii) NET PREMIUMS WRITTEN WITH RESPECT TO MEDICAID BUSINESS.—

(I) IN GENERAL.—The net premiums written with respect to Medicaid business that are taken into account during the calendar year shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written with respect to Medicaid business during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $100,000,000	0 percent
More than $100,000,000 but not more than $150,000,000	25 percent
More than $150,000,000 but not more than $200,000,000	50 percent
More than $200,000,000	100 percent.

(II) MEDICAID BUSINESS.—For purposes of this section, net premiums written with respect to Medicaid business means, with respect to any covered entity, that portion of the net premiums written with respect to health insurance for United States health risks which are written with respect to individuals who are eligible for medical assistance under, and enrolled in, a State plan under title XIX of the Social Security Act or a waiver of such plan. Such amounts shall be reported separately by each covered entity in the report required under subsection (g).

(iii) NET PREMIUMS WRITTEN WITH RESPECT TO NON-MEDICAID BUSINESS.—

(I) IN GENERAL.—The net premiums written with respect to non-Medicaid business that are taken into account during the calendar year shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written with respect to non-Medicaid business during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than $25,000,000	0 percent
More than $25,000,000 but not more than $50,000,000	50 percent
More than $50,000,000	100 percent.

(II) NON-MEDICAID BUSINESS.—For purpose of this section, the net premiums written with respect to non-Medicaid business means, with respect to any covered entity, the total amount of net premiums written with respect to health insurance for United States health risks less the net premiums written with respect to Medicaid business.

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:	The percentage of third party administration agreement fees that are taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $10,000,000	50 percent
More than $10,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) PERFORMANCE ADJUSTMENT TO ANNUAL FEE.—

(1) IN GENERAL.—The Secretary shall—

(A) in the case of a penalized covered entity, increase the fee determined under subsection (b) for a calendar year as provided in paragraph (3), and

(B) in the case of any other covered entity, reduce the fee determined under subsection (b) for a calendar year as provided in paragraph (4).

(2) PENALIZED COVERED ENTITY DESCRIBED.—

(A) IN GENERAL.—For purposes of this paragraph, the term ''penalized covered entity'' means a covered entity that the Secretary determines has failed to meet the key performance thresholds (established under subparagraph (B)) for the calendar year involved.

(B) KEY PERFORMANCE THRESHOLDS.—The key performance thresholds established under this subparagraph are as follows:

(i) MEDICAL LOSS RATIO THRESHOLD.—The covered entity has a medical loss ratio, as reported under section 2718(a)(1) of the Public Health Service Act, of not less than 85 percent. The Secretary, in consultation with the Secretary of Health and Human Services may increase, but not decrease, such percentage by regulation.

(ii) MAXIMUM FINANCIAL RESERVE THRESHOLD.—

(I) IN GENERAL.—The covered entity has a financial reserve which is not greater than the amount established under regulations by the Secretary, in consultation with the Secretary of Health and Human Services. The Secretary may establish different thresholds for different categories of covered entity under this section. The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish a uniform methodology for reporting financial reserve levels and determining maximum financial reserve thresholds under this subparagraph.

(II) REPORTS.—Each covered entity shall annually submit a report (in a manner to be established by the Secretary through regulation) to the Secretary and the Secretary of Health and Human Services containing such information about the financial reserves of the entity as the Secretary may require. The rules of subsection (g)(2) shall apply to the information required to be reported under this subclause.

(3) AMOUNT OF FEE INCREASE.—

(A) IN GENERAL.—In the case of a penalized covered entity, the fee determined under subsection (b) for the calendar year shall be increased by the penalty amount.

(B) PENALTY AMOUNT.—

(i) IN GENERAL.—The penalty amount shall be the product of—

(I) the amount determined under subsection (b), and

(II) the sum of the amounts determined under subparagraphs (C) and (D).

(ii) LIMITATION.—The penalty amount shall not exceed 20 percent of the amount determined under subsection (b).

(C) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this subparagraph is the amount equal to the excess of—

(i) the medical loss ratio threshold established under paragraph (2)(A), over

(ii) the medical loss ratio (expressed in decimal form) of the penalized covered entity.

(D) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

(i) the excess of—

(I) the financial reserves of the penalized covered entity, over

(II) the maximum financial reserve threshold established under paragraph (2)(B)(ii), to

(ii) such maximum financial reserve threshold.

(4) REDUCTION IN FEE.—

(A) IN GENERAL.—

(i) AMOUNT OF REDUCTION.—In the case of any covered entity that is not a penalized covered entity, the fee determined under subsection (b) for the calendar year shall be reduced by an amount equal to the product of—

(I) the sum of all penalty amounts assessed in the calendar year under paragraph (3), and

(II) the fee redistribution ratio.

(ii) LIMITATION.—The reduction under this paragraph shall not exceed 20 percent of the amount determined under subsection (b).

(B) FEE DISTRIBUTION RATIO.—For purposes of this paragraph, the fee redistribution ratio is the ratio of—

(i) the weighted net written premium amount of the covered entity, to

(ii) the aggregate of the weighted net written premium amount of all covered entities.

(C) WEIGHTED NET WRITTEN PREMIUM AMOUNT.—For purposes of this paragraph, the weighted net written premium amount with respect to any covered entity is the amount described in subsection (b)(1)(A)(i) with respect to such covered entity, increased by the product of—

(i) such amount, and

(ii) the product of 0.05 and the sum of the amounts determined under subparagraphs (D) and (E).

(D) MEDICAL LOSS RATIO COMPONENT.—The amount determined under this subparagraph is the amount equal to the excess of—

(i) the medical loss ratio (expressed as a percentage) of the covered entity, over

(ii) the medical loss ratio threshold established under paragraph (2)(A).

(E) FINANCIAL RESERVE COMPONENT.—The amount determined under this subparagraph is the amount equal to the ratio of—

(i) the excess of—

(I) the maximum financial reserve threshold established under paragraph (2)(B)(ii), over

(II) the financial reserves of the covered entity, to

(ii) such maximum financial reserve threshold.

SA 3227. Mr. CARDIN 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 731, strike line 17 and all that follows through line 10 on page 732 and insert the following:

''(xix) Using commonly available and inexpensive technologies, including wireless and Internet-based tools, that have a demonstrated ability to improve patient outcomes or reduce health care costs, to simplify the complex management and treatment of chronic diseases for patients and health care providers.

''(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

''(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

''(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

''(iii) Whether the model provides for in-person contact with applicable individuals.

''(iv) Whether the model utilizes technology, such as electronic health records, wireless and Internet-based tools,''.

SA 3228. Ms. LANDRIEU (for herself, Mr. WARNER, and Mr. AKAKA) 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:

SEC. 1563. PROVISIONS RELATED TO VISION BENEFITS.

(a) EXEMPTION FROM COMPREHENSIVE COVERAGE REQUIREMENT.—Section 2707 of the Public Health Service Act, as added by section 1201, is amended by adding at the end the following:

''(e) VISION ONLY.—This section shall not apply to a plan described in section 1311(d)(2)(B)(iii) of the Patient Protection and Affordable Care Act.''.

(b) ESSENTIAL HEALTH BENEFITS.—Section 1302 of this Act is amended—

(1) in subsection (b)(4)—

(A) by redesignating subparagraphs (G) and (H) as subparagraphs (H) and (I), respectively;

(B) by inserting after subparagraph (F) the following:

''(G) provide that if a plan described in section 1311(d)(2)(B)(iii) (relating to stand-alone vision benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J);''; and

(C) in subparagraph (I), as so redesignated, by striking ''(G)'' and inserting ''(H)''; and

(2) by striking ''paragraph (4)(H)'' each place such term appears and inserting ''paragraph (4)(I)''.

(c) OFFERING OF COVERAGE.—Section 1311(d)(2)(B) of this Act is amended by adding at the end the following:

''(iii) OFFERING OF STAND-ALONE VISION BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope vision benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric vision benefits meeting the requirements of section 1302(b)(1)(J)).''.

(d) REFUNDABLE CREDIT.—Section 36B(b) of the Internal Revenue Code of 1986, as added by section 1401, is amended by adding at the end the following:

''(F) SPECIAL RULE FOR PEDIATRIC VISION COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(iii) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric vision benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.''.

(e) REDUCED COST-SHARING.—Section 1402(c) of this Act is amended by adding at the end the following:

''(6) SPECIAL RULE FOR PEDIATRIC VISION PLANS.—If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(iii) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric vision benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).''.

SA 3229. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 510, strike line 10 and all that follows through page 515, line 11.

SA 3230. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

SEC. 2008. NON-APPLICATION OF MEDICAID EXPANSION MANDATES.

Notwithstanding any other provision of this Act (or an amendment made by this Act), with respect to a State, any provision of this Act or amendment made by this Act that imposes on the State an expansion of coverage under the Medicaid program shall not apply to the State if such expansion would result in the State incurring costs for providing medical assistance to individuals enrolled under the State Medicaid program that are greater than the costs the State would have incurred if this Act and such amendments had not been enacted.

SA 3231. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 828, between lines 3 and 4, insert the following:

SEC. 3130. ENHANCED FMAP TO PROVIDE INCREASED PAYMENTS FOR PHYSICIANS' SERVICES AND INPATIENT HOSPITAL SERVICES FURNISHED IN RURAL AREAS.

Notwithstanding any other provision of law, if at any time after January 1, 2014, a State increases, by not less than the rate applicable under the Medicare program, the payment rates under its State Medicaid program for medical assistance consisting of physician services or inpatient hospital services that are furnished in rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) of the State, the Federal medical assistance percentage otherwise applicable to such expenditures shall be increased by an amount equal to 100 percent of the increase in such rates from the rates applicable under the State Medicaid program for fiscal year 2009.

SA 3232. Mr. BYRD 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 1356, strike line 3 and insert the following:

''(2) PRIORITY.—In awarding grants under paragraph (1), the Secretary shall give priority to eligible entities that are located in

States that have high rates of dental health care disparities.

SA 3233. Mr. BYRD 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 94, between lines 3 and 4, insert the following:

''(4) SELECTION.—In selecting States to participate in the demonstration project under this subsection, the Secretary shall give priority to States that have populations with high rates of—

''(A) chronic diseases, with particular emphasis on inclusion of States that have populations with high rates of diabetes, hypertension, and cardiovascular disease;

''(B) smoking and use of tobacco products; or

''(C) obesity.''.

SA 3234. 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 764, between lines 2 and 3, insert the following:

''(i) APPLICATION OF PILOT PROGRAM TO CONTINUING CARE HOSPITALS.—

''(1) IN GENERAL.—In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

''(2) SPECIAL RULES.—In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

''(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

''(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

''(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term 'continuing care hospital' means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long term care hospitals (as defined in section1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).''.

SA 3235. 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 923, between lines 7 and 8, insert the following:

SEC. 3211. IMPROVEMENTS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1853(p) of the Social Security Act, as added by section 3201, is amended—

(1) in paragraph (3)—

(A) by redesignating subparagraph (C) as subparagraph (D);

(B) in subparagraph (D), as so redesignated, by striking ''(A) or (B)'' and inserting ''(A), (B), or (C)'';

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

''(C) A county—

''(i) where the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for the year is greater than 45 percent (as determined by the Secretary); and

''(ii) that is located in a State in which the percentage of residents over the age of 65 is greater than 14 percent (as determined by the Secretary).'';

(D) by inserting after subparagraph (C) the following flush sentence:

''Such term shall not include any MA local area identified under subsection (o)(1).''; and

(2) in paragraph (5), by striking ''$5,000,000,000'' and inserting ''$7,000,000,000''.

SA 3236. 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, 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 731, between lines 16 and 17, insert the following:

''(xix) Implementing the lean methodology through a network of provider systems across the country in varying geographic areas and across sites of care that offer a patient-centered approach to improving quality, reducing medical errors, and enhancing value to patients.

SA 3237. Mr. BURRIS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title III, insert the following:

SEC. ___. PERMITTING PHYSICAL THERAPY TO BE FURNISHED UNDER THE MEDICARE PROGRAM UNDER THE CARE OF A DENTIST.

(a) IN GENERAL.—Section 1861(p)(1) of the Social Security Act (42 U.S.C. 1395x(p)(1)) is amended by inserting ''(2),'' after ''(1),''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after the date of the enactment of this Act.

SA 3238. Mr. ROCKEFELLER (for himself, Mr. KOHL, Mr. CARPER, and Mr. WARNER) 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:

TITLE X—COVERAGE OF ADVANCE CARE PLANNING

SEC. 10001. MEDICARE, MEDICAID, AND CHIP COVERAGE.

(a) MEDICARE.—

(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 4103, is amended—

(A) in subsection (s)(2)—

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

(ii) by adding ''and'' at the end of subparagraph (FF); and

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

''(GG) voluntary advance care planning consultation (as defined in subsection (iii)(1));''; and

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

''Voluntary Advance Care Planning Consultation

''(iii)(1) Subject to paragraphs (3) and (4), the term 'voluntary advance care planning consultation' means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to subparagraphs (A) and (B) of paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders regarding life sustaining treatment or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed

decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary may limit the requirement for explanations under clause (i) to consultations furnished in States, localities, or other geographic areas in which orders described in such clause have been widely adopted.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in subsection (r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3)(A) An initial preventive physical examination under subsection (ww), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1).

''(B) A voluntary advance care planning consultation with respect to an individual shall be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5)(A) For purposes of this section, the term 'order regarding life sustaining treatment' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

''(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order) and is in a form that permits it to stay with the patient and be followed by health care professionals and providers across the continuum of care, including home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services;

''(ii) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

''(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary);

''(iv) is portable across care settings; and

''(v) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed by the individual.

''(B) The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—

''(i) the intensity of medical intervention if the patient is pulseless, apneic, or has serious cardiac or pulmonary problems;

''(ii) the individual's desire regarding transfer to a hospital or remaining at the current care setting;

''(iii) the use of antibiotics; and

''(iv) the use of artificially administered nutrition and hydration.''.

(2) PAYMENT.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)), as amended by section 4103(c)(2), is amended by inserting ''(2)(GG),'' after ''(2)(FF) (including administration of the health risk assessment),''.

(3) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)(1)), as amended by section 4103(d), is amended—

(A) in paragraph (1)—

(i) in subparagraph (O), by striking ''and'' at the end;

(ii) in subparagraph (P) by striking the semicolon at the end and inserting '', and''; and

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

''(Q) in the case of advance care planning consultations (as defined in section 1861(iii)(1)), which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (P)'' and inserting ''(P), or (Q)''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011 .

(b) MEDICAID.—

(1) MANDATORY BENEFIT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), as amended by section 2301(b), is amended in the matter preceding clause (i) by striking ''and (28)'' and inserting '', (28), and (29)''.

(2) MEDICAL ASSISTANCE.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2006, and 2301(a)(1), is amended—

(A) in subsection (a)—

(i) in paragraph (28), by striking ''and'' at the end;

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

(iii) by inserting after paragraph (28) the following new paragraph:

''(29) advance care planning consultations (as defined in subsection (z));''; and

(B) by inserting after subsection (y) the following new subsection:

''(z)(1) For purposes of subsection (a)(28), the term 'voluntary advance care planning consultation' means an optional consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to.

''(B) An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.

''(C) An explanation by the practitioner of the role and responsibilities of a health care proxy.

''(D) The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act).

''(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

''(F)(i) Subject to clause (ii), an explanation of orders for life sustaining treatments or similar orders, which shall include—

''(I) the reasons why the development of such an order is beneficial to the individual and the individual's family and the reasons why such an order should be updated periodically as the health of the individual changes;

''(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

''(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual resides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decisionmaker (also known as a health care proxy).

''(ii) The Secretary may limit the requirement for explanations under clause (i) to consultations furnished in States, localities, or other geographic areas in which orders described in such clause have been widely adopted.

''(2) A practitioner described in this paragraph is—

''(A) a physician (as defined in section 1861(r)(1)); and

''(B) a nurse practitioner or physician's assistant who has the authority under State law to sign orders for life sustaining treatments.

''(3) A voluntary advance care planning consultation with respect to an individual shall be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

''(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

''(5) For purposes of this subsection, the term 'orders regarding life sustaining treatment' has the meaning given that term in section 1861(iii)(5).''.

(c) CHIP.—

(1) CHILD HEALTH ASSISTANCE.—Section 2110(a) of the Social Security Act (42 U.S.C. 1397jj) is amended—

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

(B) by inserting after paragraph (27), the following:

''(28) Voluntary advance care planning consultations (as defined in section 1905(z)).''.

(2) MANDATORY COVERAGE.—

(A) IN GENERAL.—Section 2103 of such Act (42 U.S.C. 1397cc), is amended—

(i) in subsection (a), in the matter preceding paragraph (1), by striking ''and (7)'' and inserting ''(7), and (9)''; and

(ii) in subsection (c), by adding at the end the following:

''(9) END-OF-LIFE CARE.—The child health assistance provided to a targeted low-income child shall include coverage of voluntary advance care planning consultations (as defined in section 1905(z) and at the same payment rate as the rate that would apply to such a consultation under the State plan under title XIX).''.

(B) CONFORMING AMENDMENT.—Section 2102(a)(7)(B) of such Act (42 U.S.C.

1397bb(a)(7)(B)) is amended by striking ''section 2103(c)(5)'' and inserting ''paragraphs (5) and (9) of section 2103(c)''.

(d) DEFINITION OF ADVANCE DIRECTIVE UNDER MEDICARE, MEDICAID, AND CHIP.—

(1) MEDICARE.—Section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3)) is amended by striking ''means'' and all that follows through the period and inserting ''means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.''.

(2) MEDICAID AND CHIP.—Section 1902(w)(4) of such Act (42 U.S.C. 1396a(w)(4)) is amended by striking ''means'' and all that follows through the period and inserting ''means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.''.

(e) RULE OF CONSTRUCTION.—A voluntary advance care planning consultation described under any provision of this section or amendment made by this section shall be provided solely at the option of the applicable individual. Nothing in this section shall be construed to—

(1) require an individual to complete an advance directive, an order for life-sustaining treatment, or other advance care planning document;

(2) require an individual to consent to restrictions on the amount, duration, or scope of medical benefits that such individual is entitled to receive through any program under titles XVIII, XIX, or XXI of the Social Security Act; or

(3) encourage or promote suicide or assisted suicide.

(f) EFFECTIVE DATE.—The amendments made by this section take effect January 1, 2010.

SEC. 10002. DISSEMINATION OF ADVANCE CARE PLANNING INFORMATION.

(a) IN GENERAL.—A health insurance issuer offering a qualified health plan—

(1) shall provide for the dissemination of information related to end-of-life planning to individuals seeking enrollment in qualified health plans offered through the Exchange;

(2) shall present such individuals with—

(A) the option to establish advanced directives and physician's orders for life sustaining treatment according to the laws of the State in which the individual resides; and

(B) information related to other planning tools; and

(3) shall not promote suicide, assisted suicide, euthanasia, or mercy killing.

The information presented under paragraph (2) shall not presume the withdrawal of treatment and shall include end-of-life planning information that includes options to maintain all or most medical interventions.

(b) CONSTRUCTION.—Nothing in this section shall be construed—

(1) to require an individual to complete an advanced directive or a physician's order for life sustaining treatment or other end-of-life planning document;

(2) to require an individual to consent to restrictions on the amount, duration, or scope of medical benefits otherwise covered under a qualified health plan; or

(3) to promote suicide, assisted suicide, euthanasia, or mercy killing.

(c) ADVANCED DIRECTIVE DEFINED.—In this section, the term ''advanced directive'' includes a living will, a comfort care order, or a durable power of attorney for health care.

(d) PROHIBITION ON THE PROMOTION OF ASSISTED SUICIDE.—

(1) IN GENERAL.—Subject to paragraph (3), information provided to meet the requirements of subsection (a)(2) shall not include advanced directives or other planning tools that list or describe as an option suicide, assisted suicide, euthanasia, or mercy killing, regardless of legality.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to apply to or affect any option to—

(A) withhold or withdraw of medical treatment or medical care;

(B) withhold or withdraw of nutrition or hydration; and

(C) provide palliative or hospice care or use an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(3) NO PREEMPTION OF STATE LAW.—Nothing in this section shall be construed to preempt or otherwise have any effect on State laws regarding advance care planning, palliative care, or end-of-life decision-making.

SA 3239. Mr. ROCKEFELLER (for himself, Ms. COLLINS, and 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, 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:

TITLE X—ADVANCE CARE PLANNING AND COMPASSIONATE CARE

SECTION 10001. SHORT TITLE.

This title may be cited as the ''Advance Planning and Compassionate Care Act of 2009''.

SEC. 10002. DEFINITIONS.

In this title:

(1) ADVANCE CARE PLANNING.—The term ''advance care planning'' means the process of—

(A) determining an individual's priorities, values and goals for care in the future when the individual is no longer able to express his or her wishes;

(B) engaging family members, health care proxies, and health care providers in an ongoing dialogue about—

(i) the individual's wishes for care;

(ii) what the future may hold for people with serious illnesses or injuries;

(iii) how individuals, their health care proxies, and family members want their beliefs and preferences to guide care decisions; and

(iv) the steps that individuals and family members can take regarding, and the resources available to help with, finances, family matters, spiritual questions, and other issues that impact seriously ill or dying patients and their families; and

(C) executing and updating advance directives and appointing a health care proxy.

(2) ADVANCE DIRECTIVE.—The term ''advance directive'' means a living will, medical directive, health care power of attorney, durable power of attorney, or other written statement by a competent individual that is recognized under State law and indicates the individual's wishes regarding medical treatment in the event of future incompetence. Such term includes an advance health care directive and a health care directive recognized under State law.

(3) CHIP.—The term ''CHIP'' means the program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(4) END-OF-LIFE-CARE.—The term ''end-of-life care'' means all aspects of care of a patient with a potentially fatal condition, and includes care that is focused on specific preparations for an impending death.

(5) HEALTH CARE POWER OF ATTORNEY.—The term ''health care power of attorney'' means a legal document that identifies a health care proxy or decisionmaker for a patient who has the authority to act on the patient's behalf when the patient is unable to communicate his or her wishes for medical care on matters that the patient specifies when he or she is competent. Such term includes a durable power of attorney that relates to medical care.

(6) LIVING WILL.—The term ''living will'' means a legal document—

(A) used to specify the type of medical care (including any type of medical treatment, including life-sustaining procedures if that person becomes permanently unconscious or is otherwise dying) that an individual wants provided or withheld in the event the individual cannot speak for himself or herself and cannot express his or her wishes; and

(B) that requires a physician to honor the provisions of upon receipt or to transfer the care of the individual covered by the document to another physician that will honor such provisions.

(7) MEDICAID.—The term ''Medicaid'' means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(8) MEDICARE.—The term ''Medicare'' means the program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(9) ORDERS FOR LIFE-SUSTAINING TREATMENT.—The term ''orders for life-sustaining treatment'' means a process for focusing a patients' values, goals, and preferences on current medical circumstances and to translate such into visible and portable medical orders applicable across care settings, including home, long-term care, emergency medical services, and hospitals.

(10) PALLIATIVE CARE.—The term ''palliative care'' means interdisciplinary care for individuals with a life-threatening illness or injury relating to pain and symptom management and psychological, social, and spiritual needs and that seeks to improve the quality of life for the individual and the individual's family.

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

Subtitle A—Consumer and Provider Education

PART I—CONSUMER EDUCATION

Subpart A—National Initiatives

SEC. 10101. ADVANCE CARE PLANNING TELEPHONE HOTLINE.

(a) IN GENERAL.—Not later than January 1, 2011, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and operate directly, or by grant, contract, or interagency agreement, a 24-hour toll-free telephone hotline to provide consumer information regarding advance care planning, including—

(1) an explanation of advanced care planning and its importance;
(2) issues to be considered when developing an individual's advance care plan;
(3) how to establish an advance directive;
(4) procedures to help ensure that an individual's directives for end-of-life care are followed;
(5) Federal and State-specific resources for assistance with advance care planning; and
(6) hospice and palliative care (including their respective purposes and services).

(b) ESTABLISHMENT.—In carrying out the requirements under subsection (a), the Director of the Centers for Disease Control and Prevention may designate an existing 24-hour toll-free telephone hotline or, if no such service is available or appropriate, establish a new 24-hour toll-free telephone hotline.

SEC. 10102. ADVANCE CARE PLANNING INFORMATION CLEARINGHOUSES.

(a) EXPANSION OF NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—
(1) DEVELOPMENT.—Not later than January 1, 2010, the Secretary shall develop an online clearinghouse to provide comprehensive information regarding advance care planning.
(2) MAINTENANCE.—The advance care planning clearinghouse, which shall be clearly identifiable and available on the homepage of the Department of Health and Human Service's National Clearinghouse for Long-Term Care Information website, shall be maintained and publicized by the Secretary on an ongoing basis.
(3) CONTENT.—The advance care planning clearinghouse shall include—
(A) any relevant content contained in the national public education campaign required under section 10104;
(B) content addressing—
(i) an explanation of advanced care planning and its importance;
(ii) issues to be considered when developing an individual's advance care plan;
(iii) how to establish an advance directive;
(iv) procedures to help ensure that an individual's directives for end-of-life care are followed; and
(v) hospice and palliative care (including their respective purposes and services); and
(C) available Federal and State-specific resources for assistance with advance care planning, including—
(i) contact information for any State public health departments that are responsible for issues regarding end-of-life care;
(ii) contact information for relevant legal service organizations, including those funded under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and
(iii) advance directive forms for each State; and
(D) any additional information, as determined by the Secretary.

(b) ESTABLISHMENT OF PEDIATRIC ADVANCE CARE PLANNING CLEARINGHOUSE.—
(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary, in consultation with the Assistant Secretary for Children and Families of the Department of Health and Human Services, shall develop an online clearinghouse to provide comprehensive information regarding pediatric advance care planning.
(2) MAINTENANCE.—The pediatric advance care planning clearinghouse, which shall be clearly identifiable on the homepage of the Administration for Children and Families website, shall be maintained and publicized by the Secretary on an ongoing basis.
(3) CONTENT.—The pediatric advance care planning clearinghouse shall provide advance care planning information specific to children with life-threatening illnesses or injuries and their families.

SEC. 10103. ADVANCE CARE PLANNING TOOLKIT.

(a) DEVELOPMENT.—Not later than July 1, 2010, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, shall develop an online advance care planning toolkit.
(b) MAINTENANCE.—The advance care planning toolkit, which shall be available in English, Spanish, and any other languages that the Secretary deems appropriate, shall be maintained and publicized by the Secretary on an ongoing basis and made available on the following websites:
(1) The Centers for Disease Control and Prevention.
(2) The Department of Health and Human Service's National Clearinghouse for Long-Term Care Information.
(3) The Administration for Children and Families.
(c) CONTENT.—The advance care planning toolkit shall include content addressing—
(1) common issues and questions regarding advance care planning, including individuals and resources to contact for further inquiries;
(2) advance directives and their uses, including living wills and durable powers of attorney;
(3) the roles and responsibilities of a health care proxy;
(4) Federal and State-specific resources to assist individuals and their families with advance care planning, including—
(A) the advance care planning toll-free telephone hotline established under section 10101;
(B) the advance care planning clearinghouses established under section 10102;
(C) the advance care planning toolkit established under this section;
(D) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and
(E) website links or addresses for State-specific advance directive forms; and
(5) any additional information, as determined by the Secretary.

SEC. 10104. NATIONAL PUBLIC EDUCATION CAMPAIGN.

(a) NATIONAL PUBLIC EDUCATION CAMPAIGN.—
(1) IN GENERAL.—Not later than January 1, 2011, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall, directly or through grants, contracts, or interagency agreements, develop and implement a national campaign to inform the public of the importance of advance care planning and of an individual's right to direct and participate in their health care decisions.
(2) CONTENT OF EDUCATIONAL CAMPAIGN.—The national public education campaign established under paragraph (1) shall—
(A) employ the use of various media, including regularly televised public service announcements;
(B) provide culturally and linguistically appropriate information;
(C) be conducted continuously over a period of not less than 5 years;
(D) identify and promote the advance care planning information available on the Department of Health and Human Service's National Clearinghouse for Long-Term Care Information website and Administration for Children and Families website, as well as any other relevant Federal or State-specific advance care planning resources;
(E) raise public awareness of the consequences that may result if an individual is no longer able to express or communicate their health care decisions;
(F) address the importance of individuals speaking to family members, health care proxies, and health care providers as part of an ongoing dialogue regarding their health care choices;
(G) address the need for individuals to obtain readily available legal documents that express their health care decisions through advance directives (including living wills, comfort care orders, and durable powers of attorney for health care);
(H) raise public awareness regarding the availability of hospice and palliative care; and
(I) encourage individuals to speak with their physicians about their options and intentions for end-of-life care.
(3) EVALUATION.—
(A) IN GENERAL.—Not later than July 1, 2013, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a nationwide survey to evaluate whether the national campaign conducted under this subsection has achieved its goal of changing public awareness, attitudes, and behaviors regarding advance care planning.
(B) BASELINE SURVEY.—In order to evaluate the effectiveness of the national campaign, the Secretary shall conduct a baseline survey prior to implementation of the campaign.
(C) REPORTING REQUIREMENT.—Not later than December 31, 2013, the Secretary shall report the findings of such survey, as well as any recommendations that the Secretary determines appropriate regarding the need for continuation or legislative or administrative changes to facilitate changing public awareness, attitudes, and behaviors regarding advance care planning, to the appropriate committees of the Congress.
(b) REPEAL.—Section 4751(d) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note; Public Law 101–508) is repealed.

SEC. 10105. UPDATE OF MEDICARE AND SOCIAL SECURITY HANDBOOKS.

(a) MEDICARE & YOU HANDBOOK.—
(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall update the online version of the ''Planning Ahead'' section of the Medicare & You Handbook to include—
(A) an explanation of advance care planning and advance directives, including—
(i) living wills;
(ii) health care proxies; and
(iii) after-death directives;
(B) Federal and State-specific resources to assist individuals and their families with advance care planning, including—
(i) the advance care planning toll-free telephone hotline established under section 10101;
(ii) the advance care planning clearinghouses established under section 10102;
(iii) the advance care planning toolkit established under section 10103;
(iv) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.); and
(v) website links or addresses for State-specific advance directive forms; and
(C) any additional information, as determined by the Secretary.
(2) UPDATE OF PAPER AND SUBSEQUENT VERSIONS.—The Secretary shall include the information described in paragraph (1) in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 60 days after the date of enactment of this Act.
(b) SOCIAL SECURITY HANDBOOK.—The Commissioner of Social Security shall—
(1) not later than 60 days after the date of enactment of this Act, update the online version of the Social Security Handbook for

beneficiaries to include the information described in subsection (a)(1); and

(2) include such information in all paper and online versions of such handbook that are published on or after the date that is 60 days after the date of enactment of this Act.

SEC. 10106. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated for the period of fiscal years 2010 through 2014—

(1) $195,000,000 to the Secretary to carry out sections 10101, 10102, 10103, 10104 and 10105(a); and

(2) $5,000,000 to the Commissioner of Social Security to carry out section 10105(b).

Subpart B—State and Local Initiatives

SEC. 10111. FINANCIAL ASSISTANCE FOR ADVANCE CARE PLANNING.

(a) LEGAL ASSISTANCE FOR ADVANCE CARE PLANNING.—

(1) DEFINITION OF RECIPIENT.—Section 1002(6) of the Legal Services Corporation Act (42 U.S.C. 2996a(6)) is amended by striking ''clause (A) of'' and inserting ''subparagraph (A) or (B) of''.

(2) ADVANCE CARE PLANNING.—Section 1006 of the Legal Services Corporation Act (42 U.S.C. 2996e) is amended—

(A) in subsection (a)(1)—

(i) by striking ''title, and (B) to make'' and inserting the following: ''title;

''(C) to make''; and

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

''(B) to provide financial assistance, and make grants and contracts, as described in subparagraph (A), on a competitive basis for the purpose of providing legal assistance in the form of advance care planning (as defined in section 10002 of the Patient Protection and Affordable Care Act, and including providing information about State-specific advance directives, as defined in that section) for eligible clients under this title, including providing such planning to the family members of eligible clients and persons with power of attorney to make health care decisions for the clients; and''; and

(B) in subsection (b), by adding at the end the following:

''(2) Advance care planning provided in accordance with subsection (a)(1)(B) shall not be construed to violate the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14401 et seq.).''.

(3) REPORTS.—Section 1008(a) of the Legal Services Corporation Act (42 U.S.C. 2996g(a)) is amended by adding at the end the following: ''The Corporation shall require such a report, on an annual basis, from each grantee, contractor, or other recipient of financial assistance under section 1006(a)(1)(B).''.

(4) AUTHORIZATION OF APPROPRIATIONS.—Section 1010 of the Legal Services Corporation Act (42 U.S.C. 2996i) is amended—

(A) in subsection (a)—

(i) by striking ''(a)'' and inserting ''(a)(1)'';

(ii) in the last sentence, by striking ''Appropriations for that purpose'' and inserting the following:

''(3) Appropriations for a purpose described in paragraph (1) or (2)''; and

(iii) by inserting before paragraph (3) (as designated by clause (ii)) the following:

''(2) There are authorized to be appropriated to carry out section 1006(a)(1)(B), $10,000,000 for each of fiscal years 2010, 2011, 2012, 2013, and 2014.''; and

(B) in subsection (d), by striking ''subsection (a)'' and inserting ''subsection (a)(1)''.

(5) EFFECTIVE DATE.—This subsection and the amendments made by this subsection take effect July 1, 2010.

(b) STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (3) to award grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990 to provide advance care planning services to Medicare beneficiaries, personal representatives of such beneficiaries, and the families of such beneficiaries. Such services shall include information regarding State-specific advance directives and ways to discuss individual care wishes with health care providers.

(2) REQUIREMENTS.—

(A) AWARD OF GRANTS.—In making grants under this subsection for a fiscal year, the Secretary shall satisfy the following requirements:

(i) Two-thirds of the total amount of funds available under paragraph (3) for a fiscal year shall be allocated among those States approved for a grant under this section that have adopted the Uniform Health-Care Decisions Act drafted by the National Conference of Commissioners on Uniform State Laws and approved and recommended for enactment by all States at the annual conference of such commissioners in 1993.

(ii) One-third of the total amount of funds available under paragraph (3) for a fiscal year shall be allocated among those States approved for a grant under this section that have adopted a uniform form regarding orders regarding life sustaining treatment (as described in section 10002) or a comparable approach to advance care planning.

(B) WORK PLAN; REPORT.—As a condition of being awarded a grant under this subsection, a State shall submit the following to the Secretary:

(i) An approved plan for expending grant funds.

(ii) For each fiscal year for which the State is paid grant funds under this subsection, an annual report regarding the use of the funds, including the number of Medicare beneficiaries served and their satisfaction with the services provided.

(C) LIMITATION.—No State shall be paid funds from a grant made under this subsection prior to July 1, 2010.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to the Centers for Medicare & Medicaid Services Program Management Account, $12,000,000 for each of fiscal years 2010 through 2014 for purposes of awarding grants to States under paragraph (1).

(c) MEDICAID TRANSFORMATION GRANTS FOR ADVANCE CARE PLANNING.—Section 1903(z) of the Social Security Act (42 U.S.C. 1396b(z)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(G) Methods for improving the effectiveness and efficiency of medical assistance provided under this title by making available to individuals enrolled in the State plan or under a waiver of such plan information regarding advance care planning (as defined in section 10002 of the Patient Protection and Affordable Care Act), including at time of enrollment or renewal of enrollment in the plan or waiver, through providers, and through such other innovative means as the State determines appropriate.'';

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(D) WORK PLAN REQUIRED FOR AWARD OF ADVANCE CARE PLANNING GRANTS.—Payment to a State under this subsection to adopt the innovative methods described in paragraph (2)(G) is conditioned on the State submitting to the Secretary an approved plan for expending the funds awarded to the State under this subsection.''; and

(3) in paragraph (4)—

(A) in subparagraph (A)—

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

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

(iii) by inserting after clause (ii), the following new clause:

''(iii) $20,000,000 for each of fiscal years 2010 through 2014.''; and

(B) by striking subparagraph (B), and inserting the following:

''(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States awarded a grant for fiscal year 2010, 2011, 2012, 2013, or 2014. Such method shall provide that—

''(i) 100 percent of such funds for each of fiscal years 2010 through 2014 shall be awarded to States that design programs to adopt the innovative methods described in paragraph (2)(G); and

''(ii) in no event shall a payment to a State awarded a grant under this subsection for fiscal year 2010 be made prior to July 1, 2010.''.

(d) ADVANCE CARE PLANNING COMMUNITY TRAINING GRANTS.—

(1) IN GENERAL.—The Secretary shall use amounts made available under paragraph (3) to award grants to area agencies on aging (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)).

(2) REQUIREMENTS.—

(A) USE OF FUNDS.—Funds awarded to an area agency on aging under this subsection shall be used to provide advance care planning education and training opportunities for local aging service providers and organizations.

(B) WORK PLAN; REPORT.—As a condition of being awarded a grant under this subsection, an area agency on aging shall submit the following to the Secretary:

(i) An approved plan for expending grant funds.

(ii) For each fiscal year for which the agency is paid grant funds under this subsection, an annual report regarding the use of the funds, including the number of Medicare beneficiaries served and their satisfaction with the services provided.

(C) LIMITATION.—No area agency on aging shall be paid funds from a grant made under this subsection prior to July 1, 2010.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary to the Centers for Medicare & Medicaid Services Program Management Account, $12,000,000 for each of fiscal years 2010 through 2014 for purposes of awarding grants to area agencies on aging under paragraph (1).

(e) NONDUPLICATION OF ACTIVITIES.—The Secretary shall establish procedures to ensure that funds made available under grants awarded under this section or pursuant to amendments made by this section supplement, not supplant, existing Federal funding, and that such funds are not used to duplicate activities carried out under such grants or under other Federally funded programs.

SEC. 10112. GRANTS FOR PROGRAMS FOR ORDERS REGARDING LIFE SUSTAINING TREATMENT.

(a) IN GENERAL.—The Secretary shall make grants to eligible entities for the purpose of—

(1) establishing new programs for orders regarding life sustaining treatment in States or localities;

(2) expanding or enhancing an existing program for orders regarding life sustaining treatment in States or localities; or

(3) providing a clearinghouse of information on programs for orders for life sustaining treatment and consultative services

for the development or enhancement of such programs.

(b) AUTHORIZED ACTIVITIES.—Activities funded through a grant under this section for an area may include—

(1) developing such a program for the area that includes home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services within the area;

(2) securing consultative services and advice from institutions with experience in developing and managing such programs; and

(3) expanding an existing program for orders regarding life sustaining treatment to serve more patients or enhance the quality of services, including educational services for patients and patients' families or training of health care professionals.

(c) DISTRIBUTION OF FUNDS.—In funding grants under this section, the Secretary shall ensure that, of the funds appropriated to carry out this section for each fiscal year—

(1) at least two-thirds are used for establishing or developing new programs for orders regarding life sustaining treatment; and

(2) one-third is used for expanding or enhancing existing programs for orders regarding life sustaining treatment.

(d) DEFINITIONS.—In this section:

(1) The term ''eligible entity'' includes—

(A) an academic medical center, a medical school, a State health department, a State medical association, a multi-State taskforce, a hospital, or a health system capable of administering a program for orders regarding life sustaining treatment for a State or locality; or

(B) any other health care agency or entity as the Secretary determines appropriate.

(2) The term ''order regarding life sustaining treatment'' means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

(A) is signed and dated by a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1))) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional's authority under State law in signing such an order) and is in a form that permits it to stay with the patient and be followed by health care professionals and providers across the continuum of care, including home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, inpatient rehabilitation facilities, hospitals, and emergency medical services;

(B) effectively communicates the individual's preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

(C) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary);

(D) is portable across care settings; and

(E) may incorporate any advance directive (as defined in section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3)) if executed by the individual. .

(3) The term ''program for orders regarding life sustaining treatment'' means, with respect to an area, a program that supports the active use of orders regarding life sustaining treatment in the area.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2009 through 2014.

PART II—PROVIDER EDUCATION

SEC. 10121. PUBLIC PROVIDER ADVANCE CARE PLANNING WEBSITE.

(a) DEVELOPMENT.—Not later than January 1, 2010, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Agency for Healthcare Research and Quality, shall establish a website for providers under Medicare, Medicaid, the Children's Health Insurance Program, the Indian Health Service (include contract providers) and other public health providers on each individual's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(b) MAINTENANCE.—The website, shall be maintained and publicized by the Secretary on an ongoing basis.

(c) CONTENT.—The website shall include content, tools, and resources necessary to do the following:

(1) Inform providers about the advance directive requirements under the health care programs described in subsection (a) and other State and Federal laws and regulations related to advance care planning.

(2) Educate providers about advance care planning quality improvement activities.

(3) Provide assistance to providers to—

(A) integrate advance directives into electronic health records, including oral directives; and

(B) develop and disseminate advance care planning informational materials for their patients.

(4) Inform providers about advance care planning continuing education requirements and opportunities.

(5) Encourage providers to discuss advance care planning with their patients of all ages.

(6) Assist providers' understanding of the continuum of end-of-life care services and supports available to patients, including palliative care and hospice.

(7) Inform providers of best practices for discussing end-of-life care with dying patients and their loved ones.

SEC. 10122. CONTINUING EDUCATION FOR PHYSICIANS AND NURSES.

(a) IN GENERAL.—Not later than January 1, 2012, the Secretary, acting through the Director of Health Resources and Services Administration, shall develop, in consultation with health care providers and State boards of medicine and nursing, a curriculum for continuing education that States may adopt for physicians and nurses on advance care planning and end-of-life care.

(b) CONTENT.—

(1) IN GENERAL.—The continuing education curriculum developed under subsection (a) for physicians and nurses shall, at a minimum, include—

(A) a description of the meaning and importance of advance care planning;

(B) a description of advance directives, including living wills and durable powers of attorney, and the use of such directives;

(C) palliative care principles and approaches to care; and

(D) the continuum of end-of-life services and supports, including palliative care and hospice.

(2) ADDITIONAL CONTENT FOR PHYSICIANS.—The continuing education curriculum for physicians developed under subsection (a) shall include instruction on how to conduct advance care planning with patients and their loved ones.

Subtitle B—Portability of Advance Directives; Health Information Technology

SEC. 10131. PORTABILITY OF ADVANCE DIRECTIVES.

(a) MEDICARE.—Section 1866(f) of the Social Security Act (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (B), by inserting ''and if presented by the individual, to include the content of such advance directive in a prominent part of such record'' before the semicolon at the end;

(B) in subparagraph (D), by striking ''and'' after the semicolon at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(D) by inserting after subparagraph (E) the following new subparagraph:

''(F) to provide each individual with the opportunity to discuss issues relating to the information provided to that individual pursuant to subparagraph (A) with an appropriately trained professional.'';

(2) in paragraph (3), by striking ''a written'' and inserting ''an''; and

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

''(5)(A) An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider of services, a Medicare Advantage organization, or a prepaid or eligible organization shall be given the same effect by that provider or organization as an advance directive validly executed under the law of the State in which it is presented would be given effect.

''(B)(i) The definition of an advanced directive shall also include actual knowledge of instructions made while an individual was able to express the wishes of such individual with regard to health care.

''(ii) For purposes of clause (i), the term 'actual knowledge' means the possession of information of an individual's wishes communicated to the health care provider orally or in writing by the individual, the individual's medical power of attorney representative, the individual's health care surrogate, or other individuals resulting in the health care provider's personal cognizance of these wishes. Other forms of imputed knowledge are not actual knowledge.

''(C) The provisions of this paragraph shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this paragraph shall not preempt any State law that provides for greater portability, more deference to a patient's wishes, or more latitude in determining a patient's wishes.''.

(b) MEDICAID.—Section 1902(w) of the Social Security Act (42 U.S.C. 1396a(w)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (B)—

(i) by striking ''in the individual's medical record'' and inserting ''in a prominent part of the individual's current medical record''; and

(ii) by inserting ''and if presented by the individual, to include the content of such advance directive in a prominent part of such record'' before the semicolon at the end;

(B) in subparagraph (D), by striking ''and'' after the semicolon at the end;

(C) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

(D) by inserting after subparagraph (E) the following new subparagraph:

''(F) to provide each individual with the opportunity to discuss issues relating to the information provided to that individual pursuant to subparagraph (A) with an appropriately trained professional.'';

(2) in paragraph (4), by striking ''a written'' and inserting ''an''; and

(3) by adding at the end the following paragraph:

''(6)(A) An advance directive validly executed outside of the State in which such advance directive is presented by an adult individual to a provider or organization shall be given the same effect by that provider or organization as an advance directive validly

executed under the law of the State in which it is presented would be given effect.

''(B)(i) The definition of an advance directive shall also include actual knowledge of instructions made while an individual was able to express the wishes of such individual with regard to health care.

''(ii) For purposes of clause (i), the term 'actual knowledge' means the possession of information of an individual's wishes communicated to the health care provider orally or in writing by the individual, the individual's medical power of attorney representative, the individual's health care surrogate, or other individuals resulting in the health care provider's personal cognizance of these wishes. Other forms of imputed knowledge are not actual knowledge.

''(C) The provisions of this paragraph shall preempt any State law to the extent such law is inconsistent with such provisions. The provisions of this paragraph shall not preempt any State law that provides for greater portability, more deference to a patient's wishes, or more latitude in determining a patient's wishes.''.

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 2101(d)(2), 2101(e), and 6401(c), is further amended—

(1) by redesignating subparagraphs (G) through (N) as subparagraphs (H) through (O), respectively; and

(2) by inserting after subparagraph (F) the following:

''(G) Section 1902(w) (relating to advance directives).''.

(d) STUDY AND REPORT REGARDING IMPLEMENTATION.—

(1) STUDY.—The Secretary shall conduct a study regarding the implementation of the amendments made by subsections (a) and (b).

(2) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsections (a), (b), and (c) shall apply to provider agreements and contracts entered into, renewed, or extended under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and to State plans under title XIX of such Act (42 U.S.C. 1396 et seq.) and State child health plans under title XXI of such Act (42 U.S.C. 1397aa et seq.), on or after such date as the Secretary specifies, but in no case may such date be later than 1 year after the date of enactment of this Act.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act or a State child health plan under title XXI of such Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by subsections (b) and (c), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 10132. STATE ADVANCE DIRECTIVE REGISTRIES; DRIVER'S LICENSE ADVANCE DIRECTIVE NOTATION.

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

''SEC. 399X. STATE ADVANCE DIRECTIVE REGISTRIES.

''(a) STATE ADVANCE DIRECTIVE REGISTRY.—In this section, the term 'State advance directive registry' means a secure, electronic database that—

''(1) is available free of charge to residents of a State; and

''(2) stores advance directive documents and makes such documents accessible to medical service providers in accordance with Federal and State privacy laws.

''(b) GRANT PROGRAM.—Beginning on July 1, 2010, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants on a competitive basis to eligible entities to establish and operate, directly or indirectly (by competitive grant or competitive contract), State advance directive registries.

''(c) ELIGIBLE ENTITIES.—

''(1) IN GENERAL.—To be eligible to receive a grant under this section, an entity shall—

''(A) be a State department of health; and

''(B) submit to the Director an application at such time, in such manner, and containing—

''(i) a plan for the establishment and operation of a State advance directive registry; and

''(ii) such other information as the Director may require.

''(2) NO REQUIREMENT OF NOTATION MECHANISM.—The Secretary shall not require that an entity establish and operate a driver's license advance directive notation mechanism for State residents under section 399Y to be eligible to receive a grant under this section.

''(d) ANNUAL REPORT.—For each year for which an entity receives an award under this section, such entity shall submit an annual report to the Director on the use of the funds received pursuant to such award, including the number of State residents served through the registry.

''(e) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal year 2010 and each fiscal year thereafter.

''SEC. 399Y. DRIVER'S LICENSE ADVANCE DIRECTIVE NOTATION.

''(a) IN GENERAL.—Beginning July 1, 2010, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants on a competitive basis to States to establish and operate a mechanism for a State resident with a driver's license to include a notice of the existence of an advance directive for such resident on such license.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, a State shall—

''(1) establish and operate a State advance directive registry under section 399X; and

''(2) submit to the Director an application at such time, in such manner, and containing—

''(A) a plan that includes a description of how the State will—

''(i) disseminate information about advance directives at the time of driver's license application or renewal;

''(ii) enable each State resident with a driver's license to include a notice of the existence of an advance directive for such resident on such license in a manner consistent with the notice on such a license indicating a driver's intent to be an organ donor; and

''(iii) coordinate with the State department of health to ensure that, if a State resident has an advance directive notice on his or her driver's license, the existence of such advance directive is included in the State registry established under section 399X; and

''(B) any other information as the Director may require.

''(c) ANNUAL REPORT.—For each year for which a State receives an award under this section, such State shall submit an annual report to the Director on the use of the funds received pursuant to such award, including the number of State residents served through the mechanism.

''(d) AUTHORIZATION.—There is authorized to be appropriated to carry out this section $50,000,000 for fiscal year 2010 and each fiscal year thereafter.''.

SEC. 10133. GAO STUDY AND REPORT ON ESTABLISHMENT OF NATIONAL ADVANCE DIRECTIVE REGISTRY.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the feasibility of a national registry for advance directives, taking into consideration the constraints created by the privacy provisions enacted as a result of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191).

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation and administrative action as the Comptroller General of the United States determines to be appropriate.

Subtitle C—National Uniform Policy on Advance Care Planning

SEC. 10141. STUDY AND REPORT BY THE SECRETARY REGARDING THE ESTABLISHMENT AND IMPLEMENTATION OF A NATIONAL UNIFORM POLICY ON ADVANCE DIRECTIVES.

(a) STUDY.—

(1) IN GENERAL.—The Secretary, acting through the Office of the Assistant Secretary for Planning and Evaluation, shall conduct a thorough study of all matters relating to the establishment and implementation of a national uniform policy on advance directives for individuals receiving items and services under titles XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.; 1397aa et seq.).

(2) MATTERS STUDIED.—The matters studied by the Secretary under paragraph (1) shall include issues concerning—

(A) family satisfaction that a patient's wishes, as stated in the patient's advance directive, were carried out;

(B) the portability of advance directives, including cases involving the transfer of an individual from 1 health care setting to another;

(C) immunity from civil liability and criminal responsibility for health care providers that follow the instructions in an individual's advance directive that was validly executed in, and consistent with the laws of, the State in which it was executed;

(D) conditions under which an advance directive is operative;

(E) revocation of an advance directive by an individual;

(F) the criteria used by States for determining that an individual has a terminal condition;

(G) surrogate decisionmaking regarding end-of-life care;

(H) the provision of adequate palliative care (as defined in paragraph (3)), including pain management;

(I) adequate and timely referrals to hospice care programs; and

(J) the end-of-life care needs of children and their families.

(3) PALLIATIVE CARE.—For purposes of paragraph (2)(H), the term ''palliative care'' means interdisciplinary care for individuals

with a life-threatening illness or injury relating to pain and symptom management and psychological, social, and spiritual needs and that seeks to improve the quality of life for the individual and the individual's family.

(b) REPORT TO CONGRESS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(c) CONSULTATION.—In conducting the study and developing the report under this section, the Secretary shall consult with the Uniform Law Commissioners, and other interested parties.

Subtitle D—Compassionate Care Workforce Development

SEC. 10151. EXEMPTION OF PALLIATIVE MEDICINE FELLOWSHIP TRAINING FROM MEDICARE GRADUATE MEDICAL EDUCATION CAPS.

(a) DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(F)), as amended by section 5503(a)(1), is amended—

(1) in clause (i), by inserting ''clause (iii) and'' after ''subject to''; and

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

''(iii) INCREASE ALLOWED FOR PALLIATIVE MEDICINE FELLOWSHIP TRAINING.—For cost reporting periods beginning on or after January 1, 2011, in applying clause (i), there shall not be taken into account full-time equivalent residents in the field of allopathic or osteopathic medicine who are in palliative medicine fellowship training that is approved by the Accreditation Council for Graduate Medical Education.''.

(b) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by sections 5503(b)(2) and 5505(b), is further amended by adding at the end the following new clause:

''(xi) Clause (iii) of subsection (h)(4)(F) shall apply to clause (v) in the same manner and for the same period as such clause (iii) applies to clause (i) of such subsection.''.

SEC. 10152. MEDICAL SCHOOL CURRICULA.

(a) IN GENERAL.—The Secretary, in consultation with the Association of American Medical Colleges, shall establish guidelines for the imposition by medical schools of a minimum amount of end-of-life training as a requirement for obtaining a Doctor of Medicine degree in the field of allopathic or osteopathic medicine.

(b) TRAINING.—Under the guidelines established under subsection (a), minimum training shall include—

(1) training in how to discuss and help patients and their loved ones with advance care planning;

(2) with respect to students and trainees who will work with children, specialized pediatric training;

(3) training in the continuum of end-of-life services and supports, including palliative care and hospice;

(4) training in how to discuss end-of-life care with dying patients and their loved ones; and

(5) medical and legal issues training.

(c) DISTRIBUTION.—Not later than January 1, 2011, the Secretary shall disseminate the guidelines established under subsection (a) to medical schools.

(d) COMPLIANCE.—Effective beginning not later than July 1, 2012, a medical school that is receiving Federal assistance shall be required to implement the guidelines established under subsection (a). A medical school that the Secretary determines is not implementing such guidelines shall not be eligible for Federal assistance.

Subtitle E—Additional Reports, Research, and Evaluations

SEC. 10161. NATIONAL MORTALITY FOLLOWBACK SURVEY.

(a) IN GENERAL.—Not later than December 31, 2010, and annually thereafter, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall renew and conduct the National Mortality Followback Survey (referred to in this section as the ''Survey'') to collect data on end-of-life care.

(b) PURPOSE.—The purpose of the Survey shall be to gain a better understanding of current end-of-life care in the United States.

(c) QUESTIONS.—

(1) IN GENERAL.—In conducting the Survey, the Director of the Centers for Disease Control and Prevention shall, at a minimum, include the following questions with respect to the loved one of a respondent:

(A) Did he or she have an advance directive, and if so, when it was completed.

(B) Did he or she have an order for life-sustaining treatment, and if so, when was it completed.

(C) Did he or she have a durable power of attorney, and if so, when it was completed.

(D) Had he or she discussed his or her wishes with loved ones, and if so, when.

(E) Had he or she discussed his or her wishes with his or her physician, and if so, when.

(F) In the opinion of the respondent, was he or she satisfied with the care he or she received in the last year of life and in the last week of life.

(G) Was he or she cared for by hospice, and if so, when.

(H) Was he or she cared for by palliative care specialists, and if so, when.

(I) Did he or she receive effective pain management (if needed).

(J) What was the experience of the main caregiver (including if such caregiver was the respondent), and whether he or she received sufficient support in this role.

(2) ADDITIONAL QUESTIONS.—Additional questions to be asked during the Survey shall be determined by the Director of the Centers for Disease Control and Prevention on an ongoing basis with input from relevant research entities.

SEC. 10162. INSPECTOR GENERAL INVESTIGATION OF FRAUD AND ABUSE.

In accordance with the recommendations of the Medicare Payment Advisory Commission for additional data (as contained in the March 2009 report entitled ''Report to Congress: Medicare Payment Policy''), the Secretary shall direct the Office of the Inspector General of the Department of Health and Human Services to investigate, not later than January 1, 2012, the following with respect to hospice benefit under Medicare, Medicaid, and CHIP:

(1) The prevalence of financial relationships between hospices and long-term care facilities, such as nursing facilities and assisted living facilities, that may represent a conflict of interest and influence admissions to hospice.

(2) Differences in patterns of nursing home referrals to hospice.

(3) The appropriateness of enrollment practices for hospices with unusual utilization patterns (such as high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices).

(4) The appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.

SEC. 10163. GAO STUDY AND REPORT ON PROVIDER ADHERENCE TO ADVANCE DIRECTIVES.

Not later than January 1, 2012, the Comptroller General of the United States shall conduct a study of the extent to which providers comply with advance directives under the Medicare and Medicaid programs and shall submit a report to Congress on the results of such study, together with such recommendations for administrative or legislative changes as the Comptroller General determines appropriate.

SA 3240. Mr. ROCKEFELLER (for himself, Mr. LIEBERMAN, Mr. WHITEHOUSE, and Mr. BINGAMAN) 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 1053, between lines 2 and 3, insert the following:

SEC. 3403A. IMPROVEMENTS TO THE INDEPENDENT MEDICARE ADVISORY BOARD.

Section 1899A of the Social Security Act, as added by section 3403, is amended—

(1) in subsection (c)—

(A) in paragraph (2)(A), by striking clause (iii) and inserting the following new clause:

''(iii) As appropriate, the proposal may include recommendations to adjust payments with respect to all providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)).'';

(B) in paragraph (3)(A)(ii)—

(i) in subclause (I), by inserting ''or'' at the end;

(ii) in subclause (II), by striking ''; or'' at the end and inserting a period; and

(iii) by striking subclause (III);

(C) in paragraph (7)(C), by striking clause (i) and inserting the following new clause:

''(i) in the case of implementation year 2015 or any subsequent implementation year, 1.5 percent; and''; and

(D) by striking paragraph (8);

(2) in subsection (e), by striking ''August 15'' each place it appears and inserting ''June 1'';

(3) in subsection (f)(3)(B), by striking ''or advisory reports to Congress'' and inserting '', advisory reports, or other reports'';

(4) by redesignating subsections (g) through (m) as subsections (i) through (o), respectively; and

(5) by adding at the end the following new subsections:

''(g) PROPOSALS IN NON-DETERMINATION YEARS.—

''(1) IN GENERAL.—In any proposal year in which the Board is not required to transmit a proposal to the President by reason of the application of subclause (I) or (II) of subsection (c)(3)(A)(ii), the Board shall transmit a proposal under this section to the President on January 15 of the year. Except as provided in paragraph (2), such a proposal shall be treated as a proposal under this section and all of the provisions of this section with respect to proposals, including the requirements under paragraphs (2) and (4) of subsection (c) and the required Congressional consideration under subsection (d), shall apply to the proposal.

''(2) EXCEPTIONS.—The following rules shall apply to a proposal transmitted pursuant to paragraph (1):

''(A) RECOMMENDATIONS FOR ACHIEVING TARGET.—The requirement under subsection (c)(2)(A)(i) shall not apply.

''(B) REQUIRED INFORMATION.—The proposal shall not include—

''(i) recommendations described in subsection (c)(2)(A)(i), pursuant to subsection (c)(3)(B)(i); or

''(ii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subsection (c)(2)(A)(i), pursuant to subsection (c)(3)(B)(iii);

''(C) CONTINGENT SECRETARIAL PROPOSAL.—The Secretary shall not submit a proposal if the Board fails to submit a proposal pursuant to subsection (c)(5).

''(D) CONGRESSIONAL CONSIDERATION.—

''(i) Subparagraphs (A) and (B) of subsection (d)(3) shall be applied by substituting 'subsection (c)(2)(C)' for 'subparagraphs (A)(i) and (C) of subsection (c)(2)'.

''(ii) Subparagraphs (D) and (E) of subsection (d)(3) and subsection (d)(4)(B)(v) shall be applied by requiring a simple majority rather than three-fifths of the Members duly chosen and sworn.

''(iii) Subsection (d)(4)(B)(iv) shall not apply.

''(iv) Subsection (d)(4)(C)(v)(II) shall be applied by substituting 'subsection (c)(2)(C)' for 'subparagraphs (A)(i) and (C) of subsection (c)(2)'.

''(v) Subsection (d)(4)(E)(iv)(II) shall be applied by substituting 'subsection (c)(2)(C)' for 'subparagraphs (A)(i) and (C) of subsection (c)(2)'.

''(E) SECRETARIAL IMPLEMENTATION.—Subsection (e) shall not apply and the Secretary shall not implement the recommendations contained in the proposal unless the Secretary otherwise has the authority to implement such recommendations.

''(h) ANNUAL REPORT WITH RECOMMENDATIONS WITH RESPECT TO THE PRIVATE SECTOR.—

''(1) IN GENERAL.—Not later than July 1, 2014, and January 15, 2015, and annually thereafter, the Board shall submit to Congress, the Secretary, and the Medicaid and CHIP Payment and Access Commission a report that includes recommendations on—

''(A) requirements under the program under this title (or requirements included in the proposal submitted under this section in the year); and

''(B) in the case of any report submitted in a year after a determination year (beginning with determination year 2017) in which the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subclause (I) or (II) of subsection (c)(3)(A)(ii), other requirements determined appropriate by the Board;

that should be included in the requirements established under section 1311(c) of the Patient Protection and Affordable Care Act for a health plan to be certified as a qualified health plan, such as requirements that improve the health care delivery system and health outcomes (including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency), decrease health care spending, and other appropriate improvements

''(2) INCORPORATION INTO CERTIFICATION REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall review the recommendations contained in the report submitted to the Secretary by the Board under paragraph (1). The Secretary may, if determined appropriate, incorporate such recommendations into the requirements for certification under such section 1311(c).

''(B) REPORT TO CONGRESS.—Not later than December 31, 2014, and June 15, 2015, and annually thereafter, the Secretary shall submit to Congress a report on the application of subparagraph (A). Such report shall include, with respect to each recommendation contained in a report submitted by the Board in that year, a description of whether or not the Secretary incorporated the recommendation into the requirements for certification under such section 1311(c), and if not, the reasons why.

''(3) MACPAC.—The Medicaid and CHIP Payment and Access Commission shall—

''(A) review whether or not recommendations contained in a report submitted to the Commission by the Board under paragraph (1) would improve the Medicaid program under title XIX and the Children's Health Insurance Program under title XXI if implemented under such programs; and

''(B) include in the Commission's annual report to Congress the results of such review.''.

SA 3241. Mr. CARPER (for himself, Mr. CONRAD, 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 722, after line 20, insert the following:

SEC. 3016. INTEGRATED HEALTH CARE SYSTEM COLLABORATION INITIATIVE.

(a) IN GENERAL.—In order to improve health care quality and reduce costs, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop, in consultation with major integrated health systems that have consistently demonstrated high quality and low cost (as determined by the Secretary and verified by a third party) a collaboration initiative (referred to in this section as ''the Collaborative''). The Collaborative shall develop an exportable model of optimal health care delivery to apply value-based measurement, integrated information technology infrastructure, standard care pathways, and population-based payment models, to measurably improve health care quality, outcomes, and patient satisfaction and achieve cost savings.

(b) PARTICIPATION.—Prior to January 1, 2010, the Secretary shall determine 5 initial participants who will form the Collaborative and at least 6 additional participants who will join the Collaborative beginning in the fourth year that the Collaborative is in effect.

(1) INITIAL PARTICIPANTS.—Initial participants selected by the Secretary shall meet the following criteria:

(A) Be integrated health systems organized for the purpose of providing health care services.

(B) Have demonstrated a record of providing high value health care for at least the 5 previous years, as determined by the Secretary in consultation with the Medicare Payment Advisory Commission.

(C) Agree to participate in the Medicare shared savings program under section 1899 of the Social Security Act, as added by section 3022, the National pilot program on payment bundling under section 1866D of such Act, as added by section 3023, or a program under the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

(D) Any additional criteria specified by the Secretary.

(2) ADDITIONAL PARTICIPANTS.—Beginning January 1, 2013, the Secretary shall select 6 or more additional participants who represent diverse geographic areas and are situated in areas of differing population densities who agree to comply with the guidelines, processes, and requirements set forth for the Collaborative. Such additional participants shall meet the following additional criteria:

(A) Be organized for the provision of patient medical care.

(B) Be capable of implementing infrastructure and health care delivery modifications necessary to enhance health care quality and efficiency, as determined by the Secretary in consultation with the Medicare Payment Advisory Commission.

(C) The participant's cost and intensity of care do not meet the definition of high value health care.

(D) Agree to participate in the Medicare shared savings program under section 1899 of the Social Security Act, as added by section 3022, the National pilot program on payment bundling under section 1866D of such Act, as added by section 3023, or a program under the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

(E) The participant would benefit from such participation (as determined by the Secretary, based on the likelihood that the participant would improve its performance under section 1886(p) of the Social Security Act, as added by section 3008, section 1886(q) of such Act, as added by section 3025, or any similar program under title XVIII of the Social Security Act).

(3) ADDITIONAL CRITERIA.—In addition to the criteria described in paragraphs (1) and (2), the participants in the Collaborative shall meet the following criteria:

(A) Agree to report on quality, cost, and efficiency in such form, manner, and frequency as specified by the Secretary.

(B) Provide care to patients enrolled in the Medicare program.

(C) Agree to contribute to a best practices network and website, that is maintained by the Collaborative for sharing strategies on quality improvement, care coordination, efficiency, and effectiveness.

(D) Use patient-centered processes of care, including those that emphasize patient and caregiver involvement in shared decision-making for treatment decisions.

(E) Meet other criteria determined to be appropriate by the Secretary.

(c) COLLABORATIVE INITIATIVE.—

(1) IN GENERAL.—Beginning January 1, 2010, the Collaborative shall begin a 2 year development phase in which initial participants share the quantitative and qualitative methods through which they have developed high value health care followed by a dissemination of that learning model to additional participants of the Collaborative.

(2) COORDINATING MEMBER.—In consultation with the Secretary, the Collaborative shall select a coordinating member organization (hereafter identified as the Coordinating Organization) of the Collaborative.

(3) QUALIFICATIONS.—The Coordinating Organization will have in place a comprehensive Medicare database and possess experience using and analyzing Medicare data to measure health care utilization, cost, and variation. The Coordinating Organization shall be responsible for reporting to the Secretary as required and for any other requirements deemed necessary by the Secretary.

(4) RESPONSIBILITIES.—The Coordinating Member shall—

(A) lead efforts to develop each aspect of the learning model;

(B) organize efforts to disseminate the learning model for high value health care, including educating participant institutions; and

(C) provide administrative, technical, accounting, reporting, organizational and infrastructure support needed to carry out the goals of the Collaborative.

(5) DEVELOPMENT OF LEARNING MODEL.—

(A) IN GENERAL.—Initial participants in the Collaborative shall work together to develop a learning model based on their experience that includes a reliance on evidence based care that emphasizes quality and practice techniques that emphasize efficiency, joint development and implementation of health information technology, introduction of clinical microsystems of care, shared decision-making, outcomes and measurement, and the establishment of an e-learning distributive network, which have been put into practice at their respective institutions.

(B) RESPONSIBILITIES.—The Coordinating Member shall do the following:

(i) Partner with initial participants to comprehensively understand each institution's contribution to providing value-based health care.

(ii) Provide and measure value-based health care in a manner that ensures that measures are aligned with current measures approved by a consensus-based organization, such as the National Quality Forum, or other measures as determined appropriate by the Secretary, while also incorporating patient self-reported status and outcomes.

(iii) Create a replicable and scalable infrastructure for common measurement of value-based care that can be broadly disseminated across the Collaborative and other institutions.

(iv) Implement care pathways for common conditions using standard measures for assessment across institutions, targeting high variation and high cost conditions, including but not limited to—

(I) acute myocardial infarction (AMI) and angioplasty;

(II) coronary artery bypass graft surgery and percutaneous coronary intervention;

(III) hip or knee replacement;

(IV) spinal surgery; and

(V) care for chronic diseases including, but not limited to, diabetes, heart disease, and high blood pressure.

(v) Deploy and disseminate the comprehensive learning model across initial participant institutions, achieving improvements in care delivery and lowering costs, and demonstrating the portability and viability of the processes.

(6) ADDITIONAL BEST PRACTICES.—As additional methods of improving health care quality and efficiency are identified by members of the Collaborative or by other institutions, Initial Participants in the Collaborative shall incorporate those practices into the learning model.

(d) IMPLEMENTATION OF LEARNING MODEL.—Beginning January 1, 2013, as additional participants are selected by the Secretary, Initial Participants in the Collaborative shall actively engage in the deployment of the learning model to educate each additional participant in the common conditions that have been identified.

(1) DISSEMINATION OF LEARNING MODEL.—Dissemination methods shall include but not be limited to the following methods:

(A) Specialized teams deployed by the Initial Participants to teach and facilitate implementation on site.

(B) Distance-learning, taking advantage of latest interactive technologies.

(C) On-line, fully accessible repositories of shared learning and information related to best practices.

(D) Advanced population health information technology models.

(2) EVALUATION OF PARTICIPANTS.—

(A) IN GENERAL.—Evaluation of initial participants shall be based on documented success in meeting quality and efficiency measurements. Specific statistically valid measures of evaluation shall be determined by the Secretary.

(B) PERFORMANCE TARGETS.—The Secretary shall develop performance targets for participants. Performance targets developed under the preceding sentence shall be based on whether participants have improved their performance under section 1886(p) of the Social Security Act, as added by section 3008, section 1886(q) of such Act, as added by section 3025, or any similar program under title XVIII of the Social Security Act (as determined by the Secretary).

(e) MEASUREMENT OF LEARNING MODEL.—Participants shall implement techniques under the comprehensive learning model. The Secretary shall determine whether such implementation improves quality and efficiency, including cost savings relative to baseline spending for the common conditions specified under subsection (c)(5)(B)(iv) and quality measures endorsed by a consensus-based organization or otherwise chosen by the Secretary. The Collaborative shall prepare a report annually on each participant's performance with respect to the efficiency and quality measurements established by the Secretary. Such report shall be submitted to the Secretary and Congress and shall be made publicly available.

(f) ADMINISTRATIVE PAYMENT.—For purposes of carrying out this section, there are authorized to be appropriated $228,000,000, to remain available until expended. Amounts appropriated under the preceding sentence shall be distributed in the following manner:

(1) The Coordinating Organization shall receive $10,000,000 per year for program development related to the Collaborative, including for health information technology and other infrastructure, project evaluations, analysis, and measurement, compliance, auditings and other reporting. Not less than $5,000,000 of such funds shall be provided for education and training, including for support for the establishment of training teams for the Collaborative, to assist in the integration of new health information technology, best practices of care delivery, microsystems of care delivery, and a distributive e-learning network for the Collaborative.

(2) Each Initial Participant shall receive $4,000,000 per year for internal program development for health information technology and other infrastructure, education and training, project evaluations, analysis, and measurement, and compliance, auditing, and other reporting.

(3) Beginning in 2013, the Secretary may provide funding to additional participants in the Collaborative in an amount not to exceed $4,000,000 per participant per year under the same use guidelines as apply to the Initial Participants.

(g) CONTINUATION OR EXPANSION.—

(1) TERMINATION.—Subject to paragraph (2), the Collaborative shall terminate on the date that is 6 years after the date on which the Collaborative is established.

(2) EXPANSION.—The Secretary may continue or expand the Collaborative if the Collaborative is consistently exceeding quality standards and is not increasing spending under the program.

(h) TERMINATION.—The Secretary may terminate an agreement with a participating organization under the Collaborative if such organization consistently failed to meet quality standards in the fourth year or any subsequent year of the Collaborative

(i) REPORTS.—

(1) PERFORMANCE RESULTS REPORTS.—The Secretary shall provide such data as is necessary for the Collaborative to measure the efficacy of the Collaborative and facilitate regular reporting on spending and cost savings results relative to a value-based program initiative.

(2) REPORTS TO CONGRESS.—Not later than 2 years after the date the first agreement is entered into under this section, and annually thereafter, the Secretary shall submit to Congress and make publicly available a report on the authority granted to the Secretary to carry out the Collaborative under this section. Each report shall address the impact of the use of such authority on expenditures for, access to, and quality of, care under title XVIII of the Social Security Act.

(j) DEFINITIONS.—In this section:

(1) BENEFICIARY.—The term ''beneficiary'' means a Medicare beneficiary enrolled under part B and entitled to benefits under part A who is not enrolled in Medicare Advantage under Part C or a PACE program under section 1894, and meets other criteria as the Secretary determines appropriate.

(2) HIGH VALUE HEALTH CARE.—The term ''high value health care'' means the care delivered by organizations shown by statistically valid methods to meet the highest quality measures established by the Secretary as of or after the date of enactment of this Act and to be delivering low-cost care with high patient satisfaction and clinical outcomes.

(3) LEARNING MODEL.—The term ''learning model'' means a standardized model developed by the Initial Participants in the Collaborative and based on best practices, as jointly developed and put into practice at the Initial Participant's respective institutions.

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

(k) ADDITIONAL MONITORING.—The Secretary may monitor data on expenditures and quality of services under title XVIII of the Social Security Act with respect to a beneficiary after the beneficiary discontinues receiving services under the Collaborative.

(l) OTHER PROVISIONS.—

(1) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under this section or otherwise of—

(A) the elements, parameters, scope, and duration of the Collaborative, including the selection of participants in the Collaborative;

(B) the establishment of targets, measurement of performance;

(C) determinations with respect to whether savings have been achieved and the amount of savings; and

(D) decisions about the extension or expansion of the Collaborative.

(2) ADMINISTRATION.—Chapter 35 of title 44, 4 United States Code shall not apply to this section.

(3) MONITORING.—The Inspector General of the Department of Health and Human Services shall provide for monitoring of the operation of the Collaborative with regard to violations of section 1877 of the Social Security Act (popularly known as the ''Stark law'').

(4) ANTI-DISCRIMINATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the Collaborative, or with an entity to administer the Collaborative, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the Collaborative for beneficiaries to participate in the Collaborative, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

NOTICE OF HEARING

COMMITTEE ON INDIAN AFFAIRS–

Mr. DORGAN. Mr. President, I would like to announce that the Committee on Indian Affairs will meet on Thursday, December 17, 2009, at 2:15 p.m. in room 628 of the Dirksen Senate Office Building to conduct a business meeting on pending committee issues, to be followed by an oversight hearing on the Cobell v. Salazar Settlement Agreement.

Those wishing additional information may contact the Indian Affairs Committee at 202–224–2251.

AUTHORITY FOR COMMITTEES TO MEET–

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 15, 2009, at 2:30 p.m. in room 253 of the Russell Senate Office Building.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate to conduct a hearing on December 15, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

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

COMMITTEE ON THE JUDICIARY

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate, on December 15, 2009, at 10 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Ensuring the Effective Use of DNA Evidence to Solve Rape Cases Nationwide.''

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. DORGAN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 15, 2009, at 2:30 p.m.

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

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE, AND THE DISTRICT OF COLUMBIA

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs' Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia be authorized to meet during the session of the Senate on December 15, 2009, at 10 a.m. to conduct a hearing entitled ''One DHS, One Mission: Efforts to Improve Management Integration at DHS.''

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

NEAR EASTERN AND SOUTH AND CENTRAL ASIAN AFFAIRS SUBCOMMITTEE

Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 15, 2009, at 10 a.m., to hold a Near Eastern Subcommittee hearing entitled ''Reevaluating U.S. Policy in Central Asia.''

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

PRIVILEGES OF THE FLOOR

Mr. CRAPO. Mr. President, I ask unanimous consent that Rachel Johnson and Amanda Critchfield, two staffers from my office, be granted the privilege of the floor for the remainder of the consideration of H.R. 3590.

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

Mr. MENENDEZ. Mr. President, I ask unanimous consent that Megan Moreau, a fellow in my office, be given floor privileges for the remainder of debate on H.R. 3590, the health care reform legislation currently pending.

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

ORDERS

Mr. PRYOR. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m. Wednesday, December 16; 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, with the first hour equally divided and controlled between the leaders or their designees, with the majority leader controlling the first half and the Republicans controlling the second half.

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

PROGRAM

Mr. PRYOR. Mr. President, we expect votes tomorrow in relation to the Hutchison motion to commit regarding taxes and implementation and the Sanders amendment regarding a national single-payer system. Senators will be notified when any votes are scheduled.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

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

There being no objection, the Senate, at 7:56 p.m., adjourned until Wednesday, December 16, 2009, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate:

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED AND FOR APPOINTMENT AS THE JUDGE ADVOCATE GENERAL OF THE AIR FORCE UNDER TITLE 10, U.S.C., SECTION 8037:

To be lieutenant general

BRIG. GEN. RICHARD C. HARDING

THE FOLLOWING NAMED INDIVIDUAL FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE AIR FORCE UNDER TITLE 10, U.S.C., SECTION 12203(A):

To be colonel

LAWRENCE W. STEINKRAUS, JR.

THE FOLLOWING NAMED INDIVIDUALS FOR APPOINTMENT TO THE GRADE INDICATED IN THE REGULAR AIR FORCE UNDER TITLE 10, U.S.C., SECTION 531(A):

To be major

KRISTI L. JONES
JAMES A. OBESTER, JR.
PAVEENA POSANG
BRUNO A. SCHMITZ

THE FOLLOWING NAMED INDIVIDUALS FOR APPOINTMENT TO THE GRADES INDICATED IN THE REGULAR AIR FORCE UNDER TITLE 10, U.S.C., SECTION 531(A):

To be lieutenant colonel

RAYMOND KING

To be major

LISA B. BROWNING
BERNHARD K. STEPKE

IN THE ARMY

THE FOLLOWING NAMED INDIVIDUAL FOR REGULAR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY NURSE CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

To be major

DAWN Y. TAYLOR

THE FOLLOWING NAMED INDIVIDUALS FOR REGULAR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY MEDICAL SERVICE CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

To be major

WALTER COFFEY
RUSSELL P. REITER

THE FOLLOWING NAMED INDIVIDUALS FOR REGULAR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY MEDICAL CORPS UNDER TITLE 10, U.S.C., SECTIONS 531 AND 3064:

To be major

DEAN A. AMBROSE
RONALD R. DURBIN
THOMAS R. PRINCE
JOHN W. TROGDON

THE FOLLOWING NAMED ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12211:

To be colonel

PATRICK R. BOSSETTA
WILLIAM J. COFFIN
DENNIS C. DEELEY
HAMILTON D. RICHARDS
HELEN E. ROGERS
JOHN R. WHITFORD

IN THE MARINE CORPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES MARINE CORPS UNDER TITLE 10, U.S.C., SECTION 624:

To be major

WILLIAM J. MITCHELL

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES MARINE CORPS RESERVE UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

SAM B. CLONTS, JR.
JAMES C. FAILMEZGER
CAROLINE P. FERMIN
HENRY E. MULL, JR.
RALPH L. PRICE III