111TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { 111–

ENERGY AND COMMERCE RECOVERY AND REINVESTMENT ACT

JANUARY , 2009.—Ordered to be printed

Mr. WAXMAN, from the Committee on Energy and Commmerce, submitted the following

R E P O R T

together with

_____ VIEWS

[To accompany H.R. 629]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 629) to provide energy and commerce provisions of the American Recovery and Reinvestment Act of 2009, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

[Showing Text of H.R. 629 as Ordered to be Reported by E & C on January 22, 2009]

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Energy and Commerce Recovery and Reinvestment Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—BROADBAND COMMUNICATIONS

SEC. 1001. INVENTORY OF BROADBAND SERVICE CAPABILITY AND AVAILABILITY.

(a) ESTABLISHMENT.—To provide a comprehensive nationwide inventory of existing broadband service capability and availability, the National Telecommunications and Information Administration (''NTIA'') shall develop and maintain a broadband inventory map of the United States that identifies and depicts the geographic extent to which broadband service capability is deployed and available from a commercial provider or public provider throughout each State.

(b) PUBLIC AVAILABILITY AND INTERACTIVITY.—Not later than 2 years after the date of enactment of this

Act, the NTIA shall make the broadband inventory map developed and maintained pursuant to this section accessible by the public on a World Wide Web site of the NTIA in a form that is interactive and searchable.

SEC. 1002. WIRELESS AND BROADBAND DEPLOYMENT GRANT PROGRAMS.

(a) GRANTS AUTHORIZED.—

(1) IN GENERAL.—The National Telecommunications and Information Administration (''NTIA'') is authorized to carry out a program to award grants to eligible entities for the non-recurring costs associated with the deployment of broadband infrastructure in rural, suburban, and urban areas, in accordance with the requirements of this section.

(2) PROGRAM WEBSITE.—The NTIA shall develop and maintain a website to make publicly available information about the program described in paragraph (1), including—

(A) each prioritization report submitted by a State under subsection (b);

(B) a list of eligible entities that have applied for a grant under this section, and the area or areas the entity proposes to serve; and

(C) the status of each such application, whether approved, denied, or pending.

(b) STATE PRIORITIES.—

(1) PRIORITIES REPORT SUBMISSION.—Not later than 75 days after the date of enactment of this section, each State intending to participate in the program under this section shall submit to the NTIA a report indicating the geographic areas of the State which—

(A) for the purposes of determining the need for Wireless Deployment Grants under subsection (c), the State considers to have the greatest priority for—

(i) wireless voice service in unserved areas; and

(ii) advanced wireless broadband service in underserved areas; and

(B) for the purposes of determining the need for Broadband Deployment Grants under subsection (d), the State considers to have the greatest priority for—

(i) basic broadband service in unserved areas; and

(ii) advanced broadband service in underserved areas.

(2) LIMITATION.—The unserved and underserved areas identified by a State in the report re-

quired by this subsection shall not represent, in the aggregate, more than 20 percent of the population of such State.

(c) WIRELESS DEPLOYMENT GRANTS.—

(1) AUTHORIZED ACTIVITY.—The NTIA shall award Wireless Deployment Grants in accordance with this subsection from amounts authorized for Wireless Deployment Grants by this subtitle to eligible entities to deploy necessary infrastructure for the provision of wireless voice service or advanced wireless broadband service to end users in designated areas.

(2) GRANT DISTRIBUTION.—The NTIA shall seek to distribute grants, to the extent possible, so that 25 percent of the grants awarded under this subsection shall be awarded to eligible entities for providing wireless voice service to unserved areas and 75 percent of grants awarded under this subsection shall be awarded to eligible entities for providing advanced wireless broadband service to underserved areas.

(d) BROADBAND DEPLOYMENT GRANTS.—

(1) AUTHORIZED ACTIVITY.—The NTIA shall award Broadband Deployment Grants in accordance with this subsection from amounts authorized for

Broadband Deployment Grants by this subtitle to eligible entities to deploy necessary infrastructure for the provision of basic broadband service or advanced broadband service to end users in designated areas.

(2) GRANT DISTRIBUTION.—The NTIA shall seek to distribute grants, to the extent possible, so that 25 percent of the grants awarded under this subsection shall be awarded to eligible entities for providing basic broadband service to unserved areas and 75 percent of grants awarded under this subsection shall be awarded to eligible entities for providing advanced broadband service to underserved areas.

(e) GRANT REQUIREMENTS.—The NTIA shall—

(1) adopt rules to protect against unjust enrichment; and

(2) ensure that grant recipients—

(A) meet buildout requirements;

(B) maximize use of the supported infrastructure by the public;

(C) operate basic and advanced broadband service networks on an open access basis;

(D) operate advanced wireless broadband service on a wireless open access basis; and

(E) adhere to the principles contained in the Federal Communications Commission's broadband policy statement (FCC 05-151, adopted August 5, 2005).

(f) APPLICATIONS.—

(1) SUBMISSION.—To be considered for a grant awarded under subsection (c) or (d), an eligible entity shall submit to the NTIA an application at such time, in such manner, and containing such information and assurances as the NTIA may require. Such an application shall include—

(A) a cost-study estimate for serving the particular geographic area to be served by the entity;

(B) a proposed build-out schedule to residential households and small businesses in the area;

(C) for applicants for Wireless Deployment Grants under subsection (c), a build-out schedule for geographic coverage of such areas; and

(D) any other requirements the NTIA deems necessary.

(2) SELECTION.—

(A) NOTIFICATION.—The NTIA shall notify each eligible entity that has submitted a

complete application whether the entity has been approved or denied for a grant under this section in a timely fashion.

(B) GRANT DISTRIBUTION CONSIDERATIONS.—In awarding grants under this section, the NTIA shall, to the extent practical—

(i) award not less than one grant in each State;

(ii) give substantial weight to whether an application is from an eligible entity to deploy infrastructure in an area that is an area—

(I) identified by a State in a report submitted under subsection (b); or

(II) in which the NTIA determines there will be a significant amount of public safety or emergency response use of the infrastructure;

(iii) consider whether an application from an eligible entity to deploy infrastructure in an area—

(I) will, if approved, increase the affordability of, or subscribership to,

service to the greatest population of underserved users in the area;

(II) will, if approved, enhance service for health care delivery, education, or children to the greatest population of underserved users in the area;

(III) contains concrete plans for enhancing computer ownership or computer literacy in the area;

(IV) is from a recipient of more than 20 percent matching grants from State, local, or private entities for service in the area and the extent of such commitment;

(V) will, if approved, result in unjust enrichment because the eligible entity has applied for, or intends to apply for, support for the non-recurring costs through another Federal program for service in the area; and

(VI) will, if approved, significantly improve interoperable broadband communications systems

available for use by public safety and emergency response; and

(iv) consider whether the eligible entity is a socially and economically disadvantaged small business concern, as defined under section 8(a) of the Small Business Act (15 U.S.C. 637).

(g) COORDINATION AND CONSULTATION.—The NTIA shall coordinate with the Federal Communications Commission and shall consult with other appropriate Federal agencies in implementing this section.

(h) REPORT REQUIRED.—The NTIA shall submit an annual report to the Committee on Energy and Commerce of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate for 5 years assessing the impact of the grants funded under this section on the basis of the objectives and criteria described in subsection (f)(2)(B)(iii).

(i) RULEMAKING AUTHORITY.—The NTIA shall have the authority to prescribe such rules as necessary to carry out the purposes of this section.

(j) DEFINITIONS.—For the purpose of this section—

(1) the term ''advanced broadband service'' means a service delivering data to the end user transmitted at a speed of at least 45 megabits per

second downstream and at least 15 megabits per second upstream;

(2) the term ''advanced wireless broadband service'' means a wireless service delivering to the end user data transmitted at a speed of at least 3 megabits per second downstream and at least 1 megabit per second upstream over an end-to-end internet protocol wireless network;

(3) the term ''basic broadband service'' means a service delivering data to the end user transmitted at a speed of at least 5 megabits per second downstream and at least 1 megabit per second upstream;

(4) the term ''eligible entity'' means—

(A) a provider of wireless voice service, advanced wireless broadband service, basic broadband service, or advanced broadband service, including a satellite carrier that provides any such service;

(B) a State or unit of local government, or agency or instrumentality thereof, that is or intends to be a provider of any such service; and

(C) any other entity, including construction companies, tower companies, backhaul companies, or other service providers, that the NTIA authorizes by rule to participate in the

programs under this section, if such other entity is required to provide access to the supported infrastructure on a neutral, reasonable basis to maximize use;

(5) the term ''interoperable broadband communications systems'' means communications systems which enable public safety agencies to share information among local, State, Federal, and tribal public safety agencies in the same area using voice or data signals via advanced wireless broadband service;

(6) the term ''open access'' shall be defined by the Federal Communications Commission not later than 45 days after the date of enactment of this section;

(7) the term ''State'' includes the District of Columbia and the territories and possessions;

(8) the term ''underserved area'' shall be defined by the Federal Communications Commission not later than 45 days after the date of enactment of this section;

(9) the term ''unserved area'' shall be defined by the Federal Communications Commission not later than 45 days after the date of enactment of this section;

(10) the term ''wireless open access'' shall be defined by the Federal Communications Commission not later than 45 days after the date of enactment of this section; and

(11) the term ''wireless voice service'' means the provision of two-way, real-time, voice communications using a mobile service.

(k) REVIEW OF DEFINITIONS.—Not later than 3 months after the date the NTIA makes a broadband inventory map of the United States accessible to the public pursuant to section 1001(b), the Federal Communications Commission shall review the definitions of ''underserved area'' and ''unserved area'', as defined by the Commission within 45 days after the date of enactment of this Act (as required by paragraphs (8) and (9) of subsection (j)), and shall revise such definitions based on the data used by the NTIA to develop and maintain such map.

SEC. 1003. NATIONAL BROADBAND PLAN.

(a) REPORT REQUIRED.—Not later than 1 year after the date of enactment of this section, the Federal Communications Commission shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate, a report containing a national broadband plan.

(b) CONTENTS OF PLAN.—The national broadband plan required by this section shall seek to ensure that all people of the United States have access to broadband capability and shall establish benchmarks for meeting that goal. The plan shall also include—

(1) an analysis of the most effective and efficient mechanisms for ensuring broadband access by all people of the United States;

(2) a detailed strategy for achieving affordability of such service and maximum utilization of broadband infrastructure and service by the public; and

(3) a plan for use of broadband infrastructure and services in advancing consumer welfare, civic participation, public safety and homeland security, community development, health care delivery, energy independence and efficiency, education, worker training, private sector investment, entrepreneurial activity, job creation and economic growth, and other national purposes.

TITLE II—ENERGY

SEC. 2001. TECHNICAL CORRECTIONS TO THE ENERGY INDEPENDENCE AND SECURITY ACT OF 2007.

(a) Section 543(a) of the Energy Independence and Security Act of 2007 (42 U.S.C. 17153(a)) is amended—

(1) by redesignating paragraphs (2) through (4) as paragraphs (3) through (5), respectively; and

(2) by striking paragraph (1) and inserting the following:

''(1) 34 percent to eligible units of local government–alternative 1, in accordance with subsection (b);

''(2) 34 percent to eligible units of local government–alternative 2, in accordance with subsection (b);''.

(b) Section 543(b) of the Energy Independence and Security Act of 2007 (42 U.S.C. 17153(b)) is amended by striking ''subsection (a)(1)'' and inserting ''subsection (a)(1) or (2)''.

(c) Section 548(a)(1) of the Energy Independence and Security Act of 2007 (42 U.S.C. 17158(a)(1)) is amending by striking ''; provided'' and all that follows through ''541(3)(B)''.

SEC. 2002. AMENDMENTS TO TITLE XIII OF THE ENERGY INDEPENDENCE AND SECURITY ACT OF 2007.

Title XIII of the Energy Independence and Security Act of 2007 (42 U.S.C. 17381 and following) is amended as follows:

(1) By amending subparagraph (A) of section 1304(b)(3) to read as follows:

''(A) IN GENERAL.—In carrying out the initiative, the Secretary shall provide financial support to smart grid demonstration projects in urban, suburban, and rural areas, including areas where electric system assets are controlled by tax-exempt entities and areas where electric system assets are controlled by investor-owned utilities.''.

(2) By amending subparagraph (C) of section 1304(b)(3) to read as follows:

''(C) FEDERAL SHARE OF COST OF TECHNOLOGY INVESTMENTS.—The Secretary shall provide to an electric utility described in subparagraph (B) or to other parties financial assistance for use in paying an amount equal to not more than 50 percent of the cost of qualifying advanced grid technology investments made by the electric utility or other party to carry out a demonstration project.''.

(3) By inserting after section 1304(b)(3)(D) the following new subparagraphs:

''(E) AVAILABILITY OF DATA.—The Secretary shall establish and maintain a smart grid information clearinghouse in a timely manner which will make data from smart grid dem-

onstration projects and other sources available to the public. As a condition of receiving financial assistance under this subsection, a utility or other participant in a smart grid demonstration project shall provide such information as the Secretary may require to become available through the smart grid information clearinghouse in the form and within the timeframes as directed by the Secretary. The Secretary shall assure that business proprietary information and individual customer information is not included in the information made available through the clearinghouse.

''(F) OPEN INTERNET-BASED PROTOCOLS AND STANDARDS.—The Secretary shall require as a condition of receiving funding under this subsection that demonstration projects utilize open Internet-based protocols and standards if available.''.

(4) By amending paragraph (2) of section 1304(c) to read as follows:

''(2) to carry out subsection (b), such sums as may be necessary.''.

(5) By amending subsection (a) of section 1306 by striking ''reimbursement of one-fifth (20 per-

cent)'' and inserting ''grants of up to one-half (50 percent)''.

(6) By striking the last sentence of subsection (b)(9) of section 1306.

(7) By striking ''are eligible for'' in subsection (c)(1) of section 1306 and inserting ''utilize''.

(8) By amending subsection (e) of section 1306 to read as follows:

''(e) PROCEDURES AND RULES.—The Secretary shall—

''(1) establish within 60 days after the enactment of the Energy and Commerce Recovery and Reinvestment Act procedures by which applicants can obtain grants of not more than one-half of their documented costs;

''(2) require as a condition of receiving a grant under this section that grant recipients utilize open Internet-based protocols and standards if available;

''(3) establish procedures to ensure that there is no duplication or multiple payment or recovery for the same investment or costs, that the grant goes to the party making the actual expenditures for qualifying smart grid investments, and that the grants made have significant effect in encouraging and facilitating the development of a smart grid;

''(4) maintain public records of grants made, recipients, and qualifying smart grid investments which have received grants;

''(5) establish procedures to provide advance payment of moneys up to the full amount of the grant award; and

''(6) have and exercise the discretion to deny grants for investments that do not qualify in the reasonable judgment of the Secretary.''.

SEC. 2003. RENEWABLE ENERGY AND ELECTRIC POWER TRANSMISSION LOAN GUARANTEE PROGRAM.

(a) AMENDMENT.—Title XVII of the Energy Policy Act of 2005 (42 U.S.C. 16511 et seq.) is amended by adding the following at the end:

''SEC. 1705. TEMPORARY PROGRAM FOR RAPID DEPLOYMENT OF RENEWABLE ENERGY AND ELECTRIC POWER TRANSMISSION PROJECTS.

''(a) IN GENERAL.—Notwithstanding section 1703, the Secretary may make guarantees under this section only for commercial technology projects under subsection (b) that will commence construction not later than September 30, 2011.

''(b) CATEGORIES.—Projects from only the following categories shall be eligible for support under this section:

''(1) Renewable energy systems, including incremental hydropower, that generate electricity.

''(2) Electric power transmission systems, including upgrading and reconductoring projects.

''(3) Leading edge biofuel projects that will use technologies performing at the pilot or demonstration scale that the Secretary determines are likely to become commercial technologies and will produce transportation fuels that substantially reduce lifecycle greenhouse gas emissions compared to other transportation fuels.

''(c) FACTORS RELATING TO ELECTRIC POWER TRANSMISSION SYSTEMS.—In determining to make guarantees to projects described in subsection (b)(2), the Secretary shall consider the following factors:

''(1) The viability of the project without guarantees.

''(2) The availability of other Federal and State incentives.

''(3) The importance of the project in meeting reliability needs.

''(4) The effect of the project in meeting a State or region's environment (including climate change) and energy goals.

''(d) WAGE RATE REQUIREMENTS.—The Secretary shall require that each recipient of support under this section provide reasonable assurance that all laborers and mechanics employed in the performance of the project for which the assistance is provided, including those employed by contractors or subcontractors, will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with subchapter IV of chapter 31 of part A of subtitle II of title 40, United States Code (commonly referred to as the 'Davis-Bacon Act').

''(e) LIMITATION.—Funding under this section for projects described in subsection (b)(3) shall not exceed $500,000,000.

''(f) SUNSET.—The authority to enter into guarantees under this section shall expire on September 30, 2011.''.

(b) TABLE OF CONTENTS AMENDMENT.—The table of contents for the Energy Policy Act of 2005 is amended by inserting after the item relating to section 1704 the following new item:

''Sec. 1705. Temporary program for rapid deployment of renewable energy and electric power transmission projects.''.

SEC. 2004. WEATHERIZATION ASSISTANCE PROGRAM AMENDMENTS.

(a) INCOME LEVEL.—Section 412(7) of the Energy Conservation and Production Act (42 U.S.C. 6862(7)) is amended by striking ''150 percent'' both places it appears and inserting ''200 percent''.

(b) ASSISTANCE LEVEL PER DWELLING UNIT.—Section 415(c)(1) of the Energy Conservation and Production Act (42 U.S.C. 6865(c)(1)) is amended by striking ''$2,500'' and inserting ''$5,000''.

(c) EFFECTIVE USE OF FUNDS.—In providing funds made available by this Act for the Weatherization Assistance Program, the Secretary may encourage States to give priority to using such funds for the most cost-effective efficiency activities, which may include insulation of attics, if, in the Secretary's view, such use of funds would increase the effectiveness of the program.

SEC. 2005. RENEWABLE ELECTRICITY TRANSMISSION STUDY.

In completing the 2009 National Electric Transmission Congestion Study, the Secretary of Energy shall include—

(1) an analysis of the significant potential sources of renewable energy that are constrained in accessing appropriate market areas by lack of adequate transmission capacity;

(2) an analysis of the reasons for failure to develop the adequate transmission capacity;

(3) recommendations for achieving adequate transmission capacity;

(4) an analysis of the extent to which legal challenges filed at the State and Federal level are delaying the construction of transmission necessary to access renewable energy; and

(5) an explanation of assumptions and projections made in the Study, including—

(A) assumptions and projections relating to energy efficiency improvements in each load center;

(B) assumptions and projections regarding the location and type of projected new generation capacity; and

(C) assumptions and projections regarding projected deployment of distributed generation infrastructure.

SEC. 2006. ADDITIONAL STATE ENERGY GRANTS.

(a) IN GENERAL.—Amounts appropriated for the State Energy Program under the American Recovery and Reinvestment Act of 2009 shall be available to the Secretary of Energy for making additional grants under part D of title III of the Energy Policy and Conservation Act

(42 U.S.C. 6321 et seq.). The Secretary shall make grants under this section in excess of the base allocation established for a State under regulations issued pursuant to the authorization provided in section 365(f) of such Act only if the governor of the recipient State notifies the Secretary of Energy that the governor will seek, to the extent of his or her authority, to ensure that each of the following will occur:

(1) The applicable State regulatory authority will implement the following regulatory policies for each electric and gas utility with respect to which the State regulatory authority has ratemaking authority:

(A) Policies that ensure that a utility's recovery of prudent fixed costs of service is timely and independent of its retail sales, without in the process shifting prudent costs from variable to fixed charges. This cost shifting constraint shall not apply to rate designs adopted prior to the date of enactment of this Act.

(B) Cost recovery for prudent investments by utilities in energy efficiency.

(C) An earnings opportunity for utilities associated with cost-effective energy efficiency savings.

(2) The State, or the applicable units of local government that have authority to adopt building codes, will implement the following:

(A) A building energy code (or codes) for residential buildings that meets or exceeds the most recently published International Energy Conservation Code, or achieves equivalent or greater energy savings.

(B) A building energy code (or codes) for commercial buildings throughout the State that meets or exceeds the ANSI/ASHRAE/IESNA Standard 90.1-2007, or achieves equivalent or greater energy savings.

(C) A plan for the jurisdiction achieving compliance with the building energy code or codes described in subparagraphs (A) and (B) within 8 years of the date of enactment of this Act in at least 90 percent of new and renovated residential and commercial building space. Such plan shall include active training and enforcement programs and measurement of the rate of compliance each year.

(3) The State will to the extent practicable prioritize the grants toward funding energy efficiency and renewable energy programs, including—

(A) the expansion of existing energy efficiency programs approved by the State or the appropriate regulatory authority, including energy efficiency retrofits of buildings and industrial facilities, that are funded—

(i) by the State; or

(ii) through rates under the oversight of the applicable regulatory authority, to the extent applicable;

(B) the expansion of existing programs, approved by the State or the appropriate regulatory authority, to support renewable energy projects and deployment activities, including programs operated by entities which have the authority and capability to manage and distribute grants, loans, performance incentives, and other forms of financial assistance; and

(C) cooperation and joint activities between States to advance more efficient and effective use of this funding to support the priorities described in this paragraph.

(b) STATE MATCH.—The State cost share requirement under the item relating to ''DEPARTMENT OF ENERGY; energy conservation'' in title II of the Department of the Interior and Related Agencies Appropriations

Act, 1985 (42 U.S.C. 6323a; 98 Stat. 1861) shall not apply to assistance provided under this section.

(c) EQUIPMENT AND MATERIALS FOR ENERGY EFFICIENCY MEASURES.—No limitation on the percentage of funding that may be used for the purchase and installation of equipment and materials for energy efficiency measures under grants provided under part D of title III of the Energy Policy and Conservation Act (42 U.S.C. 6321 et seq.) shall apply to assistance provided under this section.

SEC. 2007. INAPPLICABILITY OF LIMITATION.

The limitations in section 399A(f)(2), (3), and (4) of the Energy Policy and Conservation Act (42 U.S.C. 6371h-1(f)(2), (3), and (4)) shall not apply to grants funded with appropriations provided by this Act, except that such grant funds shall be available for not more than an amount equal to 80 percent of the costs of the project for which the grant is provided.

TITLE III—HEALTH INSURANCE ASSISTANCE FOR THE UNEMPLOYED

SEC. 3001. SHORT TITLE AND TABLE OF CONTENTS OF TITLE.

(a) SHORT TITLE OF TITLE.—This title may be cited as the ''Health Insurance Assistance for the Unemployed Act of 2009''.

(b) TABLE OF CONTENTS OF TITLE.—The table of contents of this title is as follows:

SEC. 3002. PREMIUM ASSISTANCE FOR COBRA BENEFITS AND EXTENSION OF COBRA BENEFITS FOR OLDER OR LONG-TERM EMPLOYEES.

(a) PREMIUM ASSISTANCE FOR COBRA CONTINUATION COVERAGE FOR INDIVIDUALS AND THEIR FAMILIES.—

(1) PROVISION OF PREMIUM ASSISTANCE.—

(A) REDUCTION OF PREMIUMS PAYABLE.—In the case of any premium for a period of coverage beginning on or after the date of the enactment of this Act for COBRA continuation coverage with respect to any assistance eligible individual, such individual shall be treated for purposes of any COBRA continuation provision as having paid the amount of such premium if such individual pays 35 percent of the amount of such premium (as determined without regard to this subsection).

(B) PREMIUM REIMBURSEMENT.—For provisions providing the balance of such premium,

see section 6431 of the Internal Revenue Code of 1986, as added by paragraph (12).

(2) LIMITATION OF PERIOD OF PREMIUM ASSISTANCE.—

(A) IN GENERAL.—Paragraph (1)(A) shall not apply with respect to any assistance eligible individual for months of coverage beginning on or after the earlier of—

(i) the first date that such individual is eligible for coverage under any other group health plan (other than coverage consisting of only dental, vision, counseling, or referral services (or a combination thereof), coverage under a health reimbursement arrangement or a health flexible spending arrangement, or coverage of treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination thereof)) or is eligible for benefits under title XVIII of the Social Security Act, or

(ii) the earliest of—

(I) the date which is 12 months after the first day of the first month that paragraph (1)(A) applies with respect to such individual,

(II) the date following the expiration of the maximum period of continuation coverage required under the applicable COBRA continuation coverage provision, or

(III) the date following the expiration of the period of continuation coverage allowed under paragraph (4)(B)(ii).

(B) TIMING OF ELIGIBILITY FOR ADDITIONAL COVERAGE.—For purposes of subparagraph (A)(i), an individual shall not be treated as eligible for coverage under a group health plan before the first date on which such individual could be covered under such plan.

(C) NOTIFICATION REQUIREMENT.—An assistance eligible individual shall notify in writing the group health plan with respect to which paragraph (1)(A) applies if such paragraph ceases to apply by reason of subparagraph (A)(i). Such notice shall be provided to the

group health plan in such time and manner as may be specified by the Secretary of Labor.

(3) ASSISTANCE ELIGIBLE INDIVIDUAL.—For purposes of this section, the term ''assistance eligible individual'' means any qualified beneficiary if—

(A) at any time during the period that begins with September 1, 2008, and ends with December 31, 2009, such qualified beneficiary is eligible for COBRA continuation coverage,

(B) such qualified beneficiary elects such coverage,

(C) the qualifying event with respect to the COBRA continuation coverage consists of the involuntary termination of the covered employee's employment and occurred during such period, and

(D) at the time of the election such qualified beneficiary's annual income is less than $1,000,000.

(4) EXTENSION OF ELECTION PERIOD AND EFFECT ON COVERAGE.—

(A) IN GENERAL.—Notwithstanding section 605(a) of the Employee Retirement Income Security Act of 1974, section 4980B(f)(5)(A) of the Internal Revenue Code of 1986, section

2205(a) of the Public Health Service Act, and section 8905a(c)(2) of title 5, United States Code, in the case of an individual who is a qualified beneficiary described in paragraph (3)(A) as of the date of the enactment of this Act and has not made the election referred to in paragraph (3)(B) as of such date, such individual may elect the COBRA continuation coverage under the COBRA continuation coverage provisions containing such sections during the 60-day period commencing with the date on which the notification required under paragraph (7)(C) is provided to such individual.

(B) COMMENCEMENT OF COVERAGE; NO REACH-BACK.—Any COBRA continuation coverage elected by a qualified beneficiary during an extended election period under subparagraph (A)—

(i) shall commence on the date of the enactment of this Act, and

(ii) shall not extend beyond the period of COBRA continuation coverage that would have been required under the applicable COBRA continuation coverage provi-

sion if the coverage had been elected as required under such provision.

(C) PREEXISTING CONDITIONS.—With respect to a qualified beneficiary who elects COBRA continuation coverage pursuant to subparagraph (A), the period—

(i) beginning on the date of the qualifying event, and

(ii) ending with the day before the date of the enactment of this Act,

shall be disregarded for purposes of determining the 63-day periods referred to in section 701)(2) of the Employee Retirement Income Security Act of 1974, section 9801(c)(2) of the Internal Revenue Code of 1986, and section 2701(c)(2) of the Public Health Service Act.

(5) EXPEDITED REVIEW OF DENIALS OF PREMIUM ASSISTANCE.—In any case in which an individual requests treatment as an assistance eligible individual and is denied such treatment by the group health plan by reason of such individual's ineligibility for COBRA continuation coverage, the Secretary of Labor (or the Secretary of Health and Human services in connection with COBRA continuation coverage which is provided other than pursu-

ant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974), in consultation with the Secretary of the Treasury, shall provide for expedited review of such denial. An individual shall be entitled to such review upon application to such Secretary in such form and manner as shall be provided by such Secretary. Such Secretary shall make a determination regarding such individual's eligibility within 10 business days after receipt of such individual's application for review under this paragraph.

(6) DISREGARD OF SUBSIDIES FOR PURPOSES OF FEDERAL AND STATE PROGRAMS.—Notwithstanding any other provision of law, any premium reduction with respect to an assistance eligible individual under this subsection shall not be considered income or resources in determining eligibility for, or the amount of assistance or benefits provided under, any other public benefit provided under Federal law or the law of any State or political subdivision thereof.

(7) NOTICES TO INDIVIDUALS.—

(A) GENERAL NOTICE.—

(i) IN GENERAL.—In the case of notices provided under section 606(4) of the

Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(4)), section 4980B(f)(6)(D) of the Internal Revenue Code of 1986, section 2206(4) of the Public Health Service Act (42 U.S.C. 300bb-6(4)), or section 8905a(f)(2)(A) of title 5, United States Code, with respect to individuals who, during the period described in paragraph (3)(A), become entitled to elect COBRA continuation coverage, such notices shall include an additional notification to the recipient of the availability of premium reduction with respect to such coverage under this subsection.

(ii) ALTERNATIVE NOTICE.—In the case of COBRA continuation coverage to which the notice provision under such sections does not apply, the Secretary of Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall, in coordination with administrators of the group health plans (or other entities) that provide or administer the COBRA continu-

ation coverage involved, provide rules requiring the provision of such notice.

(iii) FORM.—The requirement of the additional notification under this subparagraph may be met by amendment of existing notice forms or by inclusion of a separate document with the notice otherwise required.

(B) SPECIFIC REQUIREMENTS.—Each additional notification under subparagraph (A) shall include—

(i) the forms necessary for establishing eligibility for premium reduction under this subsection,

(ii) the name, address, and telephone number necessary to contact the plan administrator and any other person maintaining relevant information in connection with such premium reduction,

(iii) a description of the extended election period provided for in paragraph (4)(A),

(iv) a description of the obligation of the qualified beneficiary under paragraph (2)(C) to notify the plan providing continu-

ation coverage of eligibility for subsequent coverage under another group health plan or eligibility for benefits under title XVIII of the Social Security Act and the penalty provided for failure to so notify the plan, and

(v) a description, displayed in a prominent manner, of the qualified beneficiary's right to a reduced premium and any conditions on entitlement to the reduced premium.

(C) NOTICE RELATING TO RETROACTIVE COVERAGE.—In the case of an individual described in paragraph (3)(A) who has elected COBRA continuation coverage as of the date of enactment of this Act or an individual described in paragraph (4)(A), the administrator of the group health plan (or other entity) involved shall provide (within 60 days after the date of enactment of this Act) for the additional notification required to be provided under subparagraph (A).

(D) MODEL NOTICES.—Not later than 30 days after the date of enactment of this Act, the Secretary of the Labor, in consultation with

the Secretary of the Treasury and the Secretary of Health and Human Services, shall prescribe models for the additional notification required under this paragraph.

(8) SAFEGUARDS.—The Secretary of the Treasury shall provide such rules, procedures, regulations, and other guidance as may be necessary and appropriate to prevent fraud and abuse under this subsection.

(9) OUTREACH.—The Secretary of Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall provide outreach consisting of public education and enrollment assistance relating to premium reduction provided under this subsection. Such outreach shall target employers, group health plan administrators, public assistance programs, States, insurers, and other entities as determined appropriate by such Secretaries. Such outreach shall include an initial focus on those individuals electing continuation coverage who are referred to in paragraph (7)(C). Information on such premium reduction, including enrollment, shall also be made available on website of the Departments of Labor, Treasury, and Health and Human Services.

(10) DEFINITIONS.—For purposes of this subsection—

(A) ADMINISTRATOR.—The term ''administrator'' has the meaning given such term in section 3(16) of the Employee Retirement Income Security Act of 1974.

(B) COBRA CONTINUATION COVERAGE.—The term ''COBRA continuation coverage'' means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 609), title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986 (other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines), or section 8905a of title 5, United States Code, or under a State program that provides continuation coverage comparable to such continuation coverage. Such term does not include coverage under a health flexible spending arrangement.

(C) COBRA CONTINUATION PROVISION.—The term ''COBRA continuation provision'' means the provisions of law described in subparagraph (B).

(D) COVERED EMPLOYEE.—The term ''covered employee'' has the meaning given such term in section 607(2) of the Employee Retirement Income Security Act of 1974.

(E) QUALIFIED BENEFICIARY.—The term ''qualified beneficiary'' has the meaning given such term in section 607(3) of the Employee Retirement Income Security Act of 1974.

(F) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 607(1) of the Employee Retirement Income Security Act of 1974.

(G) STATE.—The term ''State'' includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(11) REPORTS.—

(A) INTERIM REPORT.—The Secretary of the Treasury shall submit an interim report to the Committee on Education and Labor, the Committee on Ways and Means, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions and

the Committee on Finance of the Senate regarding the premium reduction provided under this subsection that includes—

(i) the number of individuals provided such assistance as of the date of the report; and

(ii) the total amount of expenditures incurred (with administrative expenditures noted separately) in connection with such assistance as of the date of the report.

(B) FINAL REPORT.—As soon as practicable after the last period of COBRA continuation coverage for which premium reduction is provided under this section, the Secretary of the Treasury shall submit a final report to each Committee referred to in subparagraph (A) that includes—

(i) the number of individuals provided premium reduction under this section;

(ii) the average dollar amount (monthly and annually) of premium reductions provided to such individuals; and

(iii) the total amount of expenditures incurred (with administrative expenditures

noted separately) in connection with premium reduction under this section.

(12) COBRA PREMIUM ASSISTANCE.—

(A) IN GENERAL.—Subchapter B of chapter 65 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 6431. COBRA PREMIUM ASSISTANCE.

''(a) IN GENERAL.—The entity to whom premiums are payable under COBRA continuation coverage shall be reimbursed for the amount of premiums not paid by plan beneficiaries by reason of section 3002(a) of the Health Insurance Assistance for the Unemployed Act of 2009. Such amount shall be treated as a credit against the requirement of such entity to make deposits of payroll taxes. To the extent that such amount exceeds the amount of such taxes, the Secretary shall pay to such entity the amount of such excess. No payment may be made under this subsection to an entity with respect to any assistance eligible individual until after such entity has received the reduced premium from such individual required under section 3002(a)(1)(A) of such Act.

''(b) PAYROLL TAXES.—For purposes of this section, the term 'payroll taxes' means—

''(1) amounts required to be deducted and withheld for the payroll period under section 3401 (relating to wage withholding),

''(2) amounts required to be deducted for the payroll period under section 3102 (relating to FICA employee taxes), and

''(3) amounts of the taxes imposed for the payroll period under section 3111 (relating to FICA employer taxes).

''(c) TREATMENT OF CREDIT.—Except as otherwise provided by the Secretary, the credit described in subsection (a) shall be applied as though the employer had paid to the Secretary, on the day that the qualified beneficiary's premium payment is received, an amount equal to such credit.

''(d) TREATMENT OF PAYMENT.—For purposes of section 1324(b)(2) of title 31, United States Code, any payment under this section shall be treated in the same manner as a refund of the credit under section 35.

''(e) REPORTING.—

''(1) IN GENERAL.—Each entity entitled to reimbursement under subsection (a) for any period shall submit such reports as the Secretary may require, including—

''(A) an attestation of involuntary termination of employment for each covered employee on the basis of whose termination entitlement to reimbursement is claimed under subsection (a), and

''(B) a report of the amount of payroll taxes offset under subsection (a) for the reporting period and the estimated offsets of such taxes for the subsequent reporting period in connection with reimbursements under subsection (a).

''(2) TIMING OF REPORTS RELATING TO AMOUNT OF PAYROLL TAXES.—Reports required under paragraph (1)(B) shall be submitted at the same time as deposits of taxes imposed by chapters 21, 22, and 24 or at such time as is specified by the Secretary.

''(f) REGULATIONS.—The Secretary may issue such regulations or other guidance as may be necessary or appropriate to carry out this section, including the requirement to report information or the establishment of other methods for verifying the correct amounts of payments and credits under this section.''.

(B) SOCIAL SECURITY TRUST FUNDS HELD HARMLESS.—In determining any amount trans-

ferred or appropriated to any fund under the Social Security Act, section 6431 of the Internal Revenue Code of 1986 shall not be taken into account.

(C) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 65 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

"Sec. 6431. COBRA premium assistance.".

(D) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to premiums to which subsection (a)(1)(A) applies.

(13) PENALTY FOR FAILURE TO NOTIFY HEALTH PLAN OF CESSATION OF ELIGIBILITY FOR PREMIUM ASSISTANCE.—

(A) IN GENERAL.—Part I of subchapter B of chapter 68 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 6720C. PENALTY FOR FAILURE TO NOTIFY HEALTH PLAN OF CESSATION OF ELIGIBILITY FOR COBRA PREMIUM ASSISTANCE.

"(a) IN GENERAL.—Any person required to notify a group health plan under section 3002(a)(2)(C)) of the Health Insurance Assistance for the Unemployed Act of 2009 who fails to make such a notification at such time

and in such manner as the Secretary of Labor may require shall pay a penalty of 110 percent of the premium reduction provided under such section after termination of eligibility under such subsection.

''(b) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under subsection (a) with respect to any failure if it is shown that such failure is due to reasonable cause and not to willful neglect.''.

(B) CLERICAL AMENDMENT.—The table of sections of part I of subchapter B of chapter 68 of such Code is amended by adding at the end the following new item:

''Sec. 6720C. Penalty for failure to notify health plan of cessation of eligibility for COBRA premium assistance.''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to failures occurring after the date of the enactment of this Act.

(14) COORDINATION WITH HCTC.—

(A) IN GENERAL.—Subsection (g) of section 35 of the Internal Revenue Code of 1986 is amended by redesignating paragraph (9) as paragraph (10) and inserting after paragraph (8) the following new paragraph:

''(9) COBRA PREMIUM ASSISTANCE.—In the case of an assistance eligible individual who receives

premium reduction for COBRA continuation coverage under section 3002(a) of the Health Insurance Assistance for the Unemployed Act of 2009 for any month during the taxable year, such individual shall not be treated as an eligible individual, a certified individual, or a qualifying family member for purposes of this section or section 7527 with respect to such month.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to taxable years ending after the date of the enactment of this Act.

(15) EXCLUSION OF COBRA PREMIUM ASSISTANCE FROM GROSS INCOME.—

(A) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139B the following new section:

''SEC. 139C. COBRA PREMIUM ASSISTANCE.

''In the case of an assistance eligible individual (as defined in section 3002 of the Health Insurance Assistance for the Unemployed Act of 2009), gross income does not include any premium reduction provided under subsection (a) of such section.''.

(B) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139B the following new item:

"Sec. 139C. COBRA premium assistance.".

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to taxable years ending after the date of the enactment of this Act.

(b) EXTENSION OF COBRA BENEFITS FOR OLDER OR LONG-TERM EMPLOYEES.—

(1) ERISA AMENDMENT.—Section 602(2)(A) of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new clauses:

"(x) SPECIAL RULE FOR OLDER OR LONG-TERM EMPLOYEES GENERALLY.—In the case of a qualifying event described in section 603(2) with respect to a covered employee who (as of such qualifying event) has attained age 55 or has completed 10 or more years of service with the entity that is the employer at the time of the qualifying event, clauses (i) and (ii) shall not apply.

"(xi) YEAR OF SERVICE.— For purposes of this subparagraph, the term 'year of service' shall have the meaning provided in section 202(a)(3).".

(2) IRC AMENDMENT.—Clause (i) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subclauses:

"(X) SPECIAL RULE FOR OLDER OR LONG-TERM EMPLOYEES GENERALLY.—In the case of a qualifying event described in paragraph (3)(B) with respect to a covered employee who (as of such qualifying event) has attained age 55 or has completed 10 or more years of service with the entity that is the employer at the time of the qualifying event, subclauses (I) and (II) shall not apply.

"(XI) YEAR OF SERVICE.— For purposes of this clause, the term 'year of service' shall have the meaning provided in section 202(a)(3) of the Employee Retirement Income Security Act of 1974.".

(3) PHSA AMENDMENT.—Section 2202(2)(A) of the Public Health Service Act is amended by adding at the end the following new clauses:

''(viii) SPECIAL RULE FOR OLDER OR LONG-TERM EMPLOYEES GENERALLY.—In the case of a qualifying event described in section 2203(2) with respect to a covered employee who (as of such qualifying event) has attained age 55 or has completed 10 or more years of service with the entity that is the employer at the time of the qualifying event, clauses (i) and (ii) shall not apply.

''(ix) YEAR OF SERVICE.— For purposes of this subparagraph, the term 'year of service' shall have the meaning provided in section 202(a)(3) of the Employee Retirement Income Security Act of 1974.''.

(4) EFFECTIVE DATE OF AMENDMENTS.—The amendments made by this subsection shall apply to periods of coverage which would (without regard to the amendments made by this section) end on or after the date of the enactment of this Act.

SEC. 3003. TEMPORARY OPTIONAL MEDICAID COVERAGE FOR THE UNEMPLOYED.

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

(1) in subsection (a)(10)(A)(ii)—

(A) by striking ''or'' at the end of subclause (XVIII);

(B) by adding ''or'' at the end of subclause (XIX); and

(C) by adding at the end the following new subclause

''(XX) who are described in subsection (dd)(1) (relating to certain unemployed individuals and their families);''; and

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

''(dd)(1) Individuals described in this paragraph are—

''(A) individuals who—

''(i) are within one or more of the categories described in paragraph (2), as elected under the State plan; and

''(ii) meet the applicable requirements of paragraph (3); and

''(B) individuals who—

''(i) are the spouse, or dependent child under 19 years of age, of an individual described in subparagraph (A); and

''(ii) meet the requirement of paragraph (3)(B).

''(2) The categories of individuals described in this paragraph are each of the following:

''(A) Individuals who are receiving unemployment compensation benefits.

''(B) Individuals who were receiving, but have exhausted, unemployment compensation benefits on or after July 1, 2008.

''(C) Individuals who are involuntarily unemployed and were involuntarily separated from employment on or after September 1, 2008, and before January 1, 2011, whose family gross income does not exceed a percentage specified by the State (not to exceed 200 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who, but for subsection (a)(10)(A)(ii)(XX), are not eligible for medical assistance under this title or health assistance under title XXI.

''(D) Individuals who are involuntarily unemployed and were involuntarily separated from employment on or after September 1, 2008, and before January 1, 2011, who are members of households participating in the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq), and who, but for subsection (a)(10)(A)(ii)(XX), are not eligible for medical assistance under this title or health assistance under title XXI.

A State plan may elect one or more of the categories described in this paragraph but may not elect the category described in subparagraph (B) unless the State plan also elects the category described in subparagraph (A).

''(3) The requirements of this paragraph with respect to an individual are the following:

''(A) In the case of individuals within a category described in subparagraph (A) or (B) of paragraph (2), the individual was involuntarily separated from employment on or after September 1, 2008, and before January 1, 2011, or meets such comparable requirement as the Secretary specifies through rule, guidance, or otherwise in the case of an individual who was an independent contractor.

''(B) The individual is not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)), but applied without regard to paragraph (1)(F) of such section and without regard to coverage provided by reason of the application of subsection (a)(10)(A)(ii)(XX).

''(4)(A) No income or resources test shall be applied with respect to any category of individuals described in subparagraph (A), (B), or (D) of paragraph (2) who are eligible for medical assistance only by reason of the application of subsection (a)(10)(A)(ii)(XX).

''(B) Nothing in this subsection shall be construed to prevent a State from imposing a resource test for the category of individuals described in paragraph (2)(C)).

''(C) In the case of individuals provided medical assistance by reason of the application of subsection (a)(10)(A)(ii)(XX), the requirements of subsections (i)(22) and (x) shall not apply.''.

(b) 100 PERCENT FEDERAL MATCHING RATE.—

(1) FMAP FOR TIME-LIMITED PERIOD.—The third sentence of section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by inserting before the period at the end the following: ''and for items and services furnished on or after the date of enactment

of this Act and before January 1, 2011, to individuals who are eligible for medical assistance only by reason of the application of section 1902(a)(10)(A)(ii)(XX)''.

(2) CERTAIN ENROLLMENT-RELATED ADMINISTRATIVE COSTS.—Notwithstanding any other provision of law, for purposes of applying section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)), with respect to expenditures incurred on or after the date of the enactment of this Act and before January 1, 2011, for costs of administration (including outreach and the modification and operation of eligibility information systems) attributable to eligibility determination and enrollment of individuals who are eligible for medical assistance only by reason of the application of section 1902(a)(10)(A)(ii)(XX) of such Act, as added by subsection (a)(1), the Federal matching percentage shall be 100 percent instead of the matching percentage otherwise applicable.

(c) CONFORMING AMENDMENTS.—(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396c(f)(4)) is amended by inserting ''1902(a)(10)(A)(ii)(XX), or'' after ''1902(a)(10)(A)(ii)(XIX),''.

(2) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter preceding paragraph (1)—

(A) by striking ''or'' at the end of clause (xii);

(B) by adding ''or'' at the end of clause (xiii); and

(C) by inserting after clause (xiii) the following new clause:

''(xiv) individuals described in section 1902(dd)(1),''.

TITLE IV—HEALTH INFORMATION TECHNOLOGY

SEC. 4001. SHORT TITLE; TABLE OF CONTENTS OF TITLE.

(a) SHORT TITLE.—This title may be cited as the ''Health Information Technology for Economic and Clinical Health Act'' or the ''HITECH Act''.

(b) TABLE OF CONTENTS OF TITLE.—The table of contents of this title is as follows:

Subtitle A—Promotion of Health Information Technology

PART 1—IMPROVING HEALTH CARE QUALITY, SAFETY, AND EFFICIENCY

SEC. 4101. ONCHIT; STANDARDS DEVELOPMENT AND ADOPTION.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXX—HEALTH INFORMATION TECHNOLOGY AND QUALITY

"SEC. 3000. DEFINITIONS.

''In this title:

''(1) CERTIFIED EHR TECHNOLOGY.—The term 'certified EHR technology' means a qualified electronic health record that is certified pursuant to section 3001(c)(5) as meeting standards adopted under section 3004 that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

''(2) ENTERPRISE INTEGRATION.—The term 'enterprise integration' means the electronic linkage of health care providers, health plans, the government, and other interested parties, to enable the electronic exchange and use of health information among all the components in the health care infrastructure in accordance with applicable law, and such term includes related application protocols and other related standards.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means a hospital, skilled nurs-

ing facility, nursing facility, home health entity or other long term care facility, health care clinic, Federally qualified health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a practitioner (as described in section 1842(b)(18)(C) of the Social Security Act), a provider operated by, or under contract with, the Indian Health Service or by an Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act), tribal organization, or urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act), a rural health clinic, a covered entity under section 340B, an ambulatory surgical center described in section 1833(i) of the Social Security Act, and any other category of facility or clinician determined appropriate by the Secretary.

''(4) HEALTH INFORMATION.—The term 'health information' has the meaning given such term in section 1171(4) of the Social Security Act.

''(5) HEALTH INFORMATION TECHNOLOGY.—The term 'health information technology' means hardware, software, integrated technologies and re-

lated licenses, intellectual property, upgrades, and packaged solutions sold as services that are specifically designed for use by health care entities for the electronic creation, maintenance, or exchange of health information.

''(6) HEALTH PLAN.—The term 'health plan' has the meaning given such term in section 1171(5) of the Social Security Act.

''(7) HIT POLICY COMMITTEE.—The term 'HIT Policy Committee' means such Committee established under section 3002(a).

''(8) HIT STANDARDS COMMITTEE.—The term 'HIT Standards Committee' means such Committee established under section 3003(a).

''(9) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' has the meaning given such term in section 1171(6) of the Social Security Act.

''(10) LABORATORY.—The term 'laboratory' has the meaning given such term in section 353(a).

''(11) NATIONAL COORDINATOR.—The term 'National Coordinator' means the head of the Office of the National Coordinator for Health Information Technology established under section 3001(a).

''(12) PHARMACIST.—The term 'pharmacist' has the meaning given such term in section 804(2) of the Federal Food, Drug, and Cosmetic Act.

''(13) QUALIFIED ELECTRONIC HEALTH RECORD.—The term 'qualified electronic health record' means an electronic record of health-related information on an individual that—

''(A) includes patient demographic and clinical health information, such as medical history and problem lists; and

''(B) has the capacity—

''(i) to provide clinical decision support;

''(ii) to support physician order entry;

''(iii) to capture and query information relevant to health care quality; and

''(iv) to exchange electronic health information with, and integrate such information from other sources.

''(14) STATE.—The term 'State' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Subtitle A—Promotion of Health Information Technology

"SEC. 3001. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

''(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an Office of the National Coordinator for Health Information Technology (referred to in this section as the 'Office'). The Office shall be headed by a National Coordinator who shall be appointed by the Secretary and shall report directly to the Secretary.

''(b) PURPOSE.—The National Coordinator shall perform the duties under subsection (c) in a manner consistent with the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that—

''(1) ensures that each patient's health information is secure and protected, in accordance with applicable law;

''(2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care;

''(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information;

''(4) provides appropriate information to help guide medical decisions at the time and place of care;

''(5) ensures the inclusion of meaningful public input in such development of such infrastructure;

''(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information;

''(7) improves public health activities and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks;

''(8) facilitates health and clinical research and health care quality;

''(9) promotes prevention of chronic diseases;

''(10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and

''(11) improves efforts to reduce health disparities.

''(c) DUTIES OF THE NATIONAL COORDINATOR.—

''(1) STANDARDS.—The National Coordinator shall review and determine whether to endorse each standard, implementation specification, and certification criterion for the electronic exchange and use of health information that is recommended by the HIT Standards Committee under section 3003 for purposes of adoption under section 3004. The Coordinator shall make such determination, and report to the Secretary such determination, not later than 45 days after the date the recommendation is received by the Coordinator.

''(2) HIT POLICY COORDINATION.—

''(A) IN GENERAL.—The National Coordinator shall coordinate health information technology policy and programs of the Department with those of other relevant executive branch agencies with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes health information technology activities primarily within the areas of its greatest expertise and technical capability and in a manner towards a coordinated national goal.

''(B) HIT POLICY AND STANDARDS COMMITTEES.—The National Coordinator shall be a leading member in the establishment and oper-

ations of the HIT Policy Committee and the HIT Standards Committee and shall serve as a liaison among those two Committees and the Federal Government.

''(3) STRATEGIC PLAN.—

''(A) IN GENERAL.—The National Coordinator shall, in consultation with other appropriate Federal agencies (including the National Institute of Standards and Technology), update the Federal Health IT Strategic Plan (developed as of June 3, 2008) to include specific objectives, milestones, and metrics with respect to the following:

''(i) The electronic exchange and use of health information and the enterprise integration of such information.

''(ii) The utilization of an electronic health record for each person in the United States by 2014.

''(iii) The incorporation of privacy and security protections for the electronic exchange of an individual's individually identifiable health information.

''(iv) Ensuring security methods to ensure appropriate authorization and elec-

tronic authentication of health information and specifying technologies or methodologies for rendering health information unusable, unreadable, or indecipherable.

''(v) Specifying a framework for coordination and flow of recommendations and policies under this subtitle among the Secretary, the National Coordinator, the HIT Policy Committee, the HIT Standards Committee, and other health information exchanges and other relevant entities.

''(vi) Methods to foster the public understanding of health information technology.

''(vii) Strategies to enhance the use of health information technology in improving the quality of health care, reducing medical errors, reducing health disparities, improving public health, and improving the continuity of care among health care settings.

''(B) COLLABORATION.—The strategic plan shall be updated through collaboration of public and private entities.

''(C) MEASURABLE OUTCOME GOALS.—The strategic plan update shall include measurable outcome goals.

''(D) PUBLICATION.—The National Coordinator shall republish the strategic plan, including all updates.

''(4) WEBSITE.—The National Coordinator shall maintain and frequently update an Internet website on which there is posted information on the work, schedules, reports, recommendations, and other information to ensure transparency in promotion of a nationwide health information technology infrastructure.

''(5) CERTIFICATION.—

''(A) IN GENERAL.—The National Coordinator, in consultation with the Director of the National Institute of Standards and Technology, shall develop a program (either directly or by contract) for the voluntary certification of health information technology as being in compliance with applicable certification criteria adopted under this subtitle. Such program shall include testing of the technology in accordance with section 4201(b) of the HITECH Act.

''(B) CERTIFICATION CRITERIA DESCRIBED.—In this title, the term 'certification criteria' means, with respect to standards and implementation specifications for health information technology, criteria to establish that the technology meets such standards and implementation specifications.

''(6) REPORTS AND PUBLICATIONS.—

''(A) REPORT ON ADDITIONAL FUNDING OR AUTHORITY NEEDED.—Not later than 12 months after the date of the enactment of this title, the National Coordinator shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report on any additional funding or authority the Coordinator or the HIT Policy Committee or HIT Standards Committee requires to evaluate and develop standards, implementation specifications, and certification criteria, or to achieve full participation of stakeholders in the adoption of a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information.

"(B) IMPLEMENTATION REPORT.—The National Coordinator shall prepare a report that identifies lessons learned from major public and private health care systems in their implementation of health information technology, including information on whether the technologies and practices developed by such systems may be applicable to and usable in whole or in part by other health care providers.

"(C) ASSESSMENT OF IMPACT OF HIT ON COMMUNITIES WITH HEALTH DISPARITIES AND UNINSURED, UNDERINSURED, AND MEDICALLY UNDERSERVED AREAS.—The National Coordinator shall assess and publish the impact of health information technology in communities with health disparities and in areas with a high proportion of individuals who are uninsured, underinsured, and medically underserved individuals (including urban and rural areas) and identify practices to increase the adoption of such technology by health care providers in such communities.

"(D) EVALUATION OF BENEFITS AND COSTS OF THE ELECTRONIC USE AND EXCHANGE OF HEALTH INFORMATION.—The Na-

tional Coordinator shall evaluate and publish evidence on the benefits and costs of the electronic use and exchange of health information and assess to whom these benefits and costs accrue.

''(E) RESOURCE REQUIREMENTS.—The National Coordinator shall estimate and publish resources required annually to reach the goal of utilization of an electronic health record for each person in the United States by 2014, including the required level of Federal funding, expectations for regional, State, and private investment, and the expected contributions by volunteers to activities for the utilization of such records.

''(7) ASSISTANCE.—The National Coordinator may provide financial assistance to consumer advocacy groups and not-for-profit entities that work in the public interest for purposes of defraying the cost to such groups and entities to participate under, whether in whole or in part, the National Technology Transfer Act of 1995 (15 U.S.C. 272 note).

''(8) GOVERNANCE FOR NATIONWIDE HEALTH INFORMATION NETWORK.—The National Coordi-

nator shall establish a governance mechanism for the nationwide health information network.

''(d) DETAIL OF FEDERAL EMPLOYEES.—

''(1) IN GENERAL.—Upon the request of the National Coordinator, the head of any Federal agency is authorized to detail, with or without reimbursement from the Office, any of the personnel of such agency to the Office to assist it in carrying out its duties under this section.

''(2) EFFECT OF DETAIL.—Any detail of personnel under paragraph (1) shall—

''(A) not interrupt or otherwise affect the civil service status or privileges of the Federal employee; and

''(B) be in addition to any other staff of the Department employed by the National Coordinator.

''(3) ACCEPTANCE OF DETAILEES.—Notwithstanding any other provision of law, the Office may accept detailed personnel from other Federal agencies without regard to whether the agency described under paragraph (1) is reimbursed.

''(e) CHIEF PRIVACY OFFICER OF THE OFFICE OF THE NATIONAL COORDINATOR.—Not later than 12 months after the date of the enactment of this title, the

Secretary shall appoint a Chief Privacy Officer of the Office of the National Coordinator, whose duty it shall be to advise the National Coordinator on privacy, security, and data stewardship of electronic health information and to coordinate with other Federal agencies (and similar privacy officers in such agencies), with State and regional efforts, and with foreign countries with regard to the privacy, security, and data stewardship of electronic individually identifiable health information.

"SEC. 3002. HIT POLICY COMMITTEE.

''(a) ESTABLISHMENT.—There is established a HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure, including implementation of the strategic plan described in section 3001(c)(3).

''(b) DUTIES.—

''(1) RECOMMENDATIONS ON HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE.—The HIT Policy Committee shall recommend a policy framework for the development and adoption of a nationwide health information technology infrastructure that permits the electronic exchange and use of health information as is consistent with the strategic plan under section 3001(c)(3) and that includes the

recommendations under paragraph (2). The Committee shall update such recommendations and make new recommendations as appropriate.

''(2) SPECIFIC AREAS OF STANDARD DEVELOPMENT.—

''(A) IN GENERAL.—The HIT Policy Committee shall recommend the areas in which standards, implementation specifications, and certification criteria are needed for the electronic exchange and use of health information for purposes of adoption under section 3004 and shall recommend an order of priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria among the areas so recommended. Such standards and implementation specifications shall include named standards, architectures, and software schemes for the authentication and security of individually identifiable health information and other information as needed to ensure the reproducible development of common solutions across disparate entities.

''(B) AREAS REQUIRED FOR CONSIDERATION.—For purposes of subparagraph (A), the

HIT Policy Committee shall make recommendations for at least the following areas:

''(i) Technologies that protect the privacy of health information and promote security in a qualified electronic health record, including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care (or disclose information about a condition) because of privacy concerns, in accordance with applicable law, and for the use and disclosure of limited data sets of such information.

''(ii) A nationwide health information technology infrastructure that allows for the electronic use and accurate exchange of health information.

''(iii) The utilization of a certified electronic health record for each person in the United States by 2014.

''(iv) Technologies that as a part of a qualified electronic health record allow for an accounting of disclosures made by a

covered entity (as defined for purposes of regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996) for purposes of treatment, payment, and health care operations (as such terms are defined for purposes of such regulations).

''(v) The use of certified electronic health records to improve the quality of health care, such as by promoting the coordination of health care and improving continuity of health care among health care providers, by reducing medical errors, by improving population health, by reducing health disparities, and by advancing research and education.

''(C) OTHER AREAS FOR CONSIDERATION.—In making recommendations under subparagraph (A), the HIT Policy Committee may consider the following additional areas:

''(i) The appropriate uses of a nationwide health information infrastructure, including for purposes of—

''(I) the collection of quality data and public reporting;

''(II) biosurveillance and public health;

''(III) medical and clinical research; and

''(IV) drug safety.

''(ii) Self-service technologies that facilitate the use and exchange of patient information and reduce wait times.

''(iii) Telemedicine technologies, in order to reduce travel requirements for patients in remote areas.

''(iv) Technologies that facilitate home health care and the monitoring of patients recuperating at home.

''(v) Technologies that help reduce medical errors.

''(vi) Technologies that facilitate the continuity of care among health settings.

''(vii) Technologies that meet the needs of diverse populations.

''(viii) Any other technology that the HIT Policy Committee finds to be among the technologies with the greatest potential to improve the quality and efficiency of health care.

''(3) FORUM.—The HIT Policy Committee shall serve as a forum for broad stakeholder input with specific expertise in policies relating to the matters described in paragraphs (1) and (2).

''(c) MEMBERSHIP AND OPERATIONS.—

''(1) IN GENERAL.—The National Coordinator shall provide leadership in the establishment and operations of the HIT Policy Committee.

''(2) MEMBERSHIP.—The membership of the HIT Policy Committee shall at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.

''(3) CONSIDERATION.—The National Coordinator shall ensure that the relevant recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of policies.

''(d) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14 of such Act, shall apply to the HIT Policy Committee.

''(e) PUBLICATION.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all policy recommendations made by the HIT Policy Committee under this section.

"SEC. 3003. HIT STANDARDS COMMITTEE.

''(a) ESTABLISHMENT.—There is established a committee to be known as the HIT Standards Committee to recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange and use of health information for purposes of adoption under section 3004, consistent with the implementation of the strategic plan described in section 3001(c)(3) and beginning with the areas listed in section 3002(b)(2)(B) in accordance with policies developed by the HIT Policy Committee.

''(b) DUTIES.—

''(1) STANDARDS DEVELOPMENT.—

''(A) IN GENERAL.—The HIT Standards Committee shall recommend to the National Coordinator standards, implementation specifications, and certification criteria described in subsection (a) that have been developed, harmonized, or recognized by the HIT Standards

Committee. The HIT Standards Committee shall update such recommendations and make new recommendations as appropriate, including in response to a notification sent under section 3004(b)(2). Such recommendations shall be consistent with the latest recommendations made by the HIT Policy Committee.

''(B) PILOT TESTING OF STANDARDS AND IMPLEMENTATION SPECIFICATIONS.—In the development, harmonization, or recognition of standards and implementation specifications, the HIT Standards Committee shall, as appropriate, provide for the testing of such standards and specifications by the National Institute for Standards and Technology under section 4201 of the HITECH Act.

''(C) CONSISTENCY.—The standards, implementation specifications, and certification criteria recommended under this subsection shall be consistent with the standards for information transactions and data elements adopted pursuant to section 1173 of the Social Security Act.

''(2) FORUM.—The HIT Standards Committee shall serve as a forum for the participation of a

broad range of stakeholders to provide input on the development, harmonization, and recognition of standards, implementation specifications, and certification criteria necessary for the development and adoption of a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information.

''(3) SCHEDULE.—Not later than 90 days after the date of the enactment of this title, the HIT Standards Committee shall develop a schedule for the assessment of policy recommendations developed by the HIT Policy Committee under section 3002. The HIT Standards Committee shall update such schedule annually. The Secretary shall publish such schedule in the Federal Register.

''(4) PUBLIC INPUT.—The HIT Standards Committee shall conduct open public meetings and develop a process to allow for public comment on the schedule described in paragraph (3) and recommendations described in this subsection. Under such process comments shall be submitted in a timely manner after the date of publication of a recommendation under this subsection.

''(c) MEMBERSHIP AND OPERATIONS.—

''(1) IN GENERAL.—The National Coordinator shall provide leadership in the establishment and operations of the HIT Standards Committee.

''(2) MEMBERSHIP.—The membership of the HIT Standards Committee shall at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.

''(3) CONSIDERATION.—The National Coordinator shall ensure that the relevant recommendations and comments from the National Committee on Vital and Health Statistics are considered in the development of standards.

''(4) ASSISTANCE.—For the purposes of carrying out this section, the Secretary may provide or ensure that financial assistance is provided by the HIT Standards Committee to defray in whole or in part any membership fees or dues charged by such Committee to those consumer advocacy groups and not for profit entities that work in the public interest as a part of their mission.

''(d) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.), other than section 14, shall apply to the HIT Standards Committee.

''(e) PUBLICATION.—The Secretary shall provide for publication in the Federal Register and the posting on the Internet website of the Office of the National Coordinator for Health Information Technology of all recommendations made by the HIT Standards Committee under this section.

''SEC. 3004. PROCESS FOR ADOPTION OF ENDORSED RECOMMENDATIONS; ADOPTION OF INITIAL SET OF STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.

''(a) PROCESS FOR ADOPTION OF ENDORSED RECOMMENDATIONS.—

''(1) REVIEW OF ENDORSED STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.—Not later than 90 days after the date of receipt of standards, implementation specifications, or certification criteria endorsed under section 3001(c), the Secretary, in consultation with representatives of other relevant Federal agencies, shall jointly review such standards, implementation specifications, or certification criteria and shall determine whether or not to propose adoption of such stand-

ards, implementation specifications, or certification criteria.

''(2) DETERMINATION TO ADOPT STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.—If the Secretary determines—

''(A) to propose adoption of any grouping of such standards, implementation specifications, or certification criteria, the Secretary shall, by regulation, determine whether or not to adopt such grouping of standards, implementation specifications, or certification criteria; or

''(B) not to propose adoption of any grouping of standards, implementation specifications, or certification criteria, the Secretary shall notify the National Coordinator and the HIT Standards Committee in writing of such determination and the reasons for not proposing the adoption of such recommendation.

''(3) PUBLICATION.—The Secretary shall provide for publication in the Federal Register of all determinations made by the Secretary under paragraph (1).

''(b) ADOPTION OF INITIAL SET OF STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.—

''(1) IN GENERAL.—Not later than December 31, 2009, the Secretary shall, through the rule-making process described in section 3003, adopt an initial set of standards, implementation specifications, and certification criteria for the areas required for consideration under section 3002(b)(2)(B).

''(2) APPLICATION OF CURRENT STANDARDS, IMPLEMENTATION SPECIFICATIONS, AND CERTIFICATION CRITERIA.—The standards, implementation specifications, and certification criteria adopted before the date of the enactment of this title through the process existing through the Office of the National Coordinator for Health Information Technology may be applied towards meeting the requirement of paragraph (1).

''SEC. 3005. APPLICATION AND USE OF ADOPTED STANDARDS AND IMPLEMENTATION SPECIFICATIONS BY FEDERAL AGENCIES.

''For requirements relating to the application and use by Federal agencies of the standards and implementation specifications adopted under section 3004, see section 4111 of the HITECH Act.

"SEC. 3006. VOLUNTARY APPLICATION AND USE OF ADOPTED STANDARDS AND IMPLEMENTATION SPECIFICATIONS BY PRIVATE ENTITIES.

"(a) IN GENERAL.—Except as provided under section 4112 of the HITECH Act, any standard or implementation specification adopted under section 3004 shall be voluntary with respect to private entities.

"(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to require that a private entity that enters into a contract with the Federal Government apply or use the standards and implementation specifications adopted under section 3004 with respect to activities not related to the contract.

"SEC. 3007. FEDERAL HEALTH INFORMATION TECHNOLOGY.

"(a) IN GENERAL.—The National Coordinator shall support the development, routine updating, and provision of qualified EHR technology (as defined in section 3000) consistent with subsections (b) and (c) unless the Secretary determines that the needs and demands of providers are being substantially and adequately met through the marketplace.

"(b) CERTIFICATION.—In making such EHR technology publicly available, the National Coordinator shall ensure that the qualified EHR technology described in subsection (a) is certified under the program developed

under section 3001(c)(3) to be in compliance with applicable standards adopted under section 3003(a).

''(c) AUTHORIZATION TO CHARGE A NOMINAL FEE.—The National Coordinator may impose a nominal fee for the adoption by a health care provider of the health information technology system developed or approved under subsection (a) and (b). Such fee shall take into account the financial circumstances of smaller providers, low income providers, and providers located in rural or other medically underserved areas.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require that a private or government entity adopt or use the technology provided under this section.

''SEC. 3008. TRANSITIONS.

''(a) ONCHIT.—To the extent consistent with section 3001, all functions, personnel, assets, liabilities, and administrative actions applicable to the National Coordinator for Health Information Technology appointed under Executive Order 13335 or the Office of such National Coordinator on the date before the date of the enactment of this title shall be transferred to the National Coordinator appointed under section 3001(a) and the Office of such National Coordinator as of the date of the enactment of this title.

''(b) AHIC.—

''(1) To the extent consistent with sections 3002 and 3003, all functions, personnel, assets, and liabilities applicable to the AHIC Successor, Inc. doing business as the National eHealth Collaborative as of the day before the date of the enactment of this title shall be transferred to the HIT Policy Committee or the HIT Standards Committee, established under section 3002(a) or 3003(a), as appropriate, as of the date of the enactment of this title.

''(2) In carrying out section 3003(b)(1)(A), until recommendations are made by the HIT Policy Committee, recommendations of the HIT Standards Committee shall be consistent with the most recent recommendations made by such AHIC Successor, Inc.

''(c) RULES OF CONSTRUCTION.—

''(1) ONCHIT.—Nothing in section 3001 or subsection (a) shall be construed as requiring the creation of a new entity to the extent that the Office of the National Coordinator for Health Information Technology established pursuant to Executive Order 13335 is consistent with the provisions of section 3001.

''(2) AHIC.—Nothing in sections 3002 or 3003 or subsection (b) shall be construed as prohibiting the AHIC Successor, Inc. doing business as the National eHealth Collaborative from modifying its charter, duties, membership, and any other structure or function required to be consistent with section 3002 and 3003 in a manner that would permit the Secretary to choose to recognize such AHIC Successor, Inc. as the HIT Policy Committee or the HIT Standards Committee.

''SEC. 3009. RELATION TO HIPAA PRIVACY AND SECURITY LAW.

''(a) IN GENERAL.—With respect to the relation of this title to HIPAA privacy and security law:

''(1) This title may not be construed as having any effect on the authorities of the Secretary under HIPAA privacy and security law.

''(2) The purposes of this title include ensuring that the health information technology standards and implementation specifications adopted under section 3004 take into account the requirements of HIPAA privacy and security law.

''(b) DEFINITION.—For purposes of this section, the term 'HIPAA privacy and security law' means—

''(1) the provisions of part C of title XI of the Social Security Act, section 264 of the Health Insurance Portability and Accountability Act of 1996, and subtitle D of title IV of the HITECH Act; and

''(2) regulations under such provisions.

''SEC. 3010. AUTHORIZATION FOR APPROPRIATIONS.

''There is authorized to be appropriated to the Office of the National Coordinator for Health Information Technology to carry out this subtitle $250,000,000 for fiscal year 2009.''.

SEC. 4102. TECHNICAL AMENDMENT.

Section 1171(5) of the Social Security Act (42 U.S.C. 1320d) is amended by striking ''or C'' and inserting ''C, or D''.

SEC. 4103. AMERICAN TECHNOLOGY REQUIRED.

(a) REQUIREMENT.—Any funds made available to carry out this title and the amendments made by this title (including through grants, contracts, loans, payments under title XVIII or XIX of the Social Security Act, or other assistance) may be used to purchase health information technology only if such technology is manufactured, including the engineering and programming of any software, in the United States substantially all from articles, materials, or supplies mined, produced, or manufactured, as the case may be, in the United States.

(b) DEFINITION.—In this section, the term ''health information technology'' has the meaning given to that term in section 3000 of the Public Health Service Act, as added by section 4101.

PART 2—APPLICATION AND USE OF ADOPTED HEALTH INFORMATION TECHNOLOGY STANDARDS; REPORTS

SEC. 4111. COORDINATION OF FEDERAL ACTIVITIES WITH ADOPTED STANDARDS AND IMPLEMENTATION SPECIFICATIONS.

(a) SPENDING ON HEALTH INFORMATION TECHNOLOGY SYSTEMS.—As each agency (as defined in the Executive Order issued on August 22, 2006, relating to promoting quality and efficient health care in Federal government administered or sponsored health care programs) implements, acquires, or upgrades health information technology systems used for the direct exchange of individually identifiable health information between agencies and with non-Federal entities, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under section 3004 of the Public Health Service Act, as added by section 4101.

(b) FEDERAL INFORMATION COLLECTION ACTIVITIES.—With respect to a standard or implementation

specification adopted under section 3004 of the Public Health Service Act, as added by section 4101, the President shall take measures to ensure that Federal activities involving the broad collection and submission of health information are consistent with such standard or implementation specification, respectively, within three years after the date of such adoption.

(c) APPLICATION OF DEFINITIONS.—The definitions contained in section 3000 of the Public Health Service Act, as added by section 4101, shall apply for purposes of this part.

SEC. 4112. APPLICATION TO PRIVATE ENTITIES.

Each agency (as defined in such Executive Order issued on August 22, 2006, relating to promoting quality and efficient health care in Federal government administered or sponsored health care programs) shall require in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under section 3004 of the Public Health Service Act, as added by section 4101.

SEC. 4113. STUDY AND REPORTS.

(a) REPORT ON ADOPTION OF NATIONWIDE SYSTEM.—Not later than 2 years after the date of the enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report that—

(1) describes the specific actions that have been taken by the Federal Government and private entities to facilitate the adoption of a nationwide system for the electronic use and exchange of health information;

(2) describes barriers to the adoption of such a nationwide system; and

(3) contains recommendations to achieve full implementation of such a nationwide system.

(b) REIMBURSEMENT INCENTIVE STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall carry out, or contract with a private entity to carry out, a study that examines methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report on the study carried out under paragraph (1).

(c) AGING SERVICES TECHNOLOGY STUDY AND REPORT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall carry out, or contract with a private entity to carry out, a study of matters relating to the potential use of new aging services technology to assist seniors, individuals with disabilities, and their caregivers throughout the aging process.

(2) MATTERS TO BE STUDIED.—The study under paragraph (1) shall include—

(A) an evaluation of—

(i) methods for identifying current, emerging, and future health technology that can be used to meet the needs of seniors and individuals with disabilities and their caregivers across all aging services settings, as specified by the Secretary;

(ii) methods for fostering scientific innovation with respect to aging services

technology within the business and academic communities; and

(iii) developments in aging services technology in other countries that may be applied in the United States; and

(B) identification of—

(i) barriers to innovation in aging services technology and devising strategies for removing such barriers; and

(ii) barriers to the adoption of aging services technology by health care providers and consumers and devising strategies to removing such barriers.

(3) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of jurisdiction of the House of Representatives and of the Senate a report on the study carried out under paragraph (1).

(4) DEFINITIONS.—For purposes of this subsection:

(A) AGING SERVICES TECHNOLOGY.—The term ''aging services technology'' means health technology that meets the health care needs of

seniors, individuals with disabilities, and the caregivers of such seniors and individuals.

(B) SENIOR.—The term ''senior'' has such meaning as specified by the Secretary.

Subtitle B—Testing of Health Information Technology

SEC. 4201. NATIONAL INSTITUTE FOR STANDARDS AND TECHNOLOGY TESTING.

(a) PILOT TESTING OF STANDARDS AND IMPLEMENTATION SPECIFICATIONS.—In coordination with the HIT Standards Committee established under section 3003 of the Public Health Service Act, as added by section 4101, with respect to the development of standards and implementation specifications under such section, the Director of the National Institute for Standards and Technology shall test such standards and implementation specifications, as appropriate, in order to assure the efficient implementation and use of such standards and implementation specifications.

(b) VOLUNTARY TESTING PROGRAM.—In coordination with the HIT Standards Committee established under section 3003 of the Public Health Service Act, as added by section 4101, with respect to the development of standards and implementation specifications under such section, the Director of the National Institute of Standards

and Technology shall support the establishment of a conformance testing infrastructure, including the development of technical test beds. The development of this conformance testing infrastructure may include a program to accredit independent, non-Federal laboratories to perform testing.

SEC. 4202. RESEARCH AND DEVELOPMENT PROGRAMS.

(a) HEALTH CARE INFORMATION ENTERPRISE INTEGRATION RESEARCH CENTERS.—

(1) IN GENERAL.—The Director of the National Institute of Standards and Technology, in consultation with the Director of the National Science Foundation and other appropriate Federal agencies, shall establish a program of assistance to institutions of higher education (or consortia thereof which may include nonprofit entities and Federal Government laboratories) to establish multidisciplinary Centers for Health Care Information Enterprise Integration.

(2) REVIEW; COMPETITION.—Grants shall be awarded under this subsection on a merit-reviewed, competitive basis.

(3) PURPOSE.—The purposes of the Centers described in paragraph (1) shall be—

(A) to generate innovative approaches to health care information enterprise integration

by conducting cutting-edge, multidisciplinary research on the systems challenges to health care delivery; and

(B) the development and use of health information technologies and other complementary fields.

(4) RESEARCH AREAS.—Research areas may include—

(A) interfaces between human information and communications technology systems;

(B) voice-recognition systems;

(C) software that improves interoperability and connectivity among health information systems;

(D) software dependability in systems critical to health care delivery;

(E) measurement of the impact of information technologies on the quality and productivity of health care;

(F) health information enterprise management;

(G) health information technology security and integrity; and

(H) relevant health information technology to reduce medical errors.

(5) APPLICATIONS.—An institution of higher education (or a consortium thereof) seeking funding under this subsection shall submit an application to the Director of the National Institute of Standards and Technology at such time, in such manner, and containing such information as the Director may require. The application shall include, at a minimum, a description of—

(A) the research projects that will be undertaken by the Center established pursuant to assistance under paragraph (1) and the respective contributions of the participating entities;

(B) how the Center will promote active collaboration among scientists and engineers from different disciplines, such as information technology, biologic sciences, management, social sciences, and other appropriate disciplines;

(C) technology transfer activities to demonstrate and diffuse the research results, technologies, and knowledge; and

(D) how the Center will contribute to the education and training of researchers and other professionals in fields relevant to health information enterprise integration.

(b) NATIONAL INFORMATION TECHNOLOGY RESEARCH AND DEVELOPMENT PROGRAM.—The National High-Performance Computing Program established by section 101 of the High-Performance Computing Act of 1991 (15 U.S.C. 5511) shall coordinate Federal research and development programs related to the development and deployment of health information technology, including activities related to—

(1) computer infrastructure;

(2) data security;

(3) development of large-scale, distributed, reliable computing systems;

(4) wired, wireless, and hybrid high-speed networking;

(5) development of software and software-intensive systems;

(6) human-computer interaction and information management technologies; and

(7) the social and economic implications of information technology.

Subtitle C—Incentives for the Use of Health Information Technology

PART I—GRANTS AND LOANS FUNDING

SEC. 4301. GRANT, LOAN, AND DEMONSTRATION PROGRAMS.

Title XXX of the Public Health Service Act, as added by section 4101, is amended by adding at the end the following new subtitle:

"Subtitle B—Incentives for the Use of Health Information Technology

"SEC. 3011. IMMEDIATE FUNDING TO STRENGTHEN THE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE.

"(a) IN GENERAL.—The Secretary shall, using amounts appropriated under section 3018, invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States consistent with the goals outlined in the strategic plan developed by the National Coordinator (and as available) under section 3001. To the greatest extent practicable, the Secretary shall ensure that any funds so appropriated shall be used for the acquisition of health information technology that meets standards and certification criteria adopted before the date of the enactment of this title until such date as the standards are

adopted under section 3004. The Secretary shall invest funds through the different agencies with expertise in such goals, such as the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers of Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the Indian Health Service to support the following:

''(1) Health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges, and which may include updating and implementing the infrastructure necessary within different agencies of the Department of Health and Human Services to support the electronic use and exchange of health information.

''(2) Development and adoption of appropriate certified electronic health records for categories of providers, as defined in section 3000, not eligible for support under title XVIII or XIX of the Social Security Act for the adoption of such records.

''(3) Training on and dissemination of information on best practices to integrate health information technology, including electronic health records, into

a provider's delivery of care, consistent with best practices learned from the Health Information Technology Research Center developed under section 3012(b), including community health centers receiving assistance under section 330, covered entities under section 340B, and providers participating in one or more of the programs under titles XVIII, XIX, and XXI of the Social Security Act (relating to Medicare, Medicaid, and the State Children's Health Insurance Program).

''(4) Infrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine.

''(5) Promotion of the interoperability of clinical data repositories or registries.

''(6) Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information.

''(7) Improvement and expansion of the use of health information technology by public health departments.

''(8) Provision of $300 million to support regional or sub-national efforts towards health information exchange.

''(b) COORDINATION.—The Secretary shall ensure funds under this section are used in a coordinated manner with other health information promotion activities.

''(c) ADDITIONAL USE OF FUNDS.—In addition to using funds as provided in subsection (a), the Secretary may use amounts appropriated under section 3018 to carry out health information technology activities that are provided for under laws in effect on the date of the enactment of this title.

''SEC. 3012. HEALTH INFORMATION TECHNOLOGY IMPLEMENTATION ASSISTANCE.

''(a) HEALTH INFORMATION TECHNOLOGY EXTENSION PROGRAM.—To assist health care providers to adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information, the Secretary, acting through the Office of the National Coordinator, shall establish a health information technology extension program to provide health information technology assistance services to be carried out through the Department of Health and Human Services. The National Coordinator shall consult with other Federal agencies with demonstrated experience and expertise in information technology services, such as the National Institute of Standards and Technology, in developing and implementing this program.

''(b) HEALTH INFORMATION TECHNOLOGY RESEARCH CENTER.—

''(1) IN GENERAL.—The Secretary shall create a Health Information Technology Research Center (in this section referred to as the 'Center') to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize health information technology that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted under section 3004.

''(2) INPUT.—The Center shall incorporate input from—

''(A) other Federal agencies with demonstrated experience and expertise in information technology services such as the National Institute of Standards and Technology;

''(B) users of health information technology, such as providers and their support and clerical staff and others involved in the care and care coordination of patients, from the health care and health information technology industry; and

''(C) others as appropriate.

''(3) PURPOSES.—The purposes of the Center are to—

''(A) provide a forum for the exchange of knowledge and experience;

''(B) accelerate the transfer of lessons learned from existing public and private sector initiatives, including those currently receiving Federal financial support;

''(C) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of health information technology that allows for the electronic exchange and use of information including through the regional centers described in subsection (c);

''(D) provide technical assistance for the establishment and evaluation of regional and local health information networks to facilitate the electronic exchange of information across health care settings and improve the quality of health care;

''(E) provide technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information; and

''(F) learn about effective strategies to adopt and utilize health information technology in medically underserved communities.

''(c) HEALTH INFORMATION TECHNOLOGY REGIONAL EXTENSION CENTERS.—

''(1) IN GENERAL.—The Secretary shall provide assistance for the creation and support of regional centers (in this subsection referred to as 'regional centers') to provide technical assistance and disseminate best practices and other information learned from the Center to support and accelerate efforts to adopt, implement, and effectively utilize health information technology that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted under section 3004. Activities conducted under this subsection shall be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 3001.

''(2) AFFILIATION.—Regional centers shall be affiliated with any United States-based nonprofit institution or organization, or group thereof, that applies and is awarded financial assistance under this section. Individual awards shall be decided on the basis of merit.

''(3) OBJECTIVE.—The objective of the regional centers is to enhance and promote the adoption of health information technology through—

''(A) assistance with the implementation, effective use, upgrading, and ongoing maintenance of health information technology, including electronic health records, to healthcare providers nationwide;

''(B) broad participation of individuals from industry, universities, and State governments;

''(C) active dissemination of best practices and research on the implementation, effective use, upgrading, and ongoing maintenance of health information technology, including electronic health records, to health care providers in order to improve the quality of healthcare and protect the privacy and security of health information;

''(D) participation, to the extent practicable, in health information exchanges; and

''(E) utilization, when appropriate, of the expertise and capability that exists in Federal agencies other than the Department; and

''(F) integration of health information technology, including electronic health records, into the initial and ongoing training of health professionals and others in the healthcare industry that would be instrumental to improving the quality of healthcare through the smooth and accurate electronic use and exchange of health information.

''(4) REGIONAL ASSISTANCE.—Each regional center shall aim to provide assistance and education to all providers in a region, but shall prioritize any direct assistance first to the following:

''(A) Public or not-for-profit hospitals or critical access hospitals.

''(B) Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act).

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

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

''(5) FINANCIAL SUPPORT.—The Secretary may provide financial support to any regional center created under this subsection for a period not to exceed four years. The Secretary may not provide more than 50 percent of the capital and annual operating and maintenance funds required to create and maintain such a center, except in an instance of national economic conditions which would render this cost-share requirement detrimental to the program and upon notification to Congress as to the justification to waive the cost-share requirement.

''(6) NOTICE OF PROGRAM DESCRIPTION AND AVAILABILITY OF FUNDS.—The Secretary shall publish in the Federal Register, not later than 90 days after the date of the enactment of this title, a draft description of the program for establishing regional centers under this subsection. Such description shall include the following:

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

''(B) Procedures to be followed by the applicants.

''(C) Criteria for determining qualified applicants.

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

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

''(A) the ability of the applicant to provide assistance under this subsection and utilization of health information technology appropriate to the needs of particular categories of health care providers;

''(B) the types of service to be provided to health care providers;

''(C) geographical diversity and extent of service area; and

''(D) the percentage of funding and amount of in-kind commitment from other sources.

''(8) BIENNIAL EVALUATION.—Each regional center which receives financial assistance under this subsection shall be evaluated biennially by an evaluation panel appointed by the Secretary. Each evalua-

tion panel shall be composed of private experts, none of whom shall be connected with the center involved, and of Federal officials. Each evaluation panel shall measure the involved center's performance against the objective specified in paragraph (3). The Secretary shall not continue to provide funding to a regional center unless its evaluation is overall positive.

''(9) CONTINUING SUPPORT.—After the second year of assistance under this subsection, a regional center may receive additional support under this subsection if it has received positive evaluations and a finding by the Secretary that continuation of Federal funding to the center was in the best interest of provision of health information technology extension services.

"SEC. 3013. STATE GRANTS TO PROMOTE HEALTH INFORMATION TECHNOLOGY.

''(a) IN GENERAL.—The Secretary, acting through the National Coordinator, shall establish a program in accordance with this section to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards.

''(b) PLANNING GRANTS.—The Secretary may award a grant to a State or qualified State-designated entity (as

described in subsection (f)) that submits an application to the Secretary at such time, in such manner, and containing such information as the Secretary may specify, for the purpose of planning activities described in subsection (d).

''(c) IMPLEMENTATION GRANTS.—The Secretary may award a grant to a State or qualified State designated entity that—

''(1) has submitted, and the Secretary has approved, a plan described in subsection (e) (regardless of whether such plan was prepared using amounts awarded under subsection (b); and

''(2) submits an application at such time, in such manner, and containing such information as the Secretary may specify.

''(d) USE OF FUNDS.—Amounts received under a grant under subsection (c) shall be used to conduct activities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards through activities that include—

''(1) enhancing broad and varied participation in the authorized and secure nationwide electronic use and exchange of health information;

''(2) identifying State or local resources available towards a nationwide effort to promote health information technology;

''(3) complementing other Federal grants, programs, and efforts towards the promotion of health information technology;

''(4) providing technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information;

''(5) promoting effective strategies to adopt and utilize health information technology in medically underserved communities;

''(6) assisting patients in utilizing health information technology;

''(7) encouraging clinicians to work with Health Information Technology Regional Extension Centers as described in section 3012, to the extent they are available and valuable;

''(8) supporting public health agencies' authorized use of and access to electronic health information;

''(9) promoting the use of electronic health records for quality improvement including through quality measures reporting; and

''(10) such other activities as the Secretary may specify.

''(e) PLAN.—

''(1) IN GENERAL.—A plan described in this subsection is a plan that describes the activities to be carried out by a State or by the qualified State-designated entity within such State to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications.

''(2) REQUIRED ELEMENTS.—A plan described in paragraph (1) shall—

''(A) be pursued in the public interest;

''(B) be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 3001;

''(C) include a description of the ways the State or qualified State-designated entity will carry out the activities described in subsection (b); and

''(D) contain such elements as the Secretary may require.

''(f) QUALIFIED STATE-DESIGNATED ENTITY.—For purposes of this section, to be a qualified State-designated entity, with respect to a State, an entity shall—

''(1) be designated by the State as eligible to receive awards under this section;

''(2) be a not-for-profit entity with broad stakeholder representation on its governing board;

''(3) demonstrate that one of its principal goals is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information;

''(4) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders; and

''(5) conform to such other requirements as the Secretary may establish.

''(g) REQUIRED CONSULTATION.—In carrying out activities described in subsections (b) and (c), a State or qualified State-designated entity shall consult with and consider the recommendations of—

''(1) health care providers (including providers that provide services to low income and underserved populations);

''(2) health plans;

''(3) patient or consumer organizations that represent the population to be served;

''(4) health information technology vendors;

''(5) health care purchasers and employers;

''(6) public health agencies;

''(7) health professions schools, universities and colleges;

''(8) clinical researchers;

''(9) other users of health information technology such as the support and clerical staff of providers and others involved in the care and care coordination of patients; and

''(10) such other entities, as may be determined appropriate by the Secretary.

''(h) CONTINUOUS IMPROVEMENT.—The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants under this section, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the Secretary, will lead towards the greatest improvement in quality of care, decrease in costs, and the most effective authorized and secure electronic exchange of health information.

''(i) REQUIRED MATCH.—

''(1) IN GENERAL.—For a fiscal year (beginning with fiscal year 2011), the Secretary may not make a grant under this section to a State unless the State agrees to make available non-Federal contributions (which may include in-kind contributions) toward the costs of a grant awarded under subsection (c) in an amount equal to—

''(A) for fiscal year 2011, not less than $1 for each $10 of Federal funds provided under the grant;

''(B) for fiscal year 2012, not less than $1 for each $7 of Federal funds provided under the grant; and

''(C) for fiscal year 2013 and each subsequent fiscal year, not less than $1 for each $3 of Federal funds provided under the grant.

''(2) AUTHORITY TO REQUIRE STATE MATCH FOR FISCAL YEARS BEFORE FISCAL YEAR 2011.—For any fiscal year during the grant program under this section before fiscal year 2011, the Secretary may determine the extent to which there shall be required a non-Federal contribution from a State receiving a grant under this section.

"SEC. 3014. COMPETITIVE GRANTS TO STATES AND INDIAN TRIBES FOR THE DEVELOPMENT OF LOAN PROGRAMS TO FACILITATE THE WIDESPREAD ADOPTION OF CERTIFIED EHR TECHNOLOGY.

''(a) IN GENERAL.—The National Coordinator may award competitive grants to eligible entities for the establishment of programs for loans to health care providers to conduct the activities described in subsection (e).

''(b) ELIGIBLE ENTITY DEFINED.—For purposes of this subsection, the term 'eligible entity' means a State or Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act) that—

''(1) submits to the National Coordinator an application at such time, in such manner, and containing such information as the National Coordinator may require;

''(2) submits to the National Coordinator a strategic plan in accordance with subsection (d) and provides to the National Coordinator assurances that the entity will update such plan annually in accordance with such subsection;

''(3) provides assurances to the National Coordinator that the entity will establish a Loan Fund in accordance with subsection (c);

''(4) provides assurances to the National Coordinator that the entity will not provide a loan from the Loan Fund to a health care provider unless the provider agrees to—

''(A) submit reports on quality measures adopted by the Federal Government (by not later than 90 days after the date on which such measures are adopted), to—

''(i) the Administrator of the Centers for Medicare & Medicaid Services (or his or her designee), in the case of an entity participating in the Medicare program under title XVIII of the Social Security Act or the Medicaid program under title XIX of such Act; or

''(ii) the Secretary in the case of other entities;

''(B) demonstrate to the satisfaction of the Secretary (through criteria established by the Secretary) that any certified EHR technology purchased, improved, or otherwise financially supported under a loan under this section is used to exchange health information in a manner that, in accordance with law and standards (as adopted under section 3004) applicable to

the exchange of information, improves the quality of health care, such as promoting care coordination; and

''(C) comply with such other requirements as the entity or the Secretary may require;

''(D) include a plan on how health care providers involved intend to maintain and support the certified EHR technology over time;

''(E) include a plan on how the health care providers involved intend to maintain and support the certified EHR technology that would be purchased with such loan, including the type of resources expected to be involved and any such other information as the State or Indian Tribe, respectively, may require; and

''(5) agrees to provide matching funds in accordance with subsection (h).

''(c) ESTABLISHMENT OF FUND.—For purposes of subsection (b)(3), an eligible entity shall establish a certified EHR technology loan fund (referred to in this subsection as a 'Loan Fund') and comply with the other requirements contained in this section. A grant to an eligible entity under this section shall be deposited in the Loan Fund established by the eligible entity. No funds authorized by other provisions of this title to be used for other

purposes specified in this title shall be deposited in any Loan Fund.

''(d) STRATEGIC PLAN.—

''(1) IN GENERAL.—For purposes of subsection (b)(2), a strategic plan of an eligible entity under this subsection shall identify the intended uses of amounts available to the Loan Fund of such entity.

''(2) CONTENTS.—A strategic plan under paragraph (1), with respect to a Loan Fund of an eligible entity, shall include for a year the following:

''(A) A list of the projects to be assisted through the Loan Fund during such year.

''(B) A description of the criteria and methods established for the distribution of funds from the Loan Fund during the year.

''(C) A description of the financial status of the Loan Fund as of the date of submission of the plan.

''(D) The short-term and long-term goals of the Loan Fund.

''(e) USE OF FUNDS.—Amounts deposited in a Loan Fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, making reimbursements described in subsection (g)(4)(A), or as a source of reserve and security

for leveraged loans, the proceeds of which are deposited in the Loan Fund established under subsection (c). Loans under this section may be used by a health care provider to—

''(1) facilitate the purchase of certified EHR technology;

''(2) enhance the utilization of certified EHR technology;

''(3) train personnel in the use of such technology; or

''(4) improve the secure electronic exchange of health information.

''(f) TYPES OF ASSISTANCE.—Except as otherwise limited by applicable State law, amounts deposited into a Loan Fund under this section may only be used for the following:

''(1) To award loans that comply with the following:

''(A) The interest rate for each loan shall not exceed the market interest rate.

''(B) The principal and interest payments on each loan shall commence not later than 1 year after the date the loan was awarded, and each loan shall be fully amortized not later than 10 years after the date of the loan.

''(C) The Loan Fund shall be credited with all payments of principal and interest on each loan awarded from the Loan Fund.

''(2) To guarantee, or purchase insurance for, a local obligation (all of the proceeds of which finance a project eligible for assistance under this subsection) if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

''(3) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the eligible entity if the proceeds of the sale of the bonds will be deposited into the Loan Fund.

''(4) To earn interest on the amounts deposited into the Loan Fund.

''(5) To make reimbursements described in subsection (g)(4)(A).

''(g) ADMINISTRATION OF LOAN FUNDS.—

''(1) COMBINED FINANCIAL ADMINISTRATION.—An eligible entity may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with applicable State law, the financial administration of a Loan Fund established under this subsection with the financial administration of

any other revolving fund established by the entity if otherwise not prohibited by the law under which the Loan Fund was established.

''(2) COST OF ADMINISTERING FUND.—Each eligible entity may annually use not to exceed 4 percent of the funds provided to the entity under a grant under this section to pay the reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a Loan Fund which are incurred after the date of the enactment of this title.

''(3) GUIDANCE AND REGULATIONS.—The National Coordinator shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this section, including—

''(A) provisions to ensure that each eligible entity commits and expends funds allotted to the entity under this section as efficiently as possible in accordance with this title and applicable State laws; and

''(B) guidance to prevent waste, fraud, and abuse.

''(4) PRIVATE SECTOR CONTRIBUTIONS.—

''(A) IN GENERAL.—A Loan Fund established under this section may accept contribu-

tions from private sector entities, except that such entities may not specify the recipient or recipients of any loan issued under this subsection. An eligible entity may agree to reimburse a private sector entity for any contribution made under this subparagraph, except that the amount of such reimbursement may not be greater than the principal amount of the contribution made.

''(B) AVAILABILITY OF INFORMATION.—An eligible entity shall make publicly available the identity of, and amount contributed by, any private sector entity under subparagraph (A) and may issue letters of commendation or make other awards (that have no financial value) to any such entity.

''(h) MATCHING REQUIREMENTS.—

''(1) IN GENERAL.—The National Coordinator may not make a grant under subsection (a) to an eligible entity unless the entity agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash to the costs of carrying out the activities for which the grant is awarded in an amount equal to not less

than $1 for each $5 of Federal funds provided under the grant.

''(2) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—In determining the amount of non-Federal contributions that an eligible entity has provided pursuant to subparagraph (A), the National Coordinator may not include any amounts provided to the entity by the Federal Government.

''(i) EFFECTIVE DATE.—The Secretary may not make an award under this section prior to January 1, 2010.

''SEC. 3015. DEMONSTRATION PROGRAM TO INTEGRATE INFORMATION TECHNOLOGY INTO CLINICAL EDUCATION.

''(a) IN GENERAL.—The Secretary may award grants under this section to carry out demonstration projects to develop academic curricula integrating certified EHR technology in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(2) submit to the Secretary a strategic plan for integrating certified EHR technology in the clinical education of health professionals to reduce medical errors and enhance health care quality;

''(3) be—

''(A) a school of medicine, osteopathic medicine, dentistry, or pharmacy, a graduate program in behavioral or mental health, or any other graduate health professions school;

''(B) a graduate school of nursing or physician assistant studies;

''(C) a consortium of two or more schools described in subparagraph (A) or (B); or

''(D) an institution with a graduate medical education program in medicine, osteopathic medicine, dentistry, pharmacy, nursing, or physician assistance studies;

''(4) provide for the collection of data regarding the effectiveness of the demonstration project to be funded under the grant in improving the safety of patients, the efficiency of health care delivery, and in increasing the likelihood that graduates of the

grantee will adopt and incorporate certified EHR technology, in the delivery of health care services; and

''(5) provide matching funds in accordance with subsection (d).

''(c) USE OF FUNDS.—

''(1) IN GENERAL.—With respect to a grant under subsection (a), an eligible entity shall—

''(A) use grant funds in collaboration with 2 or more disciplines; and

''(B) use grant funds to integrate certified EHR technology into community-based clinical education.

''(2) LIMITATION.—An eligible entity shall not use amounts received under a grant under subsection (a) to purchase hardware, software, or services.

''(d) FINANCIAL SUPPORT.—The Secretary may not provide more than 50 percent of the costs of any activity for which assistance is provided under subsection (a), except in an instance of national economic conditions which would render the cost-share requirement under this subsection detrimental to the program and upon notification to Congress as to the justification to waive the cost-share requirement.

''(e) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make available, and disseminate the results of such evaluations on as wide a basis as is practicable.

''(f) REPORTS.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce of the House of Representatives a report that—

''(1) describes the specific projects established under this section; and

''(2) contains recommendations for Congress based on the evaluation conducted under subsection (e).

''SEC. 3016. INFORMATION TECHNOLOGY PROFESSIONALS ON HEALTH CARE.

''(a) IN GENERAL.—The Secretary, in consultation with the Director of the National Science Foundation, shall provide assistance to institutions of higher education (or consortia thereof) to establish or expand medical health informatics education programs, including certification, undergraduate, and masters degree programs, for

both health care and information technology students to ensure the rapid and effective utilization and development of health information technologies (in the United States health care infrastructure).

''(b) ACTIVITIES.—Activities for which assistance may be provided under subsection (a) may include the following:

''(1) Developing and revising curricula in medical health informatics and related disciplines.

''(2) Recruiting and retaining students to the program involved.

''(3) Acquiring equipment necessary for student instruction in these programs, including the installation of testbed networks for student use.

''(4) Establishing or enhancing bridge programs in the health informatics fields between community colleges and universities.

''(c) PRIORITY.—In providing assistance under subsection (a), the Secretary shall give preference to the following:

''(1) Existing education and training programs.

''(2) Programs designed to be completed in less than six months.

''(d) FINANCIAL SUPPORT.—The Secretary may not provide more than 50 percent of the costs of any activity

for which assistance is provided under subsection (a), except in an instance of national economic conditions which would render the cost-share requirement under this subsection detrimental to the program and upon notification to Congress as to the justification to waive the cost-share requirement.

"SEC. 3017. GENERAL GRANT AND LOAN PROVISIONS.

''(a) REPORTS.—The Secretary may require that an entity receiving assistance under this subtitle shall submit to the Secretary, not later than the date that is 1 year after the date of receipt of such assistance, a report that includes—

''(1) an analysis of the effectiveness of the activities for which the entity receives such assistance, as compared to the goals for such activities; and

''(2) an analysis of the impact of the project on health care quality and safety.

''(b) REQUIREMENT TO IMPROVE QUALITY OF CARE AND DECREASE IN COSTS.—The National Coordinator shall annually evaluate the activities conducted under this subtitle and shall, in awarding grants, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the National

Coordinator, will result in the greatest improvement in the quality and efficiency of health care.

''SEC. 3018. AUTHORIZATION FOR APPROPRIATIONS.

''For the purposes of carrying out this subtitle, there is authorized to be appropriated such sums as may be necessary for each of the fiscal years 2009 through 2013. Amounts so appropriated shall remain available until expended.''.

PART II—MEDICARE PROGRAM

SEC. 4311. INCENTIVES FOR ELIGIBLE PROFESSIONALS.

(a) INCENTIVE PAYMENTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

''(o) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

''(1) INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—Subject to the succeeding subparagraphs of this paragraph, with respect to covered professional services furnished by an eligible professional during a payment year (as defined in subparagraph (E)), if the eligible professional is a meaningful EHR user (as determined under paragraph (2)) for the reporting period with respect to such year, in addition to the amount otherwise paid under

this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)), from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year.

''(B) LIMITATIONS ON AMOUNTS OF INCENTIVE PAYMENTS.—

''(i) IN GENERAL.—In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

''(ii) AMOUNT.—Subject to clause (iii), the applicable amount specified in this subparagraph for an eligible professional is as follows:

''(I) For the first payment year for such professional, $15,000.

''(II) For the second payment year for such professional, $12,000.

''(III) For the third payment year for such professional, $8,000.

''(IV) For the fourth payment year for such professional, $4,000.

''(V) For the fifth payment year for such professional, $2,000.

''(VI) For any succeeding payment year for such professional, $0.

''(iii) PHASE DOWN FOR ELIGIBLE PROFESSIONALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013. If the first payment year for an eligible professional is after 2015 then the applicable amount specified in this sub-

paragraph for such professional for such year and any subsequent year shall be $0.

"(C) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.—

"(i) IN GENERAL.—No incentive payment may be made under this paragraph in the case of a hospital-based eligible professional.

"(ii) HOSPITAL-BASED ELIGIBLE PROFESSIONAL.—For purposes of clause (i), the term 'hospital-based eligible professional' means, with respect to covered professional services furnished by an eligible professional during the reporting period for a payment year, an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including computer equipment, of the hospital.

"(D) PAYMENT.—

"(i) FORM OF PAYMENT.—The payment under this paragraph may be in the

form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

''(ii) COORDINATION OF APPLICATION OF LIMITATION FOR PROFESSIONALS IN DIFFERENT PRACTICES.—In the case of an eligible professional furnishing covered professional services in more than one practice (as specified by the Secretary), the Secretary shall establish rules to coordinate the incentive payments, including the application of the limitation on amounts of such incentive payments under this paragraph, among such practices.

''(iii) COORDINATION WITH MEDICAID.—The Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State Governments to demonstrate meaningful use of certified EHR technology under this title and title XIX. In doing so, the Secretary may deem satisfaction of State requirements for such meaningful use for a payment year under title XIX to be sufficient to qualify as meaningful use

under this subsection and subsection (a)(7) and vice versa. The Secretary may also adjust the reporting periods under such title and such subsections in order to carry out this clause.

''(E) PAYMENT YEAR DEFINED.—

''(i) IN GENERAL.—For purposes of this subsection, the term 'payment year' means a year beginning with 2011.

''(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term 'first payment year' means, with respect to covered professional services furnished by an eligible professional, the first year for which an incentive payment is made for such services under this subsection. The terms 'second payment year', 'third payment year', 'fourth payment year', and 'fifth payment year' mean, with respect to covered professional services furnished by such eligible professional, each successive year immediately following the first payment year for such professional.

''(2) MEANINGFUL EHR USER.—

''(A) IN GENERAL.—For purposes of paragraph (1), an eligible professional shall be treated as a meaningful EHR user for a reporting period for a payment year (or, for purposes of subsection (a)(7), for a reporting period under such subsection for a year) if each of the following requirements is met:

''(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary.

''(ii) INFORMATION EXCHANGE.—The eligible professional demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for

the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.

''(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary under subparagraph (B)(i).

The Secretary may provide for the use of alternative means for meeting the requirements of clauses (i), (ii), and (iii) in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

''(B) REPORTING ON MEASURES.—

''(i) SELECTION.—The Secretary shall select measures for purposes of subpara-

graph (A)(iii) but only consistent with the following:

''(I) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

''(II) Prior to any measure being selected under this subparagraph, the Secretary shall publish in the Federal Register such measure and provide for a period of public comment on such measure.

''(ii) LIMITATION.—The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

''(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek

to avoid redundant or duplicative reporting otherwise required, including reporting under subsection (k)(2)(C).

''(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

''(i) IN GENERAL.—A professional may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the Secretary, which may include—

''(I) an attestation;

''(II) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);

''(III) a survey response;

''(IV) reporting under subparagraph (A)(iii); and

''(V) other means specified by the Secretary.

''(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may

use data regarding drug claims submitted for purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

''(3) APPLICATION.—

''(A) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this subsection in the same manner as they apply for purposes of such subsection.

''(B) COORDINATION WITH OTHER PAYMENTS.—The provisions of this subsection shall not be taken into account in applying the provisions of subsection (m) of this section and of section 1833(m) and any payment under such provisions shall not be taken into account in computing allowable charges under this subsection.

''(C) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the determination of any incentive payment under this subsection and the payment adjustment under subsection (a)(7), including the determination of a meaningful EHR user under

paragraph (2), a limitation under paragraph (1)(B), and the exception under subsection (a)(7)(B).

''(D) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments under paragraph (1).

''(4) CERTIFIED EHR TECHNOLOGY DEFINED.—For purposes of this section, the term 'certified EHR technology' means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

''(5) DEFINITIONS.—For purposes of this subsection:

''(A) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given such term in subsection (k)(3).

''(B) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' means a physician, as defined in section 1861(r).

''(C) REPORTING PERIOD.—The term 'reporting period' means any period (or periods), with respect to a payment year, as specified by the Secretary.''.

(b) INCENTIVE PAYMENT ADJUSTMENT.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

''(7) INCENTIVES FOR MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

''(A) ADJUSTMENT.—

''(i) IN GENERAL.—Subject to subparagraphs (B) and (D), with respect to covered professional services furnished by an eligible professional during 2016 or any subsequent payment year, if the eligible

professional is not a meaningful EHR user (as determined under subsection (o)(2)) for a reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).

''(ii) APPLICABLE PERCENT.—Subject to clause (iii), for purposes of clause (i), the term 'applicable percent' means—

''(I) for 2016, 99 percent;

''(II) for 2017, 98 percent; and

''(III) for 2018 and each subsequent year, 97 percent.

''(iii) AUTHORITY TO DECREASE APPLICABLE PERCENTAGE FOR 2019 AND SUBSEQUENT YEARS.—For 2019 and each subsequent year, if the Secretary finds that the proportion of eligible professionals who

are meaningful EHR users (as determined under subsection (o)(2)) is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case shall the applicable percent be less than 95 percent.

''(B) SIGNIFICANT HARDSHIP EXCEPTION.—The Secretary may, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case may an eligible professional be granted an exemption under this subparagraph for more than 5 years.

''(C) APPLICATION OF PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

''(D) NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.—No payment adjustment may be made under subparagraph (A) in the case of hospital-based eligible professionals (as defined in subsection (o)(1)(C)(ii)).

''(E) DEFINITIONS.—For purposes of this paragraph:

''(i) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given such term in subsection (k)(3).

''(ii) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' means a physician, as defined in section 1861(r).

''(iii) REPORTING PERIOD.—The term 'reporting period' means, with respect to a year, a period specified by the Secretary.''.

(c) APPLICATION TO CERTAIN HMO-AFFILIATED ELIGIBLE PROFESSIONALS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(l) APPLICATION OF ELIGIBLE PROFESSIONAL INCENTIVES FOR CERTAIN MA ORGANIZATIONS FOR ADOP-

TION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

''(1) IN GENERAL.—Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1848(o) and 1848(a)(7) shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

''(2) ELIGIBLE PROFESSIONAL DESCRIBED.—With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1848(o)) who—

''(A)(i) is employed by the organization; or

''(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's patient care services to enrollees of such organization; and

''(II) furnishes at least 75 percent of the professional services of the eligible professional to enrollees of the organization; and

''(B) furnishes, on average, at least 20 hours per week of patient care services.

''(3) ELIGIBLE PROFESSIONAL INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—In applying section 1848(o) under paragraph (1), instead of the additional payment amount under section 1848(o)(1)(A) and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.

''(B) AVOIDING DUPLICATION OF PAYMENTS.—

''(i) IN GENERAL.—If an eligible professional described in paragraph (2) is eligible for the maximum incentive payment under section 1848(o)(1)(A) for the same payment period, the payment incentive

shall be made only under such section and not under this subsection.

''(ii) METHODS.—In the case of an eligible professional described in paragraph (2) who is eligible for an incentive payment under section 1848(o)(1)(A) but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

''(I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1848(o)(1)(A); and

''(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

''(C) FIXED SCHEDULE FOR APPLICATION OF LIMITATION ON INCENTIVE PAYMENTS FOR ALL ELIGIBLE PROFESSIONALS.—In applying section 1848(o)(1)(B)(ii) under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eli-

gible professionals with respect to such organization.

''(4) PAYMENT ADJUSTMENT.—

''(A) IN GENERAL.—In applying section 1848(a)(7) under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year.

''(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

''(i) the number of percentage points by which the applicable percent (under section 1848(a)(7)(A)(ii)) for the year is less than 100 percent; and

''(ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year.

''(C) MEDICARE PHYSICIAN EXPENDITURE PROPORTION.—The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians' services.

''(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible professionals are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of such eligible professionals that are not meaningful EHR users for such year.

''(5) QUALIFYING MA ORGANIZATION DEFINED.—In this subsection and subsection (m), the term 'qualifying MA organization' means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act).

''(6) MEANINGFUL EHR USER ATTESTATION.—For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attes-

tation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1854(a)(1)(A)(iv), identifying—

''(A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1848(o)(2)) for a year specified by the Secretary; and

''(B) whether each eligible hospital described in subsection (m)(1), with respect to such organization, is a meaningful EHR user (as defined in section 1886(n)(3)) for an applicable period specified by the Secretary.''.

(d) CONFORMING AMENDMENTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)(1)(A), by striking ''and (i)'' and inserting ''(i), and (l)'';

(2) in subsection (c)—

(A) in paragraph (1)(D)(i), by striking ''section 1886(h)'' and inserting ''sections 1848(o) and 1886(h)''; and

(B) in paragraph (6)(A), by inserting after ''under part B,'' the following: ''excluding ex-

penditures attributable to subsections (a)(7) and (o) of section 1848,''; and

(3) in subsection (f), by inserting ''and for payments under subsection (l)'' after ''with the organization''.

(e) CONFORMING AMENDMENTS TO E-PRESCRIBING.—

(1) Section 1848(a)(5)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(5)(A)) is amended—

(A) in clause (i), by striking ''or any subsequent year'' and inserting '', 2013, 2014, or 2015''; and

(B) in clause (ii), by striking ''and each subsequent year'' and inserting ''and 2015''.

(2) Section 1848(m)(2) of such Act (42 U.S.C. 1395w–4(m)(2)) is amended—

(A) in subparagraph (A), by striking ''For 2009'' and inserting ''Subject to subparagraph (D), for 2009''; and

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

''(D) LIMITATION WITH RESPECT TO EHR INCENTIVE PAYMENTS.—The provisions of this paragraph shall not apply to an eligible professional (or, in the case of a group practice under

paragraph (3)(C), to the group practice) if, for the reporting period the eligible professional (or group practice) receives an incentive payment under subsection (o)(1)(A) with respect to a certified EHR technology (as defined in subsection (o)(4)) that has the capability of electronic prescribing.''.

SEC. 4312. INCENTIVES FOR HOSPITALS.

(a) INCENTIVE PAYMENT.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(n) INCENTIVES FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, with respect to inpatient hospital services furnished by an eligible hospital during a payment year (as defined in paragraph (2)(G)), if the eligible hospital is a meaningful EHR user (as determined under paragraph (3)) for the reporting period with respect to such year, in addition to the amount otherwise paid under this section, there also shall be paid to the eligible hospital, from the Federal Hospital Insurance Trust Fund established under section 1817, an amount equal to

the applicable amount specified in paragraph (2)(A) for the hospital for such payment year.

''(2) PAYMENT AMOUNT.—

''(A) IN GENERAL.—Subject to the succeeding subparagraphs of this paragraph, the applicable amount specified in this subparagraph for an eligible hospital for a payment year is equal to the product of the following:

''(i) INITIAL AMOUNT.—The sum of—

''(I) the base amount specified in subparagraph (B); plus

''(II) the discharge related amount specified in subparagraph (C) for a 12-month period selected by the Secretary with respect to such payment year.

''(ii) MEDICARE SHARE.—The Medicare share as specified in subparagraph (D) for the hospital for a period selected by the Secretary with respect to such payment year.

''(iii) TRANSITION FACTOR.—The transition factor specified in subparagraph (E) for the hospital for the payment year.

''(B) BASE AMOUNT.—The base amount specified in this subparagraph is $2,000,000.

''(C) DISCHARGE RELATED AMOUNT.—The discharge related amount specified in this subparagraph for a 12-month period selected by the Secretary shall be determined as the sum of the amount, based upon total discharges (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

''(i) For the 1,150th through the 9,200nd discharge, $200.

''(ii) For the 9,201st through the 13,800th discharge, 50 percent of the amount specified in clause (i).

''(iii) For the 13,801st through the 23,000th discharge, 30 percent of the amount specified in clause (i).

''(D) MEDICARE SHARE.—The Medicare share specified under this subparagraph for a hospital for a period selected by the Secretary for a payment year is equal to the fraction—

''(i) the numerator of which is the sum (for such period and with respect to the hospital) of—

''(I) the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

''(II) the number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

''(ii) the denominator of which is the product of—

''(I) the total number of inpatient-bed-days with respect to the hospital during such period; and

''(II) the total amount of the hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the total amount of the hospital's charges during such period.

Insofar as the Secretary determines that data are not available on charity care necessary to

calculate the portion of the formula specified in clause (ii)(II), the Secretary shall use data on uncompensated care and may adjust such data so as to be an appropriate proxy for charity care including a downward adjustment to eliminate bad debt data from uncompensated care data. In the absence of the data necessary, with respect to a hospital, for the Secretary to compute the amount described in clause (ii)(II), the amount under such clause shall be deemed to be 1. In the absence of data, with respect to a hospital, necessary to compute the amount described in clause (i)(II), the amount under such clause shall be deemed to be 0.

''(E) TRANSITION FACTOR SPECIFIED.—

''(i) IN GENERAL.—Subject to clause (ii), the transition factor specified in this subparagraph for an eligible hospital for a payment year is as follows:

''(I) For the first payment year for such hospital, 1.

''(II) For the second payment year for such hospital, ¾.

''(III) For the third payment year for such hospital, ½.

"(IV) For the fourth payment year for such hospital, ¼.

"(V) For any succeeding payment year for such hospital, 0.

"(ii) PHASE DOWN FOR ELIGIBLE HOSPITALS FIRST ADOPTING EHR AFTER 2013.—If the first payment year for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013. If the first payment year for an eligible hospital is after 2015 then the transition factor specified in this subparagraph for such hospital and for such year and any subsequent year shall be 0.

"(F) FORM OF PAYMENT.—The payment under this subsection for a payment year may be in the form of a single consolidated payment or in the form of such periodic installments as the Secretary may specify.

"(G) PAYMENT YEAR DEFINED.—

"(i) IN GENERAL.—For purposes of this subsection, the term 'payment year' means a fiscal year beginning with fiscal year 2011.

"(ii) FIRST, SECOND, ETC. PAYMENT YEAR.—The term 'first payment year' means, with respect to inpatient hospital services furnished by an eligible hospital, the first fiscal year for which an incentive payment is made for such services under this subsection. The terms 'second payment year', 'third payment year', and 'fourth payment year' mean, with respect to an eligible hospital, each successive year immediately following the first payment year for that hospital.

"(3) MEANINGFUL EHR USER.—

"(A) IN GENERAL.—For purposes of paragraph (1), an eligible hospital shall be treated as a meaningful EHR user for a reporting period for a payment year (or, for purposes of subsection (b)(3)(B)(ix), for a reporting period under such subsection for a fiscal year) if each of the following requirements are met:

''(i) MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period the hospital is using certified EHR technology in a meaningful manner.

''(ii) INFORMATION EXCHANGE.—The eligible hospital demonstrates to the satisfaction of the Secretary, in accordance with subparagraph (C)(i), that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.

''(iii) REPORTING ON MEASURES USING EHR.—Subject to subparagraph (B)(ii) and using such certified EHR technology, the eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other

measures as selected by the Secretary under subparagraph (B)(i).

The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.

''(B) REPORTING ON MEASURES.—

''(i) SELECTION.—The Secretary shall select measures for purposes of subparagraph (A)(iii) but only consistent with the following:

''(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying subsection (b)(3)(B)(viii) or that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

''(II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying subsection (b)(3)(B)(viii)) being selected under this subparagraph, the Secretary shall publish in

the Federal Register such measure and provide for a period of public comment on such measure.

''(ii) LIMITATIONS.—The Secretary may not require the electronic reporting of information on clinical quality measures under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

''(iii) COORDINATION OF REPORTING OF INFORMATION.—In selecting such measures, and in establishing the form and manner for reporting measures under subparagraph (A)(iii), the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including reporting under subsection (b)(3)(B)(viii).

''(C) DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

''(i) IN GENERAL.—A hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A)

through means specified by the Secretary, which may include—

''(I) an attestation;

''(II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);

''(III) a survey response;

''(IV) reporting under subparagraph (A)(iii); and

''(V) other means specified by the Secretary.

''(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

''(4) APPLICATION.—

''(A) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the determination of any incentive payment

under this subsection and the payment adjustment under subsection (b)(3)(B)(ix), including the determination of a meaningful EHR user under paragraph (3), determination of measures applicable to services furnished by eligible hospitals under this subsection, and the exception under subsection (b)(3)(B)(ix)(II).

''(B) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the eligible hospitals that are meaningful EHR users under this subsection or subsection (b)(3)(B)(ix) and other relevant data as determined appropriate by the Secretary. The Secretary shall ensure that a hospital has the opportunity to review the other relevant data that are to be made public with respect to the hospital prior to such data being made public.

''(5) CERTIFIED EHR TECHNOLOGY DEFINED.—The term 'certified EHR technology' has the meaning given such term in section 1848(o)(4).

''(6) DEFINITIONS.—For purposes of this subsection:

''(A) ELIGIBLE HOSPITAL.—The term 'eligible hospital' means a subsection (d) hospital.

''(B) REPORTING PERIOD.—The term 'reporting period' means any period (or periods), with respect to a payment year, as specified by the Secretary.''.

(b) INCENTIVE MARKET BASKET ADJUSTMENT.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (viii)(I), by inserting ''(or, beginning with fiscal year 2016, by one-quarter)'' after ''2.0 percentage points''; and

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

''(ix)(I) For purposes of clause (i) for fiscal year 2016 and each subsequent fiscal year, in the case of an eligible hospital (as defined in subsection (n)(6)(A)) that is not a meaningful EHR user (as defined in subsection (n)(3)) for the reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) for such fiscal year shall be reduced by 33⅓ percent for fiscal year 2016, 66⅔ percent for fiscal year 2017, and 100 percent for fiscal year 2018 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved

and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

''(II) The Secretary may, on a case-by-case basis, exempt a subsection (d) hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. In no case may a hospital be granted an exemption under this subclause for more than 5 years.

''(III) For fiscal year 2016 and each subsequent fiscal year, a State in which hospitals are paid for services under section 1814(b)(3) shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user (as defined in subsection (n)(3)) in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. The State shall report to the Secretary the methodology it will

use to make the payment adjustment under the previous sentence.

''(IV) For purposes of this clause, the term 'reporting period' means, with respect to a fiscal year, any period (or periods), with respect to the fiscal year, as specified by the Secretary.''.

(c) APPLICATION TO CERTAIN HMO-AFFILIATED ELIGIBLE HOSPITALS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23), as amended by section 4311(c), is further amended by adding at the end the following new subsection:

''(m) APPLICATION OF ELIGIBLE HOSPITAL INCENTIVES FOR CERTAIN MA ORGANIZATIONS FOR ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY.—

''(1) APPLICATION.—Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1886(n) and 1886(b)(3)(B)(ix) shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (l)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under

paragraph (4) shall apply to such qualifying organizations.

''(2) ELIGIBLE HOSPITAL DESCRIBED.—With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

''(3) ELIGIBLE HOSPITAL INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—In applying section 1886(n)(2) under paragraph (1), instead of the additional payment amount under section 1886(n)(2), there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary—

''(i) shall, insofar as data to determine the discharge related amount under section 1886(n)(2)(C) for an eligible hospital are not available to the Secretary, use

such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

''(ii) shall, insofar as data to determine the medicare share described in section 1886(n)(2)(D) for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient bed days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the total number of patient-bed-days (or discharges) with respect to such hospital during such period.

''(B) AVOIDING DUPLICATION OF PAYMENTS.—

''(i) IN GENERAL.—In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2),

is an eligible hospital under section 1886(n), and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1886(n) and not under this subsection.

''(ii) METHODS.—In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1886(n) but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

''(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1886(n); and

''(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

''(4) PAYMENT ADJUSTMENT.—

''(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in

section 1853(l)(5)), if, according to the attestation of the organization submitted under subsection (l)(6) for an applicable period, one or more eligible hospitals (as defined in section 1886(n)(6)(A)) that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1886(n)(3)) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

''(B) SPECIFIED PERCENT.—The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

''(i) the number of the percentage point reduction effected under section 1886(b)(3)(B)(ix)(I) for the period; and

''(ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year.

"(C) MEDICARE HOSPITAL EXPENDITURE PROPORTION.—The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.

"(D) APPLICATION OF PAYMENT ADJUSTMENT.—In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.".

(d) CONFORMING AMENDMENTS.—

(1) Section 1814(b) of the Social Security Act (42 U.S.C. 1395f(b)) is amended—

(A) in paragraph (3), in the matter preceding subparagraph (A), by inserting ", sub-

ject to section 1886(d)(3)(B)(ix)(III),'' after ''then''; and

(B) by adding at the end the following: ''For purposes of applying paragraph (3), there shall be taken into account incentive payments, and payment adjustments under subsection (b)(3)(B)(ix) or (n) of section 1886.''.

(2) Section 1851(i)(1) of the Social Security Act (42 U.S.C. 1395w–21(i)(1)) is amended by striking ''and 1886(h)(3)(D)'' and inserting ''1886(h)(3)(D), and 1853(m)''.

(3) Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by section 4311(d)(1), is amended—

(A) in subsection (c)—

(i) in paragraph (1)(D)(i), by striking ''1848(o)'' and inserting '', 1848(o), and 1886(n)''; and

(ii) in paragraph (6)(A), by inserting ''and subsections (b)(3)(B)(ix) and (n) of section 1886'' after ''section 1848''; and

(B) in subsection (f), by inserting ''and subsection (m)'' after ''under subsection (l)''.

SEC. 4313. TREATMENT OF PAYMENTS AND SAVINGS; IMPLEMENTATION FUNDING.

(a) PREMIUM HOLD HARMLESS.—

(1) IN GENERAL.—Section 1839(a)(1) of the Social Security Act (42 U.S.C. 1395r(a)(1)) is amended by adding at the end the following: ''In applying this paragraph there shall not be taken into account additional payments under section 1848(o) and section 1853(l)(3) and the Government contribution under section 1844(a)(3).''.

(2) PAYMENT.—Section 1844(a) of such Act (42 U.S.C. 1395w(a)) is amended—

(A) in paragraph (2), by striking the period at the end and inserting ''; plus''; and

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

''(3) a Government contribution equal to the amount of payment incentives payable under sections 1848(o) and 1853(l)(3).''.

(b) MEDICARE IMPROVEMENT FUND.—Section 1898 of the Social Security Act (42 U.S.C. 1395iii), as added by section 7002(a) of the Supplemental Appropriations Act, 2008 (Public Law 110–252) and as amended by section 188(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275; 122

Stat. 2589) and by section 6 of the QI Program Supplemental Funding Act of 2008, is amended—

(1) in subsection (a)—

(A) by inserting ''medicare'' before ''fee-for-service''; and

(B) by inserting before the period at the end the following: ''including, but not limited to, an increase in the conversion factor under section 1848(d) to address, in whole or in part, any projected shortfall in the conversion factor for 2014 relative to the conversion factor for 2008 and adjustments to payments for items and services furnished by providers of services and suppliers under such original medicare fee-for-service program''; and

(2) in subsection (b)—

(A) in paragraph (1), by striking ''during fiscal year 2014,'' and all that follows and inserting the following: ''during—

''(A) fiscal year 2014, $22,290,000,000; and

''(B) fiscal year 2020 and each subsequent fiscal year, the Secretary's estimate, as of July 1 of the fiscal year, of the aggregate reduction in expenditures under this title during the pre-

ceding fiscal year directly resulting from the reduction in payment amounts under sections 1848(a)(7), 1853(l)(4), 1853(m)(4), and 1886(b)(3)(B)(ix).''; and

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

''(4) NO EFFECT ON PAYMENTS IN SUBSEQUENT YEARS.—In the case that expenditures from the Fund are applied to, or otherwise affect, a payment rate for an item or service under this title for a year, the payment rate for such item or service shall be computed for a subsequent year as if such application or effect had never occurred.''.

(c) IMPLEMENTATION FUNDING.—In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account, $60,000,000 for each of fiscal years 2009 through 2015 and $30,000,000 for each succeeding fiscal year through fiscal year 2019, which shall be available for purposes of carrying out the provisions of (and amendments made by) this part. Amounts appropriated under this subsection for a fiscal year shall be available until expended.

SEC. 4314. STUDY ON APPLICATION OF EHR PAYMENT INCENTIVES FOR PROVIDERS NOT RECEIVING OTHER INCENTIVE PAYMENTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the extent to which and manner in which payment incentives (such as under title XVIII or XIX of the Social Security Act) and other funding for purposes of implementing and using certified EHR technology (as defined in section 3000 of the Public Health Service Act) should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, under title XVIII or XIX of the Social Security Act, or otherwise, for such purposes.

(2) DETAILS OF STUDY.—Such study shall include an examination of—

(A) the adoption rates of certified EHR technology by such health care providers;

(B) the clinical utility of such technology by such health care providers;

(C) whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology;

(D) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act, title XVIII or XIX of the Social Security Act, or otherwise;

(E) the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and

(F) any other issues the Secretary deems to be appropriate.

(b) REPORT.—Not later than June 30, 2010, the Secretary shall submit to Congress a report on the findings and conclusions of the study conducted under subsection (a).

PART III—MEDICAID FUNDING

SEC. 4321. MEDICAID PROVIDER HIT ADOPTION AND OPERATION PAYMENTS; IMPLEMENTATION FUNDING.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(3)—

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

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

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

''(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) by Medicaid providers described in subsection (t)(1); and

''(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus''; and

(2) by inserting after subsection (s) the following new subsection:

''(t)(1) For purposes of subsection (a)(3)(F), the payments for certified EHR technology (and support services including maintenance that is for, or is necessary for the operation of, such technology) by Medicaid providers de-

scribed in this paragraph are payments made by the State in accordance with this subsection of 85 percent of the net allowable costs of Medicaid providers (as defined in paragraph (2)) for such technology (and support services).

''(2) In this subsection and subsection (a)(3)(F), the term 'Medicaid provider' means—

''(A) an eligible professional (as defined in paragraph (3)(B)) who is not hospital-based and has at least 30 percent of the professional's patient volume (as estimated in accordance with standards established by the Secretary) attributable to individuals who are receiving medical assistance under this title; and

''(B)(i) a children's hospital, (ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital's patient volume (as estimated in accordance with standards established by the Secretary) attributable to individuals who are receiving medical assistance under this title, or (iii) a Federally-qualified health center or rural health clinic that has at least 30 percent of the center's or clinic's patient volume (as estimated in accordance with standards established by the Secretary) attributable to individuals who are receiving medical assistance under this title.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless the eligible professional has waived, in a manner specified by the Secretary, any right to payment under section 1848(o) with respect to the adoption or support of certified EHR technology by the professional. In applying clauses (ii) and (iii) of subparagraph (B), the standards established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

''(3) In this subsection and subsection (a)(3)(F):

''(A) The term 'certified EHR technology' means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

''(B) The term 'eligible professional' means a physician as defined in paragraphs (1) and (2) of section 1861(r), and includes a nurse mid-wife and a nurse practitioner.

''(C) The term 'hospital-based' means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual's professional services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including computer equipment, of the hospital.

''(4)(A) The term 'allowable costs' means, with respect to certified EHR technology of a Medicaid provider, costs of such technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) as determined by the Secretary to be reasonable.

''(B) The term 'net allowable costs' means allowable costs reduced by any payment that is made to the Medicaid provider involved from any other source that is directly attributable to payment for certified EHR technology or services described in subparagraph (A).

''(C) In no case shall—

''(i) the aggregate allowable costs under this subsection (covering one or more years) with respect to a Medicaid provider described in paragraph (2)(A) for purchase and initial implementation of certified EHR technology (and services described in

subparagraph (A)) exceed $25,000 or include costs over a period of longer than 5 years;

''(ii) for costs not described in clause (i) relating to the operation, maintenance, or use of certified EHR technology, the annual allowable costs under this subsection with respect to such a Medicaid provider for costs not described in clause (i) for any year exceed $10,000;

''(iii) payment described in paragraph (1) for costs described in clause (ii) be made with respect to such a Medicaid provider over a period of more than 5 years;

''(iv) the aggregate allowable costs under this subsection with respect to such a Medicaid provider for all costs exceed $75,000; or

''(v) the allowable costs, whether for purchase and initial implementation, maintenance, or otherwise, for a Medicaid provider described in paragraph (2)(B) exceed such aggregate or annual limitation as the Secretary shall establish, based on an amount determined by the Secretary as being adequate to adopt and maintain certified EHR technology, consistent with paragraph (6).

''(5) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

''(A) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to costs of a Medicaid provider are paid directly to such provider without any deduction or rebate.

''(B) Such Medicaid provider is responsible for payment of the costs described in such paragraph that are not provided under this title.

''(C) With respect to payments to such Medicaid provider for costs other than costs related to the initial adoption of certified EHR technology, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under section 1848(o) or 1886(n).

''(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

''(6)(A) In no case shall the payments described in paragraph (1), with respect to a hospital, exceed in the aggregate the product of—

''(i) the overall hospital EHR amount for the hospital computed under subparagraph (B); and

''(ii) the Medicaid share for such hospital computed under subparagraph (C).

''(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a hospital, is the sum of the applicable amounts specified in section 1886(n)(2)(A) for such hospital for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall publish in the Federal Register the overall hospital EHR amount for each hospital eligible for payments under this subsection. In computing amounts under clause (ii) for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

''(C) The Medicaid share computed under this subparagraph, for a hospital for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1886(n)(2)(D) for such a

hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this title and who are not described in section 1886(n)(2)(D)(i). In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

''(7) With respect to health care providers other than hospitals, the Secretary shall ensure coordination of the different programs for payment of such health care providers for adoption or use of health information technology (including certified EHR technology), as well as payments for such health care providers provided under this title or title XVIII, to assure no duplication of funding.

''(8) In carrying out paragraph (5)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State Governments to demonstrate meaningful use of certified EHR technology under this title and title XVIII. In doing so, the Secretary may deem satisfaction of requirements

for such meaningful use for a payment year under title XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

''(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

''(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

''(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

''(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.

''(10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the

Senate on status, progress, and oversight of payments under paragraph (1).''.

(b) IMPLEMENTATION FUNDING.—In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account, $40,000,000 for each of fiscal years 2009 through 2015 and $20,000,000 for each succeeding fiscal year through fiscal year 2019, which shall be available for purposes of carrying out the provisions of (and the amendments made by) this part. Amounts appropriated under this subsection for a fiscal year shall be available until expended.

Subtitle D—Privacy

SEC. 4400. DEFINITIONS.

In this subtitle, except as specified otherwise:

(1) BREACH.—The term ''breach'' means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security, privacy, or integrity of protected health information maintained by or on behalf of a person. Such term does not include any unintentional acquisition, access, use, or disclosure of such information by an employee or agent of the covered entity or

business associate involved if such acquisition, access, use, or disclosure, respectively, was made in good faith and within the course and scope of the employment or other contractual relationship of such employee or agent, respectively, with the covered entity or business associate and if such information is not further acquired, accessed, used, or disclosed by such employee or agent.

(2) BUSINESS ASSOCIATE.—The term ''business associate'' has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations.

(3) COVERED ENTITY.—The term ''covered entity'' has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations.

(4) DISCLOSE.—The terms ''disclose'' and ''disclosure'' have the meaning given the term ''disclosure'' in section 160.103 of title 45, Code of Federal Regulations.

(5) ELECTRONIC HEALTH RECORD.—The term ''electronic health record'' means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

(6) HEALTH CARE OPERATIONS.—The term ''health care operation'' has the meaning given such term in section 164.501 of title 45, Code of Federal Regulations.

(7) HEALTH CARE PROVIDER.—The term ''health care provider'' has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations.

(8) HEALTH PLAN.—The term ''health plan'' has the meaning given such term in section 1171(5) of the Social Security Act.

(9) NATIONAL COORDINATOR.—The term ''National Coordinator'' means the head of the Office of the National Coordinator for Health Information Technology established under section 3001(a) of the Public Health Service Act, as added by section 4101.

(10) PAYMENT.—The term ''payment'' has the meaning given such term in section 164.501 of title 45, Code of Federal Regulations.

(11) PERSONAL HEALTH RECORD.—The term ''personal health record'' means an electronic record of individually identifiable health information on an individual that can be drawn from multiple sources

and that is managed, shared, and controlled by or for the individual.

(12) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations.

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

(14) SECURITY.—The term ''security'' has the meaning given such term in section 164.304 of title 45, Code of Federal Regulations.

(15) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(16) TREATMENT.—The term ''treatment'' has the meaning given such term in section 164.501 of title 45, Code of Federal Regulations.

(17) USE.—The term ''use'' has the meaning given such term in section 160.103 of title 45, Code of Federal Regulations.

(18) VENDOR OF PERSONAL HEALTH RECORDS.—The term ''vendor of personal health records'' means an entity, other than a covered enti-

ty (as defined in paragraph (3)), that offers or maintains a personal health record.

PART I—IMPROVED PRIVACY PROVISIONS AND SECURITY PROVISIONS

SEC. 4401. APPLICATION OF SECURITY PROVISIONS AND PENALTIES TO BUSINESS ASSOCIATES OF COVERED ENTITIES; ANNUAL GUIDANCE ON SECURITY PROVISIONS.

(a) APPLICATION OF SECURITY PROVISIONS.—Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations, shall apply to a business associate of a covered entity in the same manner that such sections apply to the covered entity. The additional requirements of this title that relate to security and that are made applicable with respect to covered entities shall also be applicable to such a business associate and shall be incorporated into the business associate agreement between the business associate and the covered entity.

(b) APPLICATION OF CIVIL AND CRIMINAL PENALTIES.—In the case of a business associate that violates any security provision specified in subsection (a), sections 1176 and 1177 of the Social Security Act (42 U.S.C. 1320d-5, 1320d-6) shall apply to the business associate with respect to such violation in the same manner such

sections apply to a covered entity that violates such security provision.

(c) ANNUAL GUIDANCE.—For the first year beginning after the date of the enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall, in consultation with industry stakeholders, annually issue guidance on the most effective and appropriate technical safeguards for use in carrying out the sections referred to in subsection (a) and the security standards in subpart C of part 164 of title 45, Code of Federal Regulations, as such provisions are in effect as of the date before the enactment of this Act.

SEC. 4402. NOTIFICATION IN THE CASE OF BREACH.

(a) IN GENERAL.—A covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information (as defined in subsection (h)(1)) shall, in the case of a breach of such information that is discovered by the covered entity, notify each individual whose unsecured protected health information has been, or is reasonably believed by the covered entity to have been, accessed, acquired, or disclosed as a result of such breach.

(b) NOTIFICATION OF COVERED ENTITY BY BUSINESS ASSOCIATE.—A business associate of a covered entity that accesses, maintains, retains, modifies, records,

stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, following the discovery of a breach of such information, notify the covered entity of such breach. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the business associate to have been, accessed, acquired, or disclosed during such breach.

(c) BREACHES TREATED AS DISCOVERED.—For purposes of this section, a breach shall be treated as discovered by a covered entity or by a business associate as of the first day on which such breach is known to such entity or associate, respectively, (including any person, other than the individual committing the breach, that is an employee, officer, or other agent of such entity or associate, respectively) or should reasonably have been known to such entity or associate (or person) to have occurred.

(d) TIMELINESS OF NOTIFICATION.—

(1) IN GENERAL.—Subject to subsection (g), all notifications required under this section shall be made without unreasonable delay and in no case later than 60 calendar days after the discovery of a breach by the covered entity involved (or business associate involved in the case of a notification required under subsection (b)).

(2) BURDEN OF PROOF.—The covered entity involved (or business associate involved in the case of a notification required under subsection (b)), shall have the burden of demonstrating that all notifications were made as required under this part, including evidence demonstrating the necessity of any delay.

(e) METHODS OF NOTICE.—

(1) INDIVIDUAL NOTICE.—Notice required under this section to be provided to an individual, with respect to a breach, shall be provided promptly and in the following form:

(A) Written notification by first-class mail to the individual (or the next of kin of the individual if the individual is deceased) at the last known address of the individual or the next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. The notification may be provided in one or more mailings as information is available.

(B) In the case in which there is insufficient, or out-of-date contact information (including a phone number, email address, or any other form of appropriate communication) that precludes direct written (or, if specified by the

individual under subparagraph (A), electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting for a period determined by the Secretary on the home page of the Web site of the covered entity involved or notice in major print or broadcast media, including major media in geographic areas where the individuals affected by the breach likely reside. Such a notice in media or web posting will include a toll-free phone number where an individual can learn whether or not the individual's unsecured protected health information is possibly included in the breach.

(C) In any case deemed by the covered entity involved to require urgency because of possible imminent misuse of unsecured protected health information, the covered entity, in addition to notice provided under subparagraph (A), may provide information to individuals by telephone or other means, as appropriate.

(2) MEDIA NOTICE.—Notice shall be provided to prominent media outlets serving a State or juris-

diction, following the discovery of a breach described in subsection (a), if the unsecured protected health information of more than 500 residents of such State or jurisdiction is, or is reasonably believed to have been, accessed, acquired, or disclosed during such breach.

(3) NOTICE TO SECRETARY.—Notice shall be provided to the Secretary by covered entities of unsecured protected health information that has been acquired or disclosed in a breach. If the breach was with respect to 500 or more individuals than such notice must be provided immediately. If the breach was with respect to less than 500 individuals, the covered entity involved may maintain a log of any such breach occurring and annually submit such a log to the Secretary documenting such breaches occurring during the year involved.

(4) POSTING ON HHS PUBLIC WEBSITE.—The Secretary shall make available to the public on the Internet website of the Department of Health and Human Services a list that identifies each covered entity involved in a breach described in subsection (a) in which the unsecured protected health information of more than 500 individuals is acquired or disclosed.

(f) CONTENT OF NOTIFICATION.—Regardless of the method by which notice is provided to individuals under this section, notice of a breach shall include, to the extent possible, the following:

(1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

(2) A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).

(3) The steps individuals should take to protect themselves from potential harm resulting from the breach.

(4) A brief description of what the covered entity involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.

(5) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

(g) DELAY OF NOTIFICATION AUTHORIZED FOR LAW ENFORCEMENT PURPOSES.—If a law enforcement official

determines that a notification, notice, or posting required under this section would impede a criminal investigation or cause damage to national security, such notification, notice, or posting shall be delayed in the same manner as provided under section 164.528(a)(2) of title 45, Code of Federal Regulations, in the case of a disclosure covered under such section.

(h) UNSECURED PROTECTED HEALTH INFORMATION.—

(1) DEFINITION.—

(A) IN GENERAL.—Subject to subparagraph (B), for purposes of this section, the term ''unsecured protected health information'' means protected health information that is not secured through the use of a technology or methodology specified by the Secretary in the guidance issued under paragraph (2).

(B) EXCEPTION IN CASE TIMELY GUIDANCE NOT ISSUED.—In the case that the Secretary does not issue guidance under paragraph (2) by the date specified in such paragraph, for purposes of this section, the term ''unsecured protected health information'' shall mean protected health information that is not secured by a technology standard that renders protected

health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

(2) GUIDANCE.—For purposes of paragraph (1) and section 407(f)(3), not later than the date that is 60 days after the date of the enactment of this Act, the Secretary shall, after consultation with stakeholders, issue (and annually update) guidance specifying the technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals.

(i) REPORT TO CONGRESS ON BREACHES.—

(1) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act and annually thereafter, the Secretary shall prepare and submit to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the information described in paragraph (2) regard-

ing breaches for which notice was provided to the Secretary under subsection (e)(3).

(2) INFORMATION.—The information described in this paragraph regarding breaches specified in paragraph (1) shall include—

(A) the number and nature of such breaches; and

(B) actions taken in response to such breaches.

(j) REGULATIONS; EFFECTIVE DATE.—To carry out this section, the Secretary of Health and Human Services shall promulgate interim final regulations by not later than the date that is 180 days after the date of the enactment of this title. The provisions of this section shall apply to breaches that are discovered on or after the date that is 30 days after the date of publication of such interim final regulations.

SEC. 4403. EDUCATION ON HEALTH INFORMATION PRIVACY.

(a) REGIONAL OFFICE PRIVACY ADVISORS.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall designate an individual in each regional office of the Department of Health and Human Services to offer guidance and education to covered entities, business associates, and individuals on their

rights and responsibilities related to Federal privacy and security requirements for protected health information.

(b) EDUCATION INITIATIVE ON USES OF HEALTH INFORMATION.—Not later than 12 months after the date of the enactment of this Act, the Office for Civil Rights within the Department of Health and Human Services shall develop and maintain a multi-faceted national education initiative to enhance public transparency regarding the uses of protected health information, including programs to educate individuals about the potential uses of their protected health information, the effects of such uses, and the rights of individuals with respect to such uses. Such programs shall be conducted in a variety of languages and present information in a clear and understandable manner.

SEC. 4404. APPLICATION OF PRIVACY PROVISIONS AND PENALTIES TO BUSINESS ASSOCIATES OF COVERED ENTITIES.

(a) APPLICATION OF CONTRACT REQUIREMENTS.—In the case of a business associate of a covered entity that obtains or creates protected health information pursuant to a written contract (or other written arrangement) described in section 164.502(e)(2) of title 45, Code of Federal Regulations, with such covered entity, the business associate may use and disclose such protected health infor-

mation only if such use or disclosure, respectively, is in compliance with each applicable requirement of section 164.504(e) of such title. The additional requirements of this subtitle that relate to privacy and that are made applicable with respect to covered entities shall also be applicable to such a business associate and shall be incorporated into the business associate agreement between the business associate and the covered entity.

(b) APPLICATION OF KNOWLEDGE ELEMENTS ASSOCIATED WITH CONTRACTS.—Section 164.504(e)(1)(ii) of title 45, Code of Federal Regulations, shall apply to a business associate described in subsection (a), with respect to compliance with such subsection, in the same manner that such section applies to a covered entity, with respect to compliance with the standards in sections 164.502(e) and 164.504(e) of such title, except that in applying such section 164.504(e)(1)(ii) each reference to the business associate, with respect to a contract, shall be treated as a reference to the covered entity involved in such contract.

(c) APPLICATION OF CIVIL AND CRIMINAL PENALTIES.—In the case of a business associate that violates any provision of subsection (a) or (b), the provisions of sections 1176 and 1177 of the Social Security Act (42 U.S.C. 1320d-5, 1320d-6) shall apply to the business associate with respect to such violation in the same manner

as such provisions apply to a person who violates a provision of part C of title XI of such Act.

SEC. 4405. RESTRICTIONS ON CERTAIN DISCLOSURES AND SALES OF HEALTH INFORMATION; ACCOUNTING OF CERTAIN PROTECTED HEALTH INFORMATION DISCLOSURES; ACCESS TO CERTAIN INFORMATION IN ELECTRONIC FORMAT.

(a) REQUESTED RESTRICTIONS ON CERTAIN DISCLOSURES OF HEALTH INFORMATION.—In the case that an individual requests under paragraph (a)(1)(i)(A) of section 164.522 of title 45, Code of Federal Regulations, that a covered entity restrict the disclosure of the protected health information of the individual, notwithstanding paragraph (a)(1)(ii) of such section, the covered entity must comply with the requested restriction if—

(1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and

(2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

(b) DISCLOSURES REQUIRED TO BE LIMITED TO THE LIMITED DATA SET OR THE MINIMUM NECESSARY.—

(1) IN GENERAL.—

(A) IN GENERAL.—Subject to subparagraph (B), a covered entity shall be treated as being in compliance with section 164.502(b)(1) of title 45, Code of Federal Regulations, with respect to the use, disclosure, or request of protected health information described in such section, only if the covered entity limits such protected health information, to the extent practicable, to the limited data set (as defined in section 164.514(e)(2) of such title) or, if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, respectively.

(B) GUIDANCE.—Not later than 18 months after the date of the enactment of this section, the Secretary shall issue guidance on what constitutes ''minimum necessary'' for purposes of subpart E of part 164 of title 45, Code of Federal Regulation. In issuing such guidance the Secretary shall take into consideration the guidance under section 4424(c).

(C) SUNSET.—Subparagraph (A) shall not apply on and after the effective date on which the Secretary issues the guidance under subparagraph (B).

(2) DETERMINATION OF MINIMUM NECESSARY.—For purposes of paragraph (1), in the case of the disclosure of protected health information, the covered entity or business associate disclosing such information shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure.

(3) APPLICATION OF EXCEPTIONS.—The exceptions described in section 164.502(b)(2) of title 45, Code of Federal Regulations, shall apply to the requirement under paragraph (1) as of the effective date described in section 4423 in the same manner that such exceptions apply to section 164.502(b)(1) of such title before such date.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the use, disclosure, or request of protected health information that has been de-identified.

(c) ACCOUNTING OF CERTAIN PROTECTED HEALTH INFORMATION DISCLOSURES REQUIRED IF COVERED ENTITY USES ELECTRONIC HEALTH RECORD.—

(1) IN GENERAL.—In applying section 164.528 of title 45, Code of Federal Regulations, in the case that a covered entity uses or maintains an electronic health record with respect to protected health information—

(A) the exception under paragraph (a)(1)(i) of such section shall not apply to disclosures through an electronic health record made by such entity of such information; and

(B) an individual shall have a right to receive an accounting of disclosures described in such paragraph of such information made by such covered entity during only the three years prior to the date on which the accounting is requested.

(2) REGULATIONS.—The Secretary shall promulgate regulations on what information shall be collected about each disclosure referred to in paragraph (1)(A) not later than 18 months after the date on which the Secretary adopts standards on accounting for disclosure described in the section 3002(b)(2)(B)(iv) of the Public Health Service Act, as added by section 4101. Such regulations shall only require such information to be collected through an electronic health record in a manner that takes

into account the interests of individuals in learning the circumstances under which their protected health information is being disclosed and takes into account the administrative burden of accounting for such disclosures.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a covered entity to account for disclosures of protected health information that are not made by such covered entity or by a business associate acting on behalf of the covered entity.

(4) EFFECTIVE DATE.—

(A) CURRENT USERS OF ELECTRONIC RECORDS.—In the case of a covered entity insofar as it acquired an electronic health record as of January 1, 2009, paragraph (1) shall apply to disclosures, with respect to protected health information, made by the covered entity from such a record on and after January 1, 2014.

(B) OTHERS.—In the case of a covered entity insofar as it acquires an electronic health record after January 1, 2009, paragraph (1) shall apply to disclosures, with respect to protected health information, made by the covered

entity from such record on and after the later of the following:

(i) January 1, 2011; or

(ii) the date that it acquires an electronic health record.

(d) REVIEW OF HEALTH CARE OPERATIONS.—Not later than 18 months after the date of the enactment of this title, the Secretary shall promulgate regulations to eliminate from the definition of health care operations under section 164.501 of title 45, Code of Federal Regulations, those activities that can reasonably and efficiently be conducted through the use of information that is de-identified (in accordance with the requirements of section 164.514(b) of such title) or that should require a valid authorization for use or disclosure. In promulgating such regulations, the Secretary may choose to narrow or clarify activities that the Secretary chooses to retain in the definition of health care operations and the Secretary shall take into account the report under section 424(d). In such regulations the Secretary shall specify the date on which such regulations shall apply to disclosures made by a covered entity, but in no case would such date be sooner than the date that is 24 months after the date of the enactment of this section.

(e) PROHIBITION ON SALE OF ELECTRONIC HEALTH RECORDS OR PROTECTED HEALTH INFORMATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), a covered entity or business associate shall not directly or indirectly receive remuneration in exchange for any protected health information of an individual unless the covered entity obtained from the individual, in accordance with section 164.508 of title 45, Code of Federal Regulations, a valid authorization that includes, in accordance with such section, a specification of whether the protected health information can be further exchanged for remuneration by the entity receiving protected health information of that individual.

(2) EXCEPTIONS.—Paragraph (1) shall not apply in the following cases:

(A) The purpose of the exchange is for research or public health activities (as described in sections 164.501, 164.512(i), and 164.512(b) of title 45, Code of Federal Regulations) and the price charged reflects the costs of preparation and transmittal of the data for such purpose.

(B) The purpose of the exchange is for the treatment of the individual and the price

charges reflects not more than the costs of preparation and transmittal of the data for such purpose.

(C) The purpose of the exchange is the health care operation specifically described in subparagraph (iv) of paragraph (6) of the definition of health care operations in section 164.501 of title 45, Code of Federal Regulations.

(D) The purpose of the exchange is for remuneration that is provided by a covered entity to a business associate for activities involving the exchange of protected health information that the business associate undertakes on behalf of and at the specific request of the covered entity pursuant to a business associate agreement.

(E) The purpose of the exchange is to provide an individual with a copy of the individual's protected health information pursuant to section 164.524 of title 45, Code of Federal Regulations.

(F) The purpose of the exchange is otherwise determined by the Secretary in regulations to be similarly necessary and appropriate as the

exceptions provided in subparagraphs (A) through (E).

(3) REGULATIONS.—The Secretary shall promulgate regulations to carry out paragraph (this subsection, including exceptions described in paragraph (2), not later than 18 months after the date of the enactment of this title.

(4) EFFECTIVE DATE.—Paragraph (1) shall apply to exchanges occurring on or after the date that is 6 months after the date of the promulgation of final regulations implementing this subsection.

(f) ACCESS TO CERTAIN INFORMATION IN ELECTRONIC FORMAT.—In applying section 164.524 of title 45, Code of Federal Regulations, in the case that a covered entity uses or maintains an electronic health record with respect to protected health information of an individual—

(1) the individual shall have a right to obtain from such covered entity a copy of such information in an electronic format; and

(2) notwithstanding paragraph (c)(4) of such section, any fee that the covered entity may impose for providing such individual with a copy of such information (or a summary or explanation of such information) if such copy (or summary or explanation)

is in an electronic form shall not be greater than the entity's labor costs in responding to the request for the copy (or summary or explanation).

SEC. 4406. CONDITIONS ON CERTAIN CONTACTS AS PART OF HEALTH CARE OPERATIONS.

(a) MARKETING.—

(1) IN GENERAL.—A communication by a covered entity or business associate that is about a product or service and that encourages recipients of the communication to purchase or use the product or service shall not be considered a health care operation for purposes of subpart E of part 164 of title 45, Code of Federal Regulations, unless the communication is made as described in subparagraph (i), (ii), or (iii) of paragraph (1) of the definition of marketing in section 164.501 of such title.

(2) PAYMENT FOR CERTAIN COMMUNICATIONS.—A covered entity or business associate may not receive direct or indirect payment in exchange for making any communication described in subparagraph (i), (ii), or (iii) of paragraph (1) of the definition of marketing in section 164.501 of title 45, Code of Federal Regulations, except—

(A) a business associate of a covered entity may receive payment from the covered entity

for making any such communication on behalf of the covered entity that is consistent with the written contract (or other written arrangement) described in section 164.502(e)(2) of such title between such business associate and covered entity; or

(B) a covered entity may receive payment in exchange for making any such communication if the entity obtains from the recipient of the communication, in accordance with section 164.508 of title 45, Code of Federal Regulations, a valid authorization (as described in paragraph (b) of such section) with respect to such communication.

(b) FUNDRAISING.—Fundraising for the benefit of a covered entity shall not be considered a health care operation for purposes of section 164.501 of title 45, Code of Federal Regulations.

(c) EFFECTIVE DATE.—This section shall apply to contracting occurring on or after the effective date specified under section 4423.

SEC. 4407. TEMPORARY BREACH NOTIFICATION REQUIREMENT FOR VENDORS OF PERSONAL HEALTH RECORDS AND OTHER NON-HIPAA COVERED ENTITIES.

(a) IN GENERAL.—In accordance with subsection (c), each vendor of personal health records, following the discovery of a breach of security of unsecured PHR identifiable health information that is in a personal health record maintained or offered by such vendor, and each entity described in clause (ii) or (iii) of section 4424(b)(1)(A), following the discovery of a breach of security of such information that is obtained through a product or service provided by such entity, shall—

(1) notify each individual who is a citizen or resident of the United States whose unsecured PHR identifiable health information was acquired by an unauthorized person as a result of such a breach of security; and

(2) notify the Federal Trade Commission.

(b) NOTIFICATION BY THIRD PARTY SERVICE PROVIDERS.—A third party service provider that provides services to a vendor of personal health records or to an entity described in clause (ii) or (iii) of section 4424(b)(1)(A) in connection with the offering or maintenance of a personal health record or a related product or service and that accesses, maintains, retains, modifies,

records, stores, destroys, or otherwise holds, uses, or discloses unsecured PHR identifiable health information in such a record as a result of such services shall, following the discovery of a breach of security of such information, notify such vendor or entity, respectively, of such breach. Such notice shall include the identification of each individual whose unsecured PHR identifiable health information has been, or is reasonably believed to have been, accessed, acquired, or disclosed during such breach.

(c) APPLICATION OF REQUIREMENTS FOR TIMELINESS, METHOD, AND CONTENT OF NOTIFICATIONS.—Subsections (c), (d), (e), and (f) of section 402 shall apply to a notification required under subsection (a) and a vendor of personal health records, an entity described in subsection (a) and a third party service provider described in subsection (b), with respect to a breach of security under subsection (a) of unsecured PHR identifiable health information in such records maintained or offered by such vendor, in a manner specified by the Federal Trade Commission.

(d) NOTIFICATION OF THE SECRETARY.—Upon receipt of a notification of a breach of security under subsection (a)(2), the Federal Trade Commission shall notify the Secretary of such breach.

(e) ENFORCEMENT.—A violation of subsection (a) or (b) shall be treated as an unfair and deceptive act or practice in violation of a regulation under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57*a*(a)(1)(B)) regarding unfair or deceptive acts or practices.

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

(1) BREACH OF SECURITY.—The term ''breach of security'' means, with respect to unsecured PHR identifiable health information of an individual in a personal health record, acquisition of such information without the authorization of the individual.

(2) PHR IDENTIFIABLE HEALTH INFORMATION.—The term ''PHR identifiable health information'' means individually identifiable health information, as defined in section 1171(6) of the Social Security Act (42 U.S.C. 1320d(6)), and includes, with respect to an individual, information—

(A) that is provided by or on behalf of the individual; and

(B) that identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

(3) UNSECURED PHR IDENTIFIABLE HEALTH INFORMATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''unsecured PHR identifiable health information'' means PHR identifiable health information that is not protected through the use of a technology or methodology specified by the Secretary in the guidance issued under section 4402(h)(2).

(B) EXCEPTION IN CASE TIMELY GUIDANCE NOT ISSUED.—In the case that the Secretary does not issue guidance under section 4402(h)(2) by the date specified in such section, for purposes of this section, the term ''unsecured PHR identifiable health information'' shall mean PHR identifiable health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and that is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

(g) REGULATIONS; EFFECTIVE DATE; SUNSET.—

(1) REGULATIONS; EFFECTIVE DATE.—To carry out this section, the Secretary of Health and Human Services shall promulgate interim final regulations by not later than the date that is 180 days after the date of the enactment of this section. The provisions of this section shall apply to breaches of security that are discovered on or after the date that is 30 days after the date of publication of such interim final regulations.

(2) SUNSET.—The provisions of this section shall not apply to breaches of security occurring on or after the earlier of the following the dates:

(A) The date on which a standard relating to requirements for entities that are not covered entities that includes requirements relating to breach notification has been promulgated by the Secretary.

(B) The date on which a standard relating to requirements for entities that are not covered entities that includes requirements relating to breach notification has been promulgated by the Federal Trade Commission and has taken effect.

SEC. 4408. BUSINESS ASSOCIATE CONTRACTS REQUIRED FOR CERTAIN ENTITIES.

Each organization, with respect to a covered entity, that provides data transmission of protected health information to such entity (or its business associate) and that requires access on a routine basis to such protected health information, such as a Health Information Exchange Organization, Regional Health Information Organization, E-prescribing Gateway, or each vendor that contracts with a covered entity to allow that covered entity to offer a personal health record to patients as part of its electronic health record, is required to enter into a written contract (or other written arrangement) described in section 164.502(e)(2) of title 45, Code of Federal Regulations and a written contract (or other arrangement) described in section 164.308(b) of such title, with such entity and shall be treated as a business associate of the covered entity for purposes of the provisions of this subtitle and subparts C and E of part 164 of title 45, Code of Federal Regulations, as such provisions are in effect as of the date of enactment of this title.

SEC. 4409. CLARIFICATION OF APPLICATION OF WRONGFUL DISCLOSURES CRIMINAL PENALTIES.

Section 1177(a) of the Social Security Act (42 U.S.C. 1320d–6(a)) is amended by adding at the end the following new sentence: ''For purposes of the previous sen-

tence, a person (including an employee or other individual) shall be considered to have obtained or disclosed individually identifiable health information in violation of this part if the information is maintained by a covered entity (as defined in the HIPAA privacy regulation described in section 1180(b)(3)) and the individual obtained or disclosed such information without authorization.''.

SEC. 4410. IMPROVED ENFORCEMENT.

(a) IN GENERAL.—Section 1176 of the Social Security Act (42 U.S.C. 1320d-5) is amended—

(1) in subsection (b)(1), by striking ''the act constitutes an offense punishable under section 1177'' and inserting ''a penalty has been imposed under section 1177 with respect to such act''; and

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

''(c) NONCOMPLIANCE DUE TO WILLFUL NEGLECT.—

''(1) IN GENERAL.—A violation of a provision of this part due to willful neglect is a violation for which the Secretary is required to impose a penalty under subsection (a)(1).

''(2) REQUIRED INVESTIGATION.—For purposes of paragraph (1), the Secretary shall formally investigate any complaint of a violation of a provision of

this part if a preliminary investigation of the facts of the complaint indicate such a possible violation due to willful neglect.''.

(b) EFFECTIVE DATE; REGULATIONS.—

(1) The amendments made by subsection (a) shall apply to penalties imposed on or after the date that is 24 months after the date of the enactment of this title.

(2) Not later than 18 months after the date of the enactment of this title, the Secretary of Health and Human Services shall promulgate regulations to implement such amendments.

(c) DISTRIBUTION OF CERTAIN CIVIL MONETARY PENALTIES COLLECTED.—

(1) IN GENERAL.—Subject to the regulation promulgated pursuant to paragraph (3), any civil monetary penalty or monetary settlement collected with respect to an offense punishable under this subtitle or section 1176 of the Social Security Act (42 U.S.C. 1320d-5) insofar as such section relates to privacy or security shall be transferred to the Office of Civil Rights of the Department of Health and Human Services to be used for purposes of enforcing the provisions of this subtitle and subparts C and E of part 164 of title 45, Code of Federal Regulations,

as such provisions are in effect as of the date of enactment of this Act.

(2) GAO REPORT.—Not later than 18 months after the date of the enactment of this title, the Comptroller General shall submit to the Secretary a report including recommendations for a methodology under which an individual who is harmed by an act that constitutes an offense referred to in paragraph (1) may receive a percentage of any civil monetary penalty or monetary settlement collected with respect to such offense.

(3) ESTABLISHMENT OF METHODOLOGY TO DISTRIBUTE PERCENTAGE OF CMPS COLLECTED TO HARMED INDIVIDUALS.—Not later than 3 years after the date of the enactment of this title, the Secretary shall establish by regulation and based on the recommendations submitted under paragraph (2), a methodology under which an individual who is harmed by an act that constitutes an offense referred to in paragraph (1) may receive a percentage of any civil monetary penalty or monetary settlement collected with respect to such offense.

(4) APPLICATION OF METHODOLOGY.—The methodology under paragraph (3) shall be applied with respect to civil monetary penalties or monetary

settlements imposed on or after the effective date of the regulation.

(d) TIERED INCREASE IN AMOUNT OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1176(a)(1) of the Social Security Act (42 U.S.C. 1320d-5(a)(1)) is amended by striking ''who violates a provision of this part a penalty of not more than'' and all that follows and inserting the following: ''who violates a provision of this part—

''(A) in the case of a violation of such provision in which it is established that the person did not know (and by exercising reasonable diligence would not have known) that such person violated such provision, a penalty for each such violation of an amount that is at least the amount described in paragraph (3)(A) but not to exceed the amount described in paragraph (3)(D);

''(B) in the case of a violation of such provision in which it is established that the violation was due to reasonable cause and not to willful neglect, a penalty for each such violation of an amount that is at least the amount de-

scribed in paragraph (3)(B) but not to exceed the amount described in paragraph (3)(D); and

''(C) in the case of a violation of such provision in which it is established that the violation was due to willful neglect—

''(i) if the violation is corrected as described in subsection (b)(3)(A), a penalty in an amount that is at least the amount described in paragraph (3)(C) but not to exceed the amount described in paragraph (3)(D); and

''(ii) if the violation is not corrected as described in such subsection, a penalty in an amount that is at least the amount described in paragraph (3)(D).

In determining the amount of a penalty under this section for a violation, the Secretary shall base such determination on the nature and extent of the violation and the nature and extent of the harm resulting from such violation.''.

(2) TIERS OF PENALTIES DESCRIBED.—Section 1176(a) of such Act (42 U.S.C. 1320d-5(a)) is further amended by adding at the end the following new paragraph:

''(3) TIERS OF PENALTIES DESCRIBED.—For purposes of paragraph (1), with respect to a violation by a person of a provision of this part—

''(A) the amount described in this subparagraph is $100 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $25,000;

''(B) the amount described in this subparagraph is $1,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $100,000;

''(C) the amount described in this subparagraph is $10,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical requirement or prohibition during a calendar year may not exceed $250,000; and

''(D) the amount described in this subparagraph is $50,000 for each such violation, except that the total amount imposed on the person for all such violations of an identical re-

quirement or prohibition during a calendar year may not exceed $1,500,000.''.

(3) CONFORMING AMENDMENTS.—Section 1176(b) of such Act (42 U.S.C. 1320d-5(b)) is amended—

(A) by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively; and

(B) in paragraph (2), as so redesignated—

(i) in subparagraph (A), by striking ''in subparagraph (B), a penalty may not be imposed under subsection (a) if'' and all that follows through ''the failure to comply is corrected'' and inserting ''in subparagraph (B) or subsection (a)(1)(C), a penalty may not be imposed under subsection (a) if the failure to comply is corrected''; and

(ii) in subparagraph (B), by striking ''(A)(ii)'' and inserting ''(A)'' each place it appears.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to violations occurring after the date of the enactment of this title.

(e) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—

(1) IN GENERAL.—Section 1176 of the Social Security Act (42 U.S.C. 1320d–5) is amended by adding at the end the following new subsection:

''(e) ENFORCEMENT BY STATE ATTORNEYS GENERAL.—

''(1) CIVIL ACTION.—Except as provided in subsection (b), in any case in which the attorney general of a State has reason to believe that an interest of one or more of the residents of that State has been or is threatened or adversely affected by any person who violates a provision of this part, the attorney general of the State, as parens patriae, may bring a civil action on behalf of such residents of the State in a district court of the United States of appropriate jurisdiction—

''(A) to enjoin further such violation by the defendant; or

''(B) to obtain damages on behalf of such residents of the State, in an amount equal to the amount determined under paragraph (2).

''(2) STATUTORY DAMAGES.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the amount determined under

this paragraph is the amount calculated by multiplying the number of violations by up to $100. For purposes of the preceding sentence, in the case of a continuing violation, the number of violations shall be determined consistent with the HIPAA privacy regulations (as defined in section 1180(b)(3)) for violations of subsection (a).

''(B) LIMITATION.—The total amount of damages imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

''(C) REDUCTION OF DAMAGES.—In assessing damages under subparagraph (A), the court may consider the factors the Secretary may consider in determining the amount of a civil money penalty under subsection (a) under the HIPAA privacy regulations.

''(3) ATTORNEY FEES.—In the case of any successful action under paragraph (1), the court, in its discretion, may award the costs of the action and reasonable attorney fees to the State.

''(4) NOTICE TO SECRETARY.—The State shall serve prior written notice of any action under paragraph (1) upon the Secretary and provide the Sec-

retary with a copy of its complaint, except in any case in which such prior notice is not feasible, in which case the State shall serve such notice immediately upon instituting such action. The Secretary shall have the right—

''(A) to intervene in the action;

''(B) upon so intervening, to be heard on all matters arising therein; and

''(C) to file petitions for appeal.

''(5) CONSTRUCTION.—For purposes of bringing any civil action under paragraph (1), nothing in this section shall be construed to prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of that State.

''(6) VENUE; SERVICE OF PROCESS.—

''(A) VENUE.—Any action brought under paragraph (1) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.

''(B) SERVICE OF PROCESS.—In an action brought under paragraph (1), process may be served in any district in which the defendant—

''(i) is an inhabitant; or

''(ii) maintains a physical place of business.

''(7) LIMITATION ON STATE ACTION WHILE FEDERAL ACTION IS PENDING.—If the Secretary has instituted an action against a person under subsection (a) with respect to a specific violation of this part, no State attorney general may bring an action under this subsection against the person with respect to such violation during the pendency of that action.

''(8) APPLICATION OF CMP STATUTE OF LIMITATION.—A civil action may not be instituted with respect to a violation of this part unless an action to impose a civil money penalty may be instituted under subsection (a) with respect to such violation consistent with the second sentence of section 1128A(c)(1).''.

(2) CONFORMING AMENDMENTS.—Subsection (b) of such section, as amended by subsection (d)(3), is amended—

(A) in paragraph (1), by striking ''A penalty may not be imposed under subsection (a)'' and inserting ''No penalty may be imposed under subsection (a) and no damages obtained under subsection (c)'';

(B) in paragraph (2)(A)—

(i) in the matter before clause (i), by striking ''a penalty may not be imposed under subsection (a)'' and inserting ''no penalty may be imposed under subsection (a) and no damages obtained under subsection (c)''; and

(ii) in clause (ii), by inserting ''or damages'' after ''the penalty'';

(C) in paragraph (2)(B)(i), by striking ''The period'' and inserting ''With respect to the imposition of a penalty by the Secretary under subsection (a), the period''; and

(D) in paragraph (3), by inserting ''and any damages under subsection (c)'' after ''any penalty under subsection (a)''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to violations occurring after the date of the enactment of this Act.

(f) ALLOWING CONTINUED USE OF CORRECTIVE ACTION.—Such section is further amended by adding at the end the following new subsection:

''(d) ALLOWING CONTINUED USE OF CORRECTIVE ACTION.—Nothing in this section shall be construed as preventing the Office of Civil Rights of the Department

of Health and Human Services from continuing, in its discretion, to use corrective action without a penalty in cases where the person did not know (and by exercising reasonable diligence would not have known) of the violation involved.''.

SEC. 4411. AUDITS.

The Secretary shall provide for periodic audits to ensure that covered entities and business associates that are subject to the requirements of this subtitle and subparts C and E of part 164 of title 45, Code of Federal Regulations, as such provisions are in effect as of the date of enactment of this Act, comply with such requirements.

SEC. 4412. SECURING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

Notwithstanding the previous provisions of this title, a covered entity or business associate must use a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute to secure individually identifiable health information that is transmitted in the nationwide health information network supported in this title or physically transported outside of a covered entity's or business associate's secured, physical perimeter, including in-

formation transported on removable media and on portable devices. The Secretary may establish implementation criteria such that smaller covered entities with fewer resources are granted a longer period of time to comply with these requirements.

SEC. 4413. SPECIAL RULE FOR INFORMATION TO REDUCE MEDICATION ERRORS AND IMPROVE PATIENT SAFETY.

Nothing under this subtitle shall prevent a pharmacist from collecting and sharing information with patients in order to reduce medication errors and improve patient safety as long as any renumeration received for making such communication is reasonable and cost-based. Within 180 days of the date of the enactment of this Act, the Secretary shall promulgate regulations implementing this section.

PART II—RELATIONSHIP TO OTHER LAWS; REGULATORY REFERENCES; EFFECTIVE DATE; REPORTS

SEC. 4421. RELATIONSHIP TO OTHER LAWS.

(a) APPLICATION OF HIPAA STATE PREEMPTION.—Section 1178 of the Social Security Act (42 U.S.C. 1320d–7) shall apply to a provision or requirement under this subtitle in the same manner that such section applies to a provision or requirement under part C of title XI of

such Act or a standard or implementation specification adopted or established under sections 1172 through 1174 of such Act.

(b) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.—The standards governing the privacy and security of individually identifiable health information promulgated by the Secretary under sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 shall remain in effect to the extent that they are consistent with this subtitle. The Secretary shall by rule amend such Federal regulations as required to make such regulations consistent with this subtitle.

SEC. 4422. REGULATORY REFERENCES.

Each reference in this subtitle to a provision of the Code of Federal Regulations refers to such provision as in effect on the date of the enactment of this title (or to the most recent update of such provision).

SEC. 4423. EFFECTIVE DATE.

Except as otherwise specifically provided, the provisions of part I shall take effect on the date that is 12 months after the date of the enactment of this title.

SEC. 4424. STUDIES, REPORTS, GUIDANCE.

(a) REPORT ON COMPLIANCE.—

(1) IN GENERAL.—For the first year beginning after the date of the enactment of this Act and annually thereafter, the Secretary shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report concerning complaints of alleged violations of law, including the provisions of this subtitle as well as the provisions of subparts C and E of part 164 of title 45, Code of Federal Regulations, (as such provisions are in effect as of the date of enactment of this Act) relating to privacy and security of health information that are received by the Secretary during the year for which the report is being prepared. Each such report shall include, with respect to such complaints received during the year—

(A) the number of such complaints;

(B) the number of such complaints resolved informally, a summary of the types of such complaints so resolved, and the number of covered entities that received technical assistance from the Secretary during such year in order to achieve compliance with such provi-

sions and the types of such technical assistance provided;

(C) the number of such complaints that have resulted in the imposition of civil monetary penalties or have been resolved through monetary settlements, including the nature of the complaints involved and the amount paid in each penalty or settlement;

(D) the number of compliance reviews conducted and the outcome of each such review;

(E) the number of subpoenas or inquiries issued;

(F) the Secretary's plan for improving compliance with and enforcement of such provisions for the following year; and

(G) the number of audits performed and a summary of audit findings pursuant to section 4411.

(2) AVAILABILITY TO PUBLIC.—Each report under paragraph (1) shall be made available to the public on the Internet website of the Department of Health and Human Services.

(b) STUDY AND REPORT ON APPLICATION OF PRIVACY AND SECURITY REQUIREMENTS TO NON-HIPAA COVERED ENTITIES.—

(1) STUDY.—Not later than one year after the date of the enactment of this title, the Secretary, in consultation with the Federal Trade Commission, shall conduct a study, and submit a report under paragraph (2), on privacy and security requirements for entities that are not covered entities or business associates as of the date of the enactment of this title, including—

(A) requirements relating to security, privacy, and notification in the case of a breach of security or privacy (including the applicability of an exemption to notification in the case of individually identifiable health information that has been rendered unusable, unreadable, or indecipherable through technologies or methodologies recognized by appropriate professional organization or standard setting bodies to provide effective security for the information) that should be applied to—

(i) vendors of personal health records;

(ii) entities that offer products or services through the website of a vendor of personal health records;

(iii) entities that are not covered entities and that offer products or services

through the websites of covered entities that offer individuals personal health records;

(iv) entities that are not covered entities and that access information in a personal health record or send information to a personal health record; and

(v) third party service providers used by a vendor or entity described in clause (i), (ii), (iii), or (iv) to assist in providing personal health record products or services;

(B) a determination of which Federal government agency is best equipped to enforce such requirements recommended to be applied to such vendors, entities, and service providers under subparagraph (A); and

(C) a timeframe for implementing regulations based on such findings.

(2) REPORT.—The Secretary shall submit to the Committee on Finance, the Committee on Health, Education, Labor, and Pensions, and the Committee on Commerce of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report on the findings of the study

under paragraph (1) and shall include in such report recommendations on the privacy and security requirements described in such paragraph.

(c) GUIDANCE ON IMPLEMENTATION SPECIFICATION TO DE-IDENTIFY PROTECTED HEALTH INFORMATION.—Not later than 12 months after the date of the enactment of this title, the Secretary shall, in consultation with stakeholders, issue guidance on how best to implement the requirements for the de-identification of protected health information under section 164.514(b) of title 45, Code of Federal Regulations.

(d) GAO REPORT ON TREATMENT DISCLOSURES.—Not later than one year after the date of the enactment of this title, the Comptroller General of the United States shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report on the best practices related to the disclosure among health care providers of protected health information of an individual for purposes of treatment of such individual. Such report shall include an examination of the best practices implemented by States and by other entities, such as health information exchanges and regional health information organizations, an examination of the extent to which such

best practices are successful with respect to the quality of the resulting health care provided to the individual and with respect to the ability of the health care provider to manage such best practices, and an examination of the use of electronic informed consent for disclosing protected health information for treatment, payment, and health care operations.

TITLE V—MEDICAID PROVISIONS

SEC. 5000. TABLE OF CONTENTS OF TITLE.

The table of contents of this title is as follows:

SEC. 5001. TEMPORARY INCREASE OF MEDICAID FMAP.

(a) PERMITTING MAINTENANCE OF FMAP.—Subject to subsections (e), (f), and (g), if the FMAP determined without regard to this section for a State for—

(1) fiscal year 2009 is less than the FMAP as so determined for fiscal year 2008, the FMAP for the State for fiscal year 2008 shall be substituted for the State's FMAP for fiscal year 2009, before the application of this section;

(2) fiscal year 2010 is less than the FMAP as so determined for fiscal year 2008 or fiscal year 2009 (after the application of paragraph (1)), the greater of such FMAP for the State for fiscal year 2008 or fiscal year 2009 shall be substituted for the State's FMAP for fiscal year 2010, before the application of this section; and

(3) fiscal year 2011 is less than the FMAP as so determined for fiscal year 2008, fiscal year 2009 (after the application of paragraph (1)), or fiscal year 2010 (after the application of paragraph (2)), the greatest of such FMAP for the State for fiscal year 2008, fiscal year 2009, or fiscal year 2010 shall be substituted for the State's FMAP for fiscal year 2011, before the application of this section, but only for the first calendar quarter in fiscal year 2011.

(b) GENERAL 4.9 PERCENTAGE POINT INCREASE.—

(1) IN GENERAL.—Subject to subsections (e), (f), and (g) and paragraph (2), for each State for calendar quarters during the recession adjustment period (as defined in subsection (h)(2)), the FMAP (after the application of subsection (a)) shall be increased (without regard to any limitation otherwise specified in section 1905(b) of the Social Security Act) by 4.9 percentage points.

(2) SPECIAL ELECTION FOR TERRITORIES.—In the case of a State that is not one of the 50 States or the District of Columbia, paragraph (1) shall only apply if the State makes a one-time election, in a form and manner specified by the Secretary and for the entire recession adjustment period, to apply the increase in FMAP under paragraph (1) and a 10 percent increase under subsection (d) instead of applying a 20 percent increase under subsection (d).

(c) ADDITIONAL ADJUSTMENT TO REFLECT INCREASE IN UNEMPLOYMENT.—

(1) IN GENERAL.—Subject to subsections (e), (f), and (g), in the case of a State that is a high unemployment State (as defined in paragraph (2)) for a calendar quarter during the recession adjustment period, the FMAP (taking into account the application of subsections (a) and (b)) for such quarter shall be further increased by the high unemployment percentage point adjustment specified in paragraph (3) for the State for the quarter.

(2) HIGH UNEMPLOYMENT STATE.—

(A) IN GENERAL.—In this subsection, subject to subparagraph (B), the term ''high unemployment State'' means, with respect to a calendar quarter in the recession adjustment pe-

riod, a State that is 1 of the 50 States or the District of Columbia and for which the State unemployment increase percentage (as computed under paragraph (5)) for the quarter is not less than 1.5 percentage points.

(B) MAINTENANCE OF STATUS.—If a State is a high unemployment State for a calendar quarter, it shall remain a high unemployment State for each subsequent calendar quarter ending before July 1, 2010.

(3) HIGH UNEMPLOYMENT PERCENTAGE POINT ADJUSTMENT.—

(A) IN GENERAL.—The high unemployment percentage point adjustment specified in this paragraph for a high unemployment State for a quarter is equal to the product of—

(i) the SMAP for such State and quarter (determined after the application of subsection (a) and before the application of subsection (b)); and

(ii) subject to subparagraph (B), the State unemployment reduction factor specified in paragraph (4) for the State and quarter.

(B) MAINTENANCE OF ADJUSTMENT LEVEL FOR CERTAIN QUARTERS.—In no case shall the State unemployment reduction factor applied under subparagraph (A)(ii) for a State for a quarter (beginning on or after January 1, 2009, and ending before July 1, 2010) be less than the State unemployment reduction factor applied to the State for the previous quarter (taking into account the application of this subparagraph).

(4) STATE UNEMPLOYMENT REDUCTION FACTOR.—In the case of a high unemployment State for which the State unemployment increase percentage (as computed under paragraph (5)) with respect to a calendar quarter is—

(A) not less than 1.5, but is less than 2.5, percentage points, the State unemployment reduction factor for the State and quarter is 6 percent;

(B) not less than 2.5, but is less than 3.5, percentage points, the State unemployment reduction factor for the State and quarter is 12 percent; or

(C) not less than 3.5 percentage points, the State unemployment reduction factor for the State and quarter is 14 percent.

(5) COMPUTATION OF STATE UNEMPLOYMENT INCREASE PERCENTAGE.—

(A) IN GENERAL.—In this subsection, the ''State unemployment increase percentage'' for a State for a calendar quarter is equal to the number of percentage points (if any) by which—

(i) the average monthly unemployment rate for the State for months in the most recent previous 3-consecutive-month period for which data are available, subject to subparagraph (C); exceeds

(ii) the lowest average monthly unemployment rate for the State for any 3-consecutive-month period preceding the period described in clause (i) and beginning on or after January 1, 2006.

(B) AVERAGE MONTHLY UNEMPLOYMENT RATE DEFINED.—In this paragraph, the term ''average monthly unemployment rate'' means the average of the monthly number unemployed, divided by the average of the monthly civilian

labor force, seasonally adjusted, as determined based on the most recent monthly publications of the Bureau of Labor Statistics of the Department of Labor.

(C) SPECIAL RULE.—With respect to—

(i) the first 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in subparagraph (A)(i) shall be the 3-consecutive-month period beginning with October 2008; and

(ii) the last 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in such subparagraph shall be the 3-consecutive-month period beginning with December 2009.

(d) INCREASE IN CAP ON MEDICAID PAYMENTS TO TERRITORIES.—Subject to subsections (f) and (g) , with respect to entire fiscal years occurring during the recession adjustment period and with respect to fiscal years only a portion of which occurs during such period (and in proportion to the portion of the fiscal year that occurs during such period), the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mar-

iana Islands, and American Samoa under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) shall each be increased by 20 percent (or, in the case of an election under subsection (b)(2), 10 percent).

(e) SCOPE OF APPLICATION.—The increases in the FMAP for a State under this section shall apply for purposes of title XIX of the Social Security Act and—

(1) the increases applied under subsections (a), (b), and (c) shall not apply with respect—

(A) to payments under parts A, B, and D of title IV or title XXI of such Act (42 U.S.C. 601 et seq. and 1397aa et seq.);

(B) to payments under title XIX of such Act that are based on the enhanced FMAP described in section 2105(b) of such Act (42 U.S.C. 1397ee(b)); and

(C) to payments for disproportionate share hospital (DSH) payment adjustments under section 1923 of such Act (42 U.S.C. 1396r–4); and

(2) the increase provided under subsection (c) shall not apply with respect to payments under part E of title IV of such Act.

(f) STATE INELIGIBILITY AND LIMITATION.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), a State is not eligible for an increase in its FMAP under subsection (a), (b), or (c), or an increase in a cap amount under subsection (d), if eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

(2) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—Subject to paragraph (3), a State that has restricted eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) after July 1, 2008, is no longer ineligible under paragraph (1) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

(3) SPECIAL RULES.—A State shall not be ineligible under paragraph (1)—

(A) before July 1, 2009, on the basis of a restriction that was applied after July 1, 2008, and before the date of the enactment of this Act; or

(B) on the basis of a restriction that was effective under State law as of July 1, 2008, and would have been in effect as of such date, but for a delay (of not longer than 1 calendar quarter) in the approval of a request for a new waiver under section 1115 of such Act with respect to such restriction.

(4) STATE'S APPLICATION TOWARD RAINY DAY FUND.—A State is not eligible for an increase in its FMAP under subsection (b) or (c), or an increase in a cap amount under subsection (d), if any amounts attributable (directly or indirectly) to such increase are deposited or credited into any reserve or rainy day fund of the State.

(5) RULE OF CONSTRUCTION.—Nothing in paragraph (1) or (2) shall be construed as affecting a State's flexibility with respect to benefits offered under the State Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)

(including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)).

(6) NO WAIVER AUTHORITY.—The Secretary may not waive the application of this subsection or subsection (g) under section 1115 of the Social Security Act or otherwise.

(g) REQUIREMENT FOR CERTAIN STATES.—In the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures under the State Medicaid plan required under section 1902(a)(2) of the Social Security Act (42 U.S.C. 1396a(a)(2)), the State is not eligible for an increase in its FMAP under subsection (a), (b), or (c), or an increase in a cap amount under subsection (d), if it requires that such political subdivisions pay a greater percentage of the non-Federal share of such expenditures for quarters during the recession adjustment period, than the percentage that would have been required by the State under such plan on September 30, 2008, prior to application of this section.

(h) DEFINITIONS.—In this section, except as otherwise provided:

(1) FMAP.—The term ''FMAP'' means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42

U.S.C. 1396d(b)), as determined without regard to this section except as otherwise specified.

(2) RECESSION ADJUSTMENT PERIOD.—The term ''recession adjustment period'' means the period beginning on October 1, 2008, and ending on December 31, 2010.

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

(4) SMAP.—The term ''SMAP'' means, for a State, 100 percent minus the Federal medical assistance percentage..

(5) STATE.—The term ''State'' has the meaning given such term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(i) SUNSET.—This section shall not apply to items and services furnished after the end of the recession adjustment period.

SEC. 5002. MORATORIA ON CERTAIN REGULATIONS.

(a) EXTENSION OF MORATORIA ON CERTAIN MEDICAID REGULATIONS.—The following sections are each amended by striking ''April 1, 2009'' and inserting ''July 1, 2009'':

(1) Section 7002(a)(1) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (Public Law 110–28), as amended by section 7001(a)(1) of the Supplemental Appropriations Act, 2008 (Public Law 110–252).

(2) Section 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), as amended by section 7001(a)(2) of the Supplemental Appropriations Act, 2008 (Public Law 110–252).

(3) Section 7001(a)(3)(A) of the Supplemental Appropriations Act, 2008 (Public Law 110–252).

(b) ADDITIONAL MEDICAID MORATORIUM.—Notwithstanding any other provision of law, with respect to expenditures for services furnished during the period beginning on December 8, 2008 and ending on June 30, 2009, the Secretary of Health and Human Services shall not take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to implement the final regulation relating to clarification of the definition of outpatient hospital facility services under the Med-

icaid program published on November 7, 2008 (73 Federal Register 66187).

SEC. 5003. TRANSITIONAL MEDICAID ASSISTANCE (TMA).

(a) 18-MONTH EXTENSION.—

(1) IN GENERAL.—Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking ''September 30, 2003'' and inserting ''December 31, 2010''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on July 1, 2009.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a)(1), by inserting ''but subject to paragraph (5)'' after ''Notwithstanding any other provision of this title'';

(2) by adding at the end of subsection (a) the following:

''(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.''; and

(3) in subsection (b)(1), by inserting ''but subject to subsection (a)(5)'' after ''Notwithstanding any other provision of this title''.

(c) REMOVAL OF REQUIREMENT FOR PREVIOUS RECEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of such Act (42 U.S.C. 1396r–6(a)(1)), as amended by subsection (b)(1), is further amended—

(1) by inserting ''subparagraph (B) and'' before ''paragraph (5)'';

(2) by redesignating the matter after ''REQUIREMENT.—'' as a subparagraph (A) with the heading ''IN GENERAL.—'' and with the same indentation as subparagraph (B) (as added by paragraph (3)); and

(3) by adding at the end the following:

''(B) STATE OPTION TO WAIVE REQUIREMENT FOR 3 MONTHS BEFORE RECEIPT OF MEDICAL ASSISTANCE.—A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.''.

(d) CMS REPORT ON ENROLLMENT AND PARTICIPATION RATES UNDER TMA.—Section 1925 of such Act (42 U.S.C. 1396r–6), as amended by this section, is further amended by adding at the end the following new subsection:

''(g) COLLECTION AND REPORTING OF PARTICIPATION INFORMATION.—

''(1) COLLECTION OF INFORMATION FROM STATES.—Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under title XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this title is submitted to the Secretary.

''(2) ANNUAL REPORTS TO CONGRESS.—Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports

concerning enrollment and participation rates described in such paragraph.''.

(e) EFFECTIVE DATE.—The amendments made by subsections (b) through (d) shall take effect on July 1, 2009.

SEC. 5004. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 3003(a) of the Health Insurance Assistance for the Unemployed Act of 2009, is amended—

(A) in subclause (XIX), by striking ''or'' at the end;

(B) in subclause (XX), by adding ''or'' at the end; and

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

''(XXI) who are described in subsection (ee) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section

3003(a) of the Health Insurance Assistance for the Unemployed Act of 2009, is amended by adding at the end the following new subsection:

''(ee)(1) Individuals described in this subsection are individuals—

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

''(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking ''and (XIV)'' and inserting ''(XIV)''; and

(B) by inserting '', and (XV) the medical assistance made available to an individual described in subsection (ee) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting'' after ''cervical cancer''.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 3003(c)(2) of the Health Insurance Assistance for the Unemployed Act of 2009, is amended in the matter preceding paragraph (1)—

(A) in clause (xiii), by striking ''or'' at the end;

(B) in clause (xiv), by adding ''or'' at the end; and

(C) by inserting after clause (xiii) the following:

''(xv) individuals described in section 1902(ee),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ee) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ee), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

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

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with re-

spect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ee); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period;

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section''.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking ''or for'' and inserting ''for''; and

(ii) by inserting before the period the following: '', or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section''.

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the

Social Security Act (42 U.S.C. 1396u–7(b)) is amended by adding at the end the following:

''(5) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 5005. PROTECTIONS FOR INDIANS UNDER MEDICAID AND CHIP.

(a) PREMIUMS AND COST SHARING PROTECTION UNDER MEDICAID.—

(1) IN GENERAL.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

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

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

''(j) NO PREMIUMS OR COST SHARING FOR INDIANS FURNISHED ITEMS OR SERVICES DIRECTLY BY INDIAN HEALTH PROGRAMS OR THROUGH REFERRAL UNDER CONTRACT HEALTH SERVICES.—

''(1) NO COST SHARING FOR ITEMS OR SERVICES FURNISHED TO INDIANS THROUGH INDIAN HEALTH PROGRAMS.—

''(A) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title.

''(B) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service

to an Indian who is eligible for assistance under such title, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

''(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.''.

(2) CONFORMING AMENDMENT.—Section 1916A(b)(3) of such Act (42 U.S.C. 1396o–1(b)(3)) is amended—

(A) in subparagraph (A), by adding at the end the following new clause:

''(vi) An Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.''; and

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

''(ix) Items and services furnished to an Indian directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on October 1, 2009.

(b) TREATMENT OF CERTAIN PROPERTY FROM RESOURCES FOR MEDICAID AND CHIP ELIGIBILITY.—

(1) MEDICAID.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 3003(a) of the Health Insurance Assistance for the Unemployed Act of 2009 and section 5004, is amended by adding at the end the following new subsection:

''(ff) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this title:

''(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

''(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

''(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

''(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsist-

ence or a traditional lifestyle according to applicable tribal law or custom.''.

(2) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

''(E) Section 1902(ff) (relating to disregard of certain property for purposes of making eligibility determinations).''.

(c) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Section 1917(b)(3) of the Social Security Act (42 U.S.C. 1396p(b)(3)) is amended—

(1) by inserting ''(A)'' after ''(3)''; and

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

''(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in

this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this title for Indians.''.

SEC. 5006. CONSULTATION ON MEDICAID AND CHIP.

(a) IN GENERAL.—Section 1139 of the Social Security Act (42 U.S.C. 1320b–9) is amended to read as follows:

''CONSULTATION WITH TRIBAL TECHNICAL ADVISORY GROUP (TTAG)

''SEC. 1139.

''The Secretary shall maintain within the Centers for Medicaid & Medicare Services (CMS) a Tribal Technical Advisory Group, which was first established in accordance with requirements of the charter dated September 30, 2003, and the Secretary shall include in such Group a representative of the Urban Indian Organizations and the Service. The representative of the Urban Indian Organization shall be deemed to be an elected officer of a tribal government for purposes of applying section 204(b) of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1534(b)).''.

(b) SOLICITATION OF ADVICE UNDER MEDICAID AND CHIP.—

(1) MEDICAID STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (70), by striking ''and'' at the end;

(B) in paragraph (71), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (71), the following new paragraph:

''(72) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

''(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

''(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title.''.

(2) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by section 5005(b), is amended by adding at the end the following new subparagraph:

''(F) Section 1902(a)(72) (relating to requiring certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).''.

(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians.

SEC. 5007. TEMPORARY INCREASE IN DSH ALLOTMENTS DURING RECESSION.

Section 1923(f)(3) of the Social Security Act (42 U.S.C. 1396r-4(f)(3)) is amended—

(1) in subparagraph (A), by striking ''paragraph (6)'' and inserting ''paragraph (6) and subparagraph (E)''; and

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

''(E) TEMPORARY INCREASE IN ALLOTMENTS DURING RECESSION.—

''(i) IN GENERAL.—Subject to clause (ii), the DSH allotment for any State—

''(I) for fiscal year 2009 is equal to 102.5 percent of the DSH allotment that would be determined under this paragraph for the State for fiscal year 2009 without application of this subparagraph, notwithstanding subparagraph (B);

''(II) for fiscal year 2010 is equal to 102.5 percent of the the DSH allotment for the State for fiscal year 2009, as determined under subclause (I); and

''(III) for each succeeding fiscal year is equal to the DSH allotment for the State under this paragraph de-

termined without applying subclauses (I) and (II).

''(ii) APPLICATION.—Clause (i) shall not apply to a State for a year in the case that the DSH allotment for such State for such year under this paragraph determined without applying clause (i) would grow higher than the DSH allotment specified under clause (i) for the State for such year.''.

CONTENTS

PURPOSE AND SUMMARY

H.R. 629, the Energy and Commerce Recovery and Investment Act, was introduced by Rep Henry A. Waxman on January 22, 2009. The purpose of the bill is to promote recovery in the nation's foundering economy by investing in the following areas: (1) broadband infrastructure so that businesses and households in rural and other underserved areas can link to the global economy; (2) clean energy technologies that will put people to work, clean our environment, and reduce our dependence on foreign oil; and (3) health to create new jobs related to health information technology, provide health insurance assistance for workers hurt by the recession, and strengthen a key safety net by increasing the federal contribution to Medicaid.

BACKGROUND AND NEED FOR LEGISLATION

Broadband

Broadband infrastructure is the foundation of the digital economy. The broadband networks that must be constructed throughout the nation will be as important to the nation's economic success as the postal roads, canals, rail lines, and interstate highways of the past. Unfortunately, the United States has fallen behind other nations in terms of broadband deployment and adoption.[1] This legislation will put people to work building new broadband infrastructure. The Communications Workers of America estimate that a $5 billion investment in broadband will result in 100,000 new jobs, and it will begin the process of restoring the United States' position as the leading broadband nation in the world.

The legislation requires the grant administrator to attempt to award 25% of available funds to areas with either no wireless voice service or no basic broadband service so that these unserved areas can begin the process of building communications infrastructure. The measure also requires the grant administrator to attempt to award 75% of the funds to areas in need of an upgrade of existing wireless and wireline broadband facilities. The aim of these provisions is to stimulate job creation in all parts of the country and to not limit the expected economic development to certain regions. These provisions will help ensure that all Americans have a chance to benefit from new and upgraded infrastructure.

Energy

In the "American Recovery and Reinvestment Act," the House Appropriations Committee has proposed to provide approximately $30 billion for energy-related programs created by the Committee on Energy and Commerce. This investment would create new jobs, increase the efficiency of the nation's existing infrastructure and upgrade critical energy infrastructure. This effort would serve as the foundation for renewed

[1] For instance, the United States ranks 15th in broadband penetration among OECD nations. *See* http://www.oecd.org/dataoecd/21/35/39574709.xls.

economic growth that is consistent with meeting our energy and environmental challenges.

In light of the levels of funding proposed for these programs and the intention to move the appropriated funds rapidly into active use, the Committee on Energy and Commerce considered whether amendments to the authorizing language creating these programs should be adopted to assure that the funds were used to their full intended effect. Specifically, the Energy and Commerce Committee considered and amended portions of the provisions that make up Sections 5001, 5002, 5003, 5005, and 5007 of the "American Recovery and Reinvestment Act" approved by the Appropriations Committee, and added new provisions with respect to conditions that should apply other programs for which authorization language changes had not been proposed by the Appropriations Committee.

Health

1. Health Insurance Assistance for the Unemployed

According to the Congressional Budget Office (CBO), the United States is in a recession that "will probably be the longest and deepest since World War II."[2] CBO estimates that the unemployment rate, which was 5.7% in 2008, is projected to increase to 8.3% in 2009 and 9% into 2010.[3]

Each 1 percentage point increase in unemployment translates into a 0.6 percentage point increase in the number of nonelderly adults without health insurance coverage. Put another way, if, as projected, the unemployment rate rises to 9%, the number of uninsured adults will increase by 4.8 million.[4]

The bill contains two provisions to address this foreseeable increase in the number of unemployed Americans without health insurance coverage. It provides temporary subsidies for COBRA premiums to enable workers who have been involuntarily terminated from their jobs to maintain the coverage they had through work. To address the needs of those workers (and their families) that do not have access to COBRA coverage, the bill also creates a temporary option for states to extend health care coverage to displaced workers through their Medicaid programs.

CBO estimates that these two provisions will provide health care coverage to a total of 8.2 million unemployed workers and dependents in 2009. Of these, 7 million will

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[2] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2009 to 2019*, at 1 (Jan. 2009).
[3] *Id.*, Table B-1.
[4] J. Holahan, A. Bowen Garrett, *Rising Unemployment, Medicaid, and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured, at 4 (Jan. 2009).

be covered through COBRA; the remaining 1.2 million will be covered through Medicaid.[5]

CBO estimates these provisions will cost $40.2 billion over the next 5 years. Of this amount, over 90 percent will be spent during 2009 and 2010, maximizing the economic impact of this spending during the recession.

2. Health Information Technology

The U.S. health care system is characterized by systemic quality and efficiency shortcomings. The system's quality problems are evidenced by high rates of medical and medication errors and a lack of adherence to practice guidelines. In a 2000 study, the Institute of Medicine (IOM) found that as many as 98,000 people die each year due to preventable medical errors.[6] According to the Agency for Healthcare Research and Quality (AHRQ), an average of 17 years is required for findings from randomized clinical trials to be implemented into clinical practice. These documented shortcomings in our quality of care contribute to higher health care costs and place patients at risk.

Nationwide adoption of health information technology (HIT), that supports the electronic exchange of health information, has the potential to ameliorate many of the quality and efficiency problems endemic to our health care system. HIT would allow for the centralization of patient information, enhanced, real-time communication between providers to improve the coordination of care, improved patient access to medical records, and access to a variety of quality enhancing programs and tools.

According to the Congressional Budget Office, only 5% of physicians have and use a comprehensive electronic health record, those that provide decision support capability, physician order entry and more.[7] Similarly, only 11% of hospitals have adopted such systems.[8] A commonly cited impediment to the adoption of HIT is cost. A study published in the New England Journal of Medicine showed that a large majority of physicians using electronic health records are satisfied and report that those systems have positive effects on the quality of patient care.[9] The study, which surveyed 2,607 physicians, showed that physicians without HIT systems were concerned about financial barriers.[10] Evidence from this study and others strongly indicate that health care

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[5] Both are preliminary estimates that reflect the total number of people over the course of CY 2009 that receive benefits from sections 3002 and 3003. These are mutually exclusive groups, so they are additive and take into account interactions between both sections.

[6] To Err is Human. IOM (2000) National Academy Press.

[7] Congressional Budget Office, *Budget Options Health Care*, Volume I, Option 46 (Dec. 2008).

[8] Congressional Budget Office, *Evidence on the Cots and Benefits of Health Information Technology* (May 2008).

[9] Catherine M. DesRoches, Dr.P.H., Eric G. Campbell, Ph.D., Sowmya R. Rao, Ph.D., Karen Donelan, Sc.D., Timothy G. Ferris, M.D., M.P.H., Ashish Jha, M.D., M.P.H., Rainu Kaushal, M.D., M.P.H., Douglas E. Levy, Ph.D., Sara Rosenbaum, J.D., Alexandra E. Shields, Ph.D., and David Blumenthal, M.D., M.P.P, "Electronic Health Records in Ambulatory Care—A National Survey of Physicians" *The New England Journal of Medicine,* Published at www.nejm.org (June18, 2008) (10.1056/NEJMsa0802005).

[10] *Id.*

providers need guidance and financial support if HIT is to be widely adopted in the United States.[11]

In addition to costs, concerns about the security and privacy of health information have also been regarded as an obstacle to the adoption of HIT. As the electronic transmission of health information between various independent entities is encouraged, the privacy and security of that health information becomes a much greater concern. The Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104–191) resulted in the Secretary of HHS developing privacy and security standards giving patients the right of access to their medical information and placing restrictions on the use and disclosure of that information without the patient's consent. The HIPAA ''Privacy Rule'' and ''Security Rule'' currently provide the federal standard for the protection of individually identifiable health information.

There are, however, clear gaps in the current privacy and security structure established under HIPAA that have become apparent over time. For example, there are no requirements that a person be notified if their information is accessed by an unauthorized party. In addition, between April 2003 and March 2007, HHS documented 26,408 complaints of Privacy Rule violations.[12] Despite the relatively large number of complaints, no civil penalties were levied during that period and only one civil fine has been levied since then.[13] The bill would address these barriers to adoption and take steps to provide for greater privacy and security of health information and stronger enforcement of violations of federal law.

3. Medicaid Provisions

The rise in unemployment during a recession also has severe impact on state Medicaid programs. Caseloads rise as workers lose their incomes. If, as projected, the unemployment rate rises to 9%, the number of children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) will increase by 2.8 million, while the number of non-elderly adults in Medicaid will rise by 1.6 million.[14]

At the same time, the revenues that states need to pay for their Medicaid programs fall as income tax, sales tax, property tax, and corporate tax receipts decline. A 1 percentage point increase in the unemployment rate causes state general fund revenue to drop by 3% to 4% below the level of revenues expected. A 9 percent unemployment rate would reduce state revenues by an estimated $26 billion.[15]

Because the states, on average, pay 43% of Medicaid program costs, states would have to reduce their Medicaid spending by over $60 billion in order to reduce their state-

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[11] *Id.*
[12] Stevens, Gina Marie, ''Enforcement of the HIPAA Privacy Rule,'' CRS Report RL33989 (Apr. 30, 2007).
[13] *Id.*
[14] Holahan and Garrett, op. cit., Table 2.
[15] *Id.* at 8.

only spending by $26 billion. Withdrawing $60 billion in aggregate demand from the health care sector of the economy is likely to prolong the recession.

The bill contains provisions to assist states in maintaining their Medicaid programs in the face of caseload increases and revenue shortfalls. The bill provides a temporary increase in the federal Medicaid matching rate (FMAP) targeted in part at states with high unemployment. The bill also extends a moratorium on regulations that would substantially reduce federal Medicaid matching payments to states.

CBO estimates that these provisions will increase federal Medicaid spending by $89.5 billion over the next five years. Of this amount, about $80 billion, or nearly 90%, will be spent during 2009 and 2010, providing immediate fiscal relief to state Medicaid programs while the recession is underway.

LEGISLATIVE HISTORY

H.R. 629, the Energy and Commerce Recovery and Investment Act, was introduced by Rep. Henry A. Waxman on January 22, 2009, and referred to the Committee on Energy and Commerce.

On January 22, 2009, the Committee g met in open markup session to consider five Committee prints that correspond to the five titles of H.R. 629. The Committee by unanimous consent substituted the text of these five prints, as amended during the markup session, for the text of H.R. 629 as introduced, and approved H.R. 629,amended, by a voice vote.

SECTION-BY-SECTION

Title I – Broadband Communications

Section 1001: Inventory of Broadband Service Capability and Availability

Subsection (a) directs the National Telecommunications and Information Administration ("NTIA") to develop and maintain a broadband inventory map of the United States that identifies and depicts broadband service availability and capability. Subsection (b) directs the NTIA to make the map accessible online no later than 2 years after the date of enactment of this Act.

Section 1002: Wireless and Broadband Deployment Grant Programs

Subsection (a) authorizes the creation of grant programs for wireless and wireline broadband infrastructure to be administered by the NTIA.

Subsection (b) authorizes a state to submit a priority report to NTIA that identifies the geographic areas within that state that have greatest need for new or additional telecommunications infrastructure. A state may not identify areas encompassing more than 20% of that state's population.

Subsection (c) authorizes the NTIA to award Wireless Broadband Grants. The NTIA shall seek to distribute grants, to the extent possible, so that 25% of the available funds to "unserved areas" for basic voice services and 75% to "underserved areas" for advanced broadband services.

Subsection (d) authorizes the NTIA to award Broadband Deployment Grants. The NTIA shall seek to distribute grants, to the extent possible, so that 25% of the available funds go to "unserved areas" for basic broadband services and 75% to "underserved areas" for advanced broadband services.

Subsection (e) directs the NTIA to establish certain grant requirements, including that grant recipients are not unjustly enriched by the program, that grant recipients adhere to the FCC's August 5, 2005, broadband Internet policy statement, which grant recipients operate networks on an open access basis, and that grant recipients adhere to a build out schedule.

Subsection (f) sets for the requirements of the grant application and grant selection criteria. The NTIA is required to consider certain public policy goals (e.g., public safety benefits and enhancement in computer ownership or literacy) before awarding grants.

Subsection (g) requires the NTIA to coordinate with the FCC and to consult with other agencies as necessary to implement this Section.

Subsection (h) requires NTIA to submit an annual report to Congress assessing the impact o the grants on the policy objectives and criteria contained in this Section.

Subsection (i) grants the NTIA authority to prescribe rules as necessary to implement this Section.

Subsection (j) contains definitions of terms used in this Section, and directs the FCC to develop definitions for certain terms.

Section 1003: National Broadband Plan

Subsection (a) requires the FCC to, not later than one year after the date of enactment of this section, develop and submit to Congress a report containing a national broadband plan.

Subsection (b) sets forth the contents of the plan.

Title II – Energy

Section 2001: Technical Corrections to the Energy Independence and Security Act of 2007

This section provides technical corrections to the Energy Independence and Security Act of 2007 (EISA) to eliminate confusion in grant fund allocations.

Section 2002: Amendments to Title XIII of the Energy Independence And Security Act of 2007.

Presented in Appropriations Committee bill as "Technical Corrections" to EISA, this section in fact comprises substantive changes to that title and has therefore been retitled "Amendments to Title XIII" of EISA by the Committee. The language of subsection (1)(A) has been clarified to avoid concern that demonstration projects would be limited to those in rural areas when the intent is to have them in a variety of geographic settings. An additional paragraph (F) was added requiring grantees for EISA section 1304 Demonstration Projects to "utilize open Internet-based protocols and standards if available." The same conditioning language is also applied to Smart Grid grantees under section 1306 of EISA as an addition to the procedural changes in subsection (8)(e)(2).

Section 2003: Renewable Energy and Electric Power Transmission Loan Guarantee Programs

This provision creates a new section of Title XVII of the Energy Policy Act of 2005 (EPAct) to provide temporary loan guarantee authority for certain commercially ready renewable energy technologies. The bill modifies the categories of eligible recipients to clarify that "renewable energy systems" would be those "including incremental hydropower, that generate electricity," and that "electric power transmission systems" would include "upgrading and reconductoring projects." The bill adds a third category of eligible users, "leading edge biofuel projects," judged by the Secretary of Energy as likely to become commercial, and limited to using $500 million of the total authority provided. These projects are required to "substantially reduce life cycle greenhouse gas emissions" and it is expected that the Secretary will use a procedure and methodology consistent for calculating emissions that is consistent with those being developed by the U.S. Environmental Protection Agency. The bill also includes factors to be considered by the Secretary in reviewing transmission projects for federal support.

Section 2004: Weatherization Program Amendments

This section contains language allowing the Secretary of Energy to encourage states to move forward with attic insulation and other low-cost high-efficiency techniques in weatherization program actions for qualifying homes rather than weatherizing single homes at once with all techniques, if the Secretary judged that such action would increase the effectiveness of the program.

Section 2005: Renewable Electricity Transmission Study

This section provides for additional elements to the triennial DOE study of transmission congestion, required under Section 1221 of the Energy Policy Act of 2005. It requires the analysis of renewable transmission constraints and legal actions as

obstacles to new renewable transmission, and requiring that assumptions and projections involved in the study be explained.

Section 2006: Additional State Energy Grants

This section adds conditions that would apply to acceptance by a state of incremental State Energy Program grant funding beyond base amounts. The funds would be conditioned on governors of states notifying the Secretary of Energy that they would seek, within the limits of their authority, to ensure that three conditions were met.

First, the governor would seek to promote policies to ensure that recovery of a utility's fixed costs of service are independent of retail sales, that a utility could recover costs for energy efficiency and that an earnings opportunity existed for energy efficiency. This provision is designed to nudge a state toward adopting policies that would remove disincentives that utilities have to invest in energy efficiency and promote new incentives to encourage energy efficiency. Experience in states that have adopted these policies show that consumer rates may fluctuate only minimally while delivering substantial benefits and reducing the need for additional power plant construction.

Care was taken to ensure that governors were not encouraged to advocate that variable charges be shifted to fixed charges. In this way, consumers can continue to save money through their own conservation efforts and rate structures that are not advantageous to consumers are not encouraged. Moreover, the Committee understands the limited effect of this condition. Public utility commissions are generally independent of a governor's office and a governor's notification under this section will not legally require a public utility commission to adopt any specific regulatory policy. In fact, nothing in this section preempts state laws or in anyway limits the authority of a state to protect its consumers. This provision is intended to aid consumers by ensuring that the most cost-effective energy solutions are sought. The Committee expects that public utility commissions will maintain their practice of ensuring that only prudent investments are recovered and that consumers are protected.

Second, the governor would seek to promote the adoption of updated energy efficient building codes adopted by leading code-setting organizations or their equivalent.

Finally, the governor would seek, to the extent practicable, to prioritize the use of such funds in the expansion of existing energy efficiency programs or renewable energy programs. A separate provision of the section eliminates the 20% state match required under current law for receipt of Economic Recovery Act revenues. Another provision removes any limits in current law as to percentages of funding that can be used for purchase and installation of equipment and materials for energy efficiency measures.

Section 2007: Inapplicability of Limitation

This provision temporarily lifts current statutory limitations and conditions on grant and loan funding pursuant to Section 471 of EISA, Sustainability and Energy

Efficiency Loans and Grants for Institutions, to accord with the "American Recovery and Reinvestment Act of 2009" appropriation timing and amounts. It provides that not more than 80% of the funding for any project can be provided in the form of grant funding.

Title III – Health Insurance Assistance for the Unemployed

Section 3001: Short Title and Table of Contents

Sets forth the short title and table of contents.

Section 3002: Premium Assistance for COBRA Benefits and Extension of Cobra Benefits for Older or Long-Term Employees

Section 3002 establishes a temporary premium assistance program for COBRA benefits and extends COBRA benefits for older or long-term employees.

To be eligible for COBRA under current law, a worker must have worked for an employer with 20 or more employees, have been enrolled in the employer's health plan, and have lost his/her health coverage due to termination of employment for reasons other than gross misconduct. Workers must pay 100% of the premium plus 2% in administrative costs. In addition, some states offer similar health care continuation coverage for those employers with less than 20 employees.

The bill provides a 65% subsidy for COBRA continuation premiums for up to 12 months for workers who have been involuntarily terminated (and their families) and are otherwise eligible for federal or state COBRA continuation coverage. To qualify for this COBRA premium assistance, a worker must be involuntarily terminated between September 1, 2008, and December 31, 2009, and not have an income of over 1 million dollars. The subsidy would terminate upon offer of any new employer-sponsored coverage.

The bill also provides that those COBRA-eligible workers who are 55 and older, or who have worked for an employer for 10 or more years, would be able to retain COBRA coverage, at their own expense, until they become Medicare eligible at age 65.

Section 3003: Temporary Optional Medicaid Coverage for the Unemployed

This section provides temporary optional Medicaid coverage for the unemployed without health insurance coverage. State Medicaid programs will have the option of covering one or more of the following groups of unemployed individuals without health insurance (and their uninsured spouses and dependents):

(1) individuals who are receiving unemployment benefits and individuals who were receiving but have exhausted unemployment benefits on or after July 1, 2008;

(2) individuals who are involuntarily unemployed and were involuntarily separated from employment on or after September 1, 2008, and before January 1, 2009, with a gross family income below 200% of the poverty level ($44,100 per year for a family of four in 2009) and are not otherwise eligible for Medicaid;

(3) individuals who are involuntarily unemployed and were involuntarily separated from employment on or after September 1, 2008, and before January 1, 2009, are member of households participating in the food stamps program, and are not otherwise eligible for Medicaid.

The federal government will assume 100% of the costs of benefits and administration for individuals enrolled under this option through December 31, 2010. The costs of administration include the cost of outreach and modification and operation of eligibility information systems.

Individuals eligible for coverage as of December 31, 2010, will continue to be entitled to coverage until their next regularly-scheduled eligibility redetermination date. During this post-December 31, 2010, coverage period, the federal government will share in the cost of covered items and services for such individuals at the state's regular matching rate.

Title IV -- Health Information Technology

Sec. 4001: Short Title, Table of Contents of Title

Provides that the title of the section is the Health Information Technology for Economic and Clinical Health Act or the HITECH Act.

Subtitle A – Promotion of Health Information Technology
Part I – Improving Health Care Quality, Safety and Efficiency

Sec. 4101: ONCHIT; Standards Development and Adoption

This section makes a number of amendments to the Public Health Service Act (PHSA):

Sec. 3000 – Definitions. These provisions define key terms related to the promotion of health information technologies.

Sec. 3001 – Office of the National Coordinator for Health Information Technology. The Office of the National Coordinator of Health Information Technology (ONCHIT), which was originally created by Executive Order 13335, is codified into statute within the U.S. Department of Health and Human Services (HHS). The head of ONCHIT (the National Coordinator) will lead the efforts for the development of policies and recognition of standards to allow for the secure electronic exchange of health information that leads to improvements in the quality of clinical care.

The National Coordinator is charged with the following duties:

- Update and maintain strategic plan on how to achieve widespread adoption and use of interoperable, secure, and clinically useful electronic health records. The plan shall include measurable goals and the National Coordinator is required to regularly evaluate and publicly report on progress toward achieving these goals.

- Provide guidance to and act as a liaison between the HIT Policy and HIT Policy Committees.

- Review and recommend standards and guidance to the Secretary to ensure interoperability, security/privacy, and clinical utility of electronic health information. Such recommendations will be developed with input from the HIT Standards Committee.

- Develop a program for the voluntary testing and certification of products as meeting the standards adopted by the Secretary for the secure electronic exchange of health information.

- Coordinate efforts throughout the federal government to promote and utilize electronic health information technology.

- Appoint a Chief Privacy Officer who shall assist the National Coordinator with initiatives to promote privacy, security, and data stewardship of electronic health information.

- Regularly report on progress on efforts to achieve the goals outlined in the strategic plan, as well as the impact of health information technology in communities with health disparities and medically underserved areas.

Sec. 3002 – HIT Policy Committee. Establishes a federal advisory committee of public and private stakeholders to provide input and assistance to the National Coordinator. The HIT Policy Committee will serve as a forum for input and expertise in the area of health information technology. The HIT Policy Committee will provide policy advice and make recommendations to the National Coordinator on how best to achieve the goals outlined in the strategic plan, including how to achieve the goal of ensuring that every person in the nation has a secure electronic health record by 2014.

Sec. 3003 – HIT Standards Committee. Establishes a federal advisory committee of public and private stakeholders to provide input and assistance to the National Coordinator. The HIT Standards Committee will recommend standards, implementation specifications, and certification criteria for the secure

electronic exchange and use of health information technology consistent with the strategic plan and policy recommendations from the HIT Policy Committee.

Sec. 3004 – Process for adoption of endorsed recommendations; adoption of initials set of standards, implementation of specifications, and certification criteria. Directs the Secretary, in consultation with other relevant agencies, to review standards recommended by the National Coordinator and, where appropriate, provide for adoption by the government through a rulemaking process. Requires that the Secretary adopt an initial set of standards, which may be based on standards already developed by the National Coordinator, no later than December 31, 2009.

Sec. 3005 – Application and use of adopted standards and implementation specifications by federal agencies. Requires that federal agencies implementing or using electronic health information do so in a way that is consistent with Section 4111.

Sec. 3006 – Voluntary application and use of adopted standards and implementation specifications by private entities. Except as provided for under Section 4112, states that standards developed under this Act shall not be binding on private entities, but may be voluntarily adopted.

Sec. 3007 – Federal health information technology. Directs the Secretary to support the development of, and make available, a low-cost electronic health record that is certified as meeting the adopted standards, unless the Secretary finds that provider demand for such systems is being met through the marketplace. States that no public or private entity will be required to adopt or use the system developed under this Section.

Sec. 3008 – Transitions. Provides for transitions to allow for the development and harmonization of standards currently taking place to continue to occur as ONCHIT is codified and the functions of the American Health Information Community Successor, Inc. flow appropriately to the HIT Policy and Standards Committees.

Sec. 3009 – Relation to HIPPA privacy and security law. Specifies that this title may not be construed as having any effect on the authorities granted to the Secretary under the HIPAA privacy and security law.

Sec. 3010 – Authorization for appropriations. Authorizes an appropriation of $250 million to ONCHIT for 2009 to implement this title.

Sec. 4102: Technical Amendment

Amends the HIPAA definition of health plan to include Medicare Part D.

Sec. 4103: American Technology Required

Requires all funds made available pursuant to this Act for the purchase of health information technology only purchase technology that is manufactured, engineered, programmed in the United States and made substantially from articles, materials, supplies, mined, produced or manufactured in the United States.

Part II – Application and Use of Adopted Health Information Technology Standards; Reports

Sec. 4111: Coordination of Federal Activities with Adopted Standards and Implementation Specifications

Codifies a 2006 executive order to require federal agencies implementing, acquiring, or upgrading HIT systems for the electronic exchange of identifiable health information use HIT products meeting standards adopted by the Secretary of HHS in accordance with this bill. It also requires that the President ensure that federal activities involving the collection and submission of health information be consistent with standards established under this bill for the electronic exchange of health information.

Sec. 4112: Application to Private Entities

Requires that private entities contracting with the federal government to carry out health activities adopt the standards established under this bill for the electronic exchange of health information.

Sec. 4113: Study and Reports

Requires the Secretary to submit an annual report to Congress on the efforts toward, and barriers to, facilitating the electronic exchange of health information nationwide. It also requires the Secretary to study methods to create efficient reimbursement incentives for improving healthcare quality in federally-qualified health centers, rural health clinics, and free clinics.

Subtitle B – Testing of Health Information Technology

Sec. 4201: National Institute for Standards and Technology Testing

Requires that the National Institute for Standards and Technology (NIST) work in coordination with the Office of the National Coordinator to test standards. These are standards being developed or recognized for the electronic exchange of health information by the Office of National Coordinator. It additionally requires the director of NIST in coordination with the Office of the National Coordinator to support the establishment of accredited testing laboratories for the voluntary testing of products for certification by the National Coordinator that they meet standards for the electronic exchange of information.

Sec. 4202: Research and Development Programs

Requires that the Director of NIST, in consultation with the Director of the National Science Foundation and other appropriate federal agencies, award competitive grants to institutes of higher education to research innovative approaches for the use of HIT in the delivery of health care. Additionally, it directs the National High-Performance Computing Program, created by the High Performance Computing Act of 1991, to coordinate federal research and programs related to the development and deployment of HIT.

Subtitle C – Incentives for the Use of Health Information Technology
Part I – Grants and Loans Funding

Sec. 4301: Grant, Loan and Demonstration Programs

This section makes a number of amendments to the Public Health Service Act (PHSA):

Sec. 3011 – Immediate funding to strengthen the health information technology infrastructure, Authorizes the Secretary to make immediate investments in the infrastructure necessary to facilitate the electronic exchange and use of health information for each individual in the United States consistent with the goals and strategies outlined in the strategic plan developed by the Office of the National Coordinator, including assistance to providers not eligible for assistance under Medicare or Medicaid.

Sec. 3012 – Health information technology implementation assistance. Establishes several programs to help providers adopt and use health information technology. These programs will serve as a forum for exchanging knowledge and experience, disseminate lessons learned and best practices, and provide technical assistance to providers and health information networks about how to implement health IT. The program will prioritize direct assistance first to non-for profit hospitals, federally qualified health care centers, providers in medically underserved areas, and individual or small group practices focused on primary care.

Sec. 3013 – State grants to promote health information technology. Authorizes the Secretary to award states, or qualified state-designated entities, grants to implement and expand the electronic exchange of health information.

Sec. 3014 – Competitive grants to States and Indian Tribes for the development of loan programs to facilitate the widespread adoption of certified EHR technology. Authorizes the National Coordinator to award states and Indian Tribes grants for the purpose of establishing health IT loan programs. Such loans could only be used to assist with the purchase of health information

technology that facilitates the electronic exchange of health information and improves the quality of care.

Sec. 3015 – Demonstration program to integrate information technology into clinical education. Establishes a demonstration program for awarding grants to medical, dental, nursing schools, and other graduate health education programs to integrate health IT into the clinical education of health care professionals.

Sec. 3016 – Information technology professionals on health care. Directs the Secretary, in consultation with the National Science Foundation, to provide financial assistance to educational institutions to support training in medical health informatics.

Sec. 3017 – General grant and loan provisions. Permits the Secretary to require that grantees report on the effectiveness of activities funded through the grant, and requires the National Coordinator to annually evaluate the effectiveness of grants in improving the quality and efficiency of health care.

Sec. 3018 – Authorization for appropriations. Authorizes appropriations of such sums as are necessary to carry out this subtitle from 2009 through 2013.

Part II – Medicare Program

Sec. 4311: Incentives for Eligible Professionals

Provides for incentive payments to Section 1861(r) physicians and providers who adopt and utilize EHR technology that is certified as meeting appropriate standards for interoperability, security and clinical functionality. In order to receive the incentives, providers must demonstrate that they are engaging in meaningful use of the EHR technology, including electronically exchanging clinical information with other providers and reporting on clinical quality measures. In selecting the quality measures the Secretary is instructed to seek to select measures that are consistent with those already in use under other quality reporting programs under Title XVIII, such as the Physician Quality Reporting Initiative (PQRI) program.

Beginning in fiscal year 2011, professionals that demonstrate they have adopted and are utilizing a certified EHR system are eligible to receive incentive payments through the Medicare program. Professionals who demonstrate they are meaningful EHR users starting in 2011, 2012, or 2013 will receive incentive payments that are phased out over a five-year period. Eligible professionals who use a certified EHR may receive up to $41,000 over five years, which may be made in annual lump-sum payments or a series of smaller payments. Professionals that become meaningful EHR users in 2014 and 2015 will receive a reduced series of payments over a 4 and 3 year period, respectively. No incentive payments are available for professionals who begin meaningful use of EHR technology after 2015. The Secretary is instructed to coordinate payments for professionals who participate in more than one practice to ensure proper application of

payment incentives and limits. The Secretary is also given authority to adjust measures of meaningful use for professionals in group practice as appropriate.

Starting in 2016, Medicare payments are reduced by a percentage of allowed charges for any eligible professional who does not demonstrate they are meaningfully using a certified EHR system. Allowed charges are reduced by 1% in 2016 and by an additional percentage point each year until payments are reduced by 3% for non-users. If less than 75% of eligible professionals are not demonstrating meaningful use of a certified EHR system, the reduction in payments will increase by 1% a year for a maximum reduction of 5%. The Secretary may provide a time-limited exemption from the payment reductions to professionals who demonstrate a significant hardship in meeting the meaningful use criteria.

Similar payment incentives and reductions will apply to professionals who are affiliated with certain staff or group model Medicare Advantage (MA) plans. Furthermore, MA benchmark payments are not affected by incentive payments or penalties that apply to professionals in fee-for-service Medicare for the use of EHRs.

Sec. 4312: Incentives for Hospitals

Provides incentive payments to Section 1886(d) hospitals that adopt and utilize EHR technology that is certified as meeting appropriate standards for interoperability, security and clinical functionality. In order to receive the incentives, hospitals must demonstrate that they are engaging in meaningful use of EHR technology, including electronically exchanging clinical information with other providers and reporting on clinical quality measures. In selecting clinical quality measures the Secretary is instructed to seek to avoid redundant or duplicative reporting with reporting required under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) Program under 1886(b)(3)(B)(viii) of the Social Security Act.

Beginning in fiscal year 2011, hospitals that demonstrate they have adopted and are utilizing an approved EHR system are eligible to receive incentive payments through Part A of the Medicare program. Hospitals that demonstrate they are meaningful EHR users by either fiscal 2011, 2012, or 2013 receive incentive payments that are phased out over a four-year period. Hospitals that become meaningful EHR users in 2014 and 2015 receive 3 and 2 years of incentive payments respectively. No incentive payments are available for hospitals that begin adoption and meaningful use of EHR technology after 2015.

All hospitals that meet the standards for meaningful EHR use receive a base payment based on their Medicare share of business. Hospitals receive additional payments based on total discharges, at a declining rate per discharge, up to a maximum number of discharges. All payments are adjusted by Medicare share, taking into account the level of charity care provided by the hospital.

The market basket update is reduced for any eligible hospital that has not adopted a certified system by 2016. The Secretary may provide a time-limited exemption from the payment reduction to professionals who demonstrate a significant hardship in meeting the meaningful use criteria.

Similar payment incentives and reductions will apply to hospitals which are affiliated with certain staff or group model Medicare Advantage (MA) plans and have less than one-third of their total discharges covered under Medicare fee-for-service. MA benchmark payments are not affected by incentive payments and penalties to 1886(d) hospitals for the development of EHRs.

Sec. 4313: Treatment of Payments and Savings; Implementation Funding

This section excludes all payment incentives made by this Act from Medicare beneficiary premiums. All funds currently held in the Medicare Improvement Fund are designated to be expended in fiscal year 2014, and any savings resulting from payment reductions for failing to use certified EHRs is deposited into the Fund starting in 2020. Provides funding to the Centers for Medicare and Medicaid Service to implement the incentive programs described in this part of the Act.

Sec. 4314: Study on Application of EHR Payment Incentives for Providers Not Receiving Other Incentive Payments

Instructs the Secretary to conduct a study to determine the extent to which and manner in which incentives and other funding for adoption and use of qualified EHR technology should be made available to health care providers who are receiving minimal or no payments under this Act, titles XVIII, or XIX of the Social Security Act, or otherwise. The study is due to Congress by June 30, 2010.

Part III – Medicaid Funding

Sec. 4321: Medicaid Provider HIT Adoption and Operation Payments; Implementation Funding

Provides incentives to encourage the adoption and use of an electronic health record that is certified as meeting appropriate standards for interoperability, security, and clinical functionality among providers participating in the Medicaid program under title XIX of the Social Security Act. Incentives are administered by state Medicaid programs according to statute and under regulatory supervision of the Secretary of Health and Human Services. There is no payment reduction associated with incentive payments under this section.

Eligible practitioners include physicians as defined in Sections 1861(r)(1) and 1861(r)(2) of the Social Security Act, nurse practitioners, and certified nurse midwives with at least 30% of patient volume attributable to patients receiving assistance under title XIX. Such practitioners would be eligible to receive 85% of the costs of implementing

and operating health information technology up to $75,000 over a period of six years, or $63,750 in federal spending. Up to $25,000 of this funding would be for the initial adoption of an electronic health record with the rest being for operation and maintenance costs spread over the succeeding five years.

Practitioners receiving such assistance would be required to demonstrate meaningful use of certified electronic health records in a manner specified by the State and satisfactory to the Secretary. In order to avoid duplicative reporting requirements such demonstration may be based on the rules developed for the Medicare program.

Other eligible providers include children's hospitals, acute care hospitals with at least 10 percent of their patient volume attributable to patients receiving assistance under title XIX, and federally qualified health centers (FQHCs) and rural health clinics (RHCs) with at least 30% of their patient volume attributable to such individuals. Payments to hospitals are calculated in a similar fashion as under Section 4312 of this Act. Hospitals demonstrating meaningful use of certified electronic health records (under standards administered by the states and acceptable to the Secretary) may receive a base payment based on their Medicaid share, with additional amounts for additional discharges. All payments are adjusted by the percentage of discharges made for individuals receiving assistance under title XIX (the Medicaid share, including individuals enrolled in managed care plans) and the amount of charity care being provided by the hospital. Payments to FQHCs and RHCs are made according to a formula to be developed by the Secretary.

State spending for payments to providers for adoption and operation of certified electronic health records will be entirely paid for by the federal government; 90% of state costs in administering the program will be reimbursed by the federal government. Funding is provided to the Centers for Medicare & Medicaid Services to administer this section.

Subtitle D – Privacy

Sec. 4400: Definitions

These provisions define key terms related to the privacy and security provisions of this bill.

Part I – Improved Privacy Provisions and Security Provisions

Sec. 4401: Application of Security Provisions and Penalties to Business Associates of Covered Entities; Annual Guidance on Security Provisions

Requires that security safeguards promulgated pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this bill, and the penalties for violation of those safeguards apply to business associates under HIPAA (see note below) in the same manner as applied to covered entities. This provision also requires that the

Secretary, in consultation with stakeholders, annually issue guidance on the most appropriate security safeguard technologies for protecting information.

Sec. 4401: Notification in the Case of Breach

Requires that, in the case of a breach of unsecured Protected Health Information (PHI), a covered entity must notify each individual whose information has been, or is reasonably believed to have been, breached. In the case of a breach of unsecured PHI that is under the control of a business associate, that business associate is required to notify the covered entity. All breach notifications must be made without unreasonable delay and no later than 60 calendar days after discovery. The provision provides instruction for the required methods by which an individual must be notified and the content of the notification. However, this notification may be delayed if it could impede a criminal investigation or damage national security.

The Secretary is also required to issue guidance within 60 days, and annually thereafter, as to the technologies or methodologies that meet the standard of making information secure (i.e. unusable, unreadable, or indecipherable). If the Secretary fails to issue guidance within 60 days, PHI will be considered secure if it is protected by technology standards developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute (ANSI).

Finally, the Secretary is required each year to compile and analyze the number and nature of breaches reported to the Secretary and issue a report to Congress concerning the scope of the problem and steps that have or will be taken to address it at a federal level and through guidance on best practices for covered entities and business associates.

Sec. 4403: Education on Health Information Technology Privacy

Requires that the Secretary designate an individual in each regional HHS office to offer education and guidance on privacy requirements regarding PHI.

Sec. 4404: Application of Privacy Provisions and Penalties to Business Associates of Covered Entities

Requires that privacy provisions promulgated pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this bill, and the penalties for violation of those privacy provisions apply to business associates under HIPAA in the same manner as applied to covered entities.

Sec. 4405: Restrictions on Certain Disclosures and Sales of Health Information; Accounting of Certain Protected Health Information Disclosures; Access to Certain Information in Electronic Format

Permits a patient to request that their PHI regarding a specific healthcare item or service not be disclosed by a covered entity to a health plan for purposes of payment or healthcare operations, unless otherwise required by law, if that patient has paid in full out-of-pocket for that item or service. In such a circumstance, the covered entity is required to honor the patient's request.

Also requires covered entities to make reasonable effort to restrict the use, disclosure, request of PHI to a "limited data set" of information as defined in the HIPAA rules until such time that the Secretary issues guidance on what constitutes the "minimum necessary" for use or disclosure of such data.

The provision also gives an individual the right to request an accounting of disclosures of PHI from an entity or business associate to another party for treatment, payment, and health care operations in the three years prior to the request if that entity is utilizing an electronic health record and the disclosure was made from the electronic health record. Covered entities would not be required to make an accounting for uses of PHI or oral disclosures of such information.

The provision additionally requires the Secretary to review the definition of health care operations to determine those activities that can reasonably and efficiently be conducted through the use of information that is de-identified. Health care operations are activities for which providers and insurers can share a patient's protected health information without their authorization.

Additionally, this provision clarifies that certain uses and disclosures of PHI are not permitted without a valid authorization, such as the sale of PHI (with some exceptions) and the unauthorized re-identification of de-identified data or the limited data set.

This provision also gives individuals the right to receive electronic copies of their PHI used or maintained by a covered entity in electronic format if the entity uses an electronic medical record or electronic health record. The provider would be able to charge a reasonable cost based fee for doing so.

Sec. 4406: Conditions on Certain Contracts as Part of Health Care Operations

Clarifies the definition of marketing under HIPAA and precludes direct or indirect payment to covered entities for the use of PHI to make certain communications without valid patient authorization. Removes fundraising from the HIPAA definition of health care operations.

Sec. 4407: Temporary Breach Notification Requirement for Vendors of Personal Health Records and Other Non-HIPPA Covered Entities

In the case that an individual's personal health record (PHR) unsecured identifiable health information is breached, requires that PHR vendors notify that

individual along with the Federal Trade Commission (FTC). The provision requires that the notification requirements applicable to covered entities under section 4402 of this bill be applied to notifications required under this section and that FTC notify HHS of breach notices received by FTC. The provision gives the FTC enforcement authority regarding breaches of health information maintained by PHR vendors. The provision sunsets when either HHS or FTC adopt privacy and security standards specific to PHRs and other non-HIPAA covered entities.

Sec. 4408: Business Associate Contracts Required for Certain Entities

Requires organizations such as Health Information Exchanges, Regional Health Information Organizations, E-prescribing Gateways, and vendors of PHRs who have entered into contracts with covered entities to have business associate agreement as defined under HIPAA.

Sec. 4409: Clarification of Application of Wrongful Disclosures Criminal Penalties

Clarifies that criminal penalties for violations of HIPAA can be applied directly to individuals, whether they are employees of covered entities or have no relationship to covered entities.

Sec. 4410: Improved Enforcement

Improves enforcement of the federal health privacy law by the Office of Civil Rights (OCR) at HHS by requiring a formal investigation of complaints and the imposition of civil monetary penalties for violations that rise to the level of willful neglect or other violations that are not corrected. The provision also increases the amount of civil monetary penalties and authorizes a percentage of the penalty to accrue to the individual(s) harmed and the OCR, through the application of a methodology to be developed by the GAO and adopted by the Secretary.

Preserves OCR's current tools for informal resolution, technical assistance, and correction without the imposition of a penalty in situations where the violation was due to a reasonable cause. Currently, all complaints and violations can be handled informally and without the imposition of civil monetary penalties.

In addition, this provision permits OCR to pursue an investigation and the imposition of civil monetary penalties against any individual for an alleged criminal violation of the federal health privacy law if the Department of Justice has not prosecuted the individual.

Finally, this provision authorizes state attorneys general to enforce federal privacy and security laws.

Sec. 4411: Audits

Directs the Secretary to perform periodic audits to oversee compliance with the privacy and security provisions.

Sec. 4412: Securing Individually Identifiable Health Information

Requires covered entities and business associates to use technology to make all data transmitted in the nationwide health information network or transported outside a covered entities or business associate's physical perimeter unusable, unreadable, or indecipherable to unauthorized individuals.

Sec. 4413: Special Rule for Information to Reduce Medication Errors and Improve Patient Safety

Clarifies that nothing in the privacy subtitle of the Act shall prevent a pharmacist from collecting and sharing information with a patient in order to reduce medication errors and improve patient safety so long as any remuneration received for making such communication is reasonable and cost based.

Part II – Relationship to other laws; regulatory references; effective date; reports

Sec. 4421: Relationship to Other Laws

Applies the preemption in Section 1178 of the Social Security Act to the provisions of title IV of this bill and preserves the HIPAA and the regulations promulgated pursuant to that Act to the extent that they are consistent with Title IV of this bill.

Sec. 4422: Regulatory References

States that each reference in this subtitle to a federal regulation refers to the most recent version of the regulation.

Sec. 4423: Effective Date

With the exception of certain specified provisions, this bill shall become effective 12 months after the date of enactment of this Act.

Sec. 4424: Studies, Reports, Guidance

This provision requires that the Secretary annually report to Congress on the number and nature of complaints of alleged violations and how they were resolved, including the imposition and amount of civil money penalties; the number of audits performed, and more.

In addition, this section requires study on the application of privacy and security requirements to vendors of personal health records. The provision requires the Secretary,

in consultation with the Federal Trade Commission (FTC) to submit recommendations to Congress regarding: (1) the requirements relating to security, privacy, and notification in the case of a breach of protected health information, including the applicability of an exemption to notification in the case of PHI that has been rendered indecipherable through the use of encryption or alternative technologies, with respect to personal health record vendors; and (2) the federal agency best equipped to enforce those requirements.

Finally, this section requires that the GAO study and report on the disclosures of protected health information made for treatment purposes and best practices used by entities and states for such disclosures.

Title V – Medicaid Provisions

Section 5000: Table of Contents of Title

Sets forth the table of contents.

Section 5001: Temporary Increase of Medicaid FMAP

Provides for a temporary increase in the federal medical assistance percentage (FMAP) to assist states in meeting the costs of increasing Medicaid caseloads at a time when their revenues are falling due to rising unemployment. Three types of temporary assistance will apply to the costs of Medicaid items and services during the period October 1, 2008, through December 31, 2010:

(1) States that would otherwise experience a drop in their federal matching rate under the regular FMAP formula during FY 2009 or FY 2010 or the first quarter of FY 2011 will be held harmless against any decline.

(2) Every state will receive an increase in its FMAP by 4.9 percentage points for the entire nine quarter period.

(3) States experiencing an increase in their unemployment rate will receive an additional percentage point increase in their FMAP as follows. Each state's average monthly unemployment rate for the most recent previous three-consecutive-month period for which data are available is compared to the state's lowest average monthly unemployment rate for any three-consecutive-month period beginning on or after January 1, 2006. If the most recent rate exceeds the lowest rate by not less than 1.5 percentage points but less than 2.5 percentage points, the additional percentage point increase in FMAP is the product of 6 percent and the state's regular state matching rate. If the most recent rate exceeds the lowest rate by not less than 2.5 percentage points but less than 3.5 percentage points, the additional percentage point increase in FMAP is the product of 12 percent and the state's regular state matching rate. If the most recent rate exceeds the lowest rate by not less than 3.5 percentage points, the additional percentage point increase in FMAP is the product of 14 percent and the state's regular state matching rate.

For purposes of this calculation, the state's regular state matching rate is determined after applying the hold harmless but before applying the 4.9 percentage point increase.

This high unemployment percentage point adjustment will automatically adjust upward, per the formula described above, to reflect increases in a state's unemployment rates until the quarter ending June 30, 2010. Until that time, the percentage point adjustment can only remain unchanged or go up; it cannot go down. For the last two quarters in calendar year 2010, the adjustment will be determined based on the state's average monthly unemployment rate for December 2009, January 2010, and February 2010.

Puerto Rico, the Virgin Islands, Guam, the Northern Marianna Islands, and American Samoa will have the option of a 20% increase in their medical assistance cap amount or a 4.9 percentage point increase in their FMAP plus a 10% increase in their cap.

The temporary increase in FMAP resulting from the hold harmless provision and the 4.9 percentage point increase will apply to payments under Title IV-E (relating to foster care and adoption assistance). None of the three temporary FMAP increases described above will apply to Medicaid payments to disproportionate share (DSH) hospital or to payments under the State Children's Health Insurance Program (SCHIP).

In order to receive the temporary FMAP increase, a state must have in place eligibility standards, methodologies, and procedures (such as the length of a redetermination period) that are no more restrictive than those in effect on July 1, 2008. The bill provides special rules for states that implemented more restrictive eligibility standards, methodologies, or procedures after July 1, 2008, but before enactment.

A state is not eligible for the 4.9 percentage point adjustment or any high unemployment adjustment if any amounts attributable (directly or indirectly) to such an increase are deposited or credited into any reserve or rainy day fund.

In the case of a state that requires a county or other locality to contribute toward the state share of Medicaid costs, the state is not eligible for any increase in its FMAP if it requires the county or other locality to pay a larger percentage of the state share than the county or other locality was required to contribute as of September 30, 2008.

Section 5002: Moratoria on Certain Medicaid Regulations

Extends from March 31, 2009, through June 30, 2009, the current law moratoria on implementation of Medicaid regulations relating to cost limits on public providers, graduate medical education (GME) payments, provider taxes, rehabilitative services, targeted case management services, and school administration and transportation services. In addition, the bill imposes a moratorium through June 30, 2009, on implementation of a final regulation published on November 7, 2008, relating to Medicaid outpatient hospital services.

Section 5003: Transitional Medical Assistance

Extends and simplifies transitional medical assistance (TMA), under which individuals who leave welfare to go to work receive up to one year of Medicaid coverage so long as they continue working. The bill extends the current TMA provision, which expires on June 30, 2009, through December 31, 2010. In addition, the bill gives states the option of simplifying TMA eligibility determinations to reduce administrative burden and turnover.

Section 5004: State Eligibility Option for Family Planning Services

This section gives states the option of providing Medicaid coverage for family planning services and supplies to individuals who are not pregnant and whose income does not exceed the highest income eligibility level for pregnant women established under the state's Medicaid or State Children's Health Insurance programs. The allowable coverage includes medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting. In addition, states will have the option of providing this coverage to such individuals during a presumptive eligibility period.

In its *Budget Options for Health Care* (December 2009), CBO presents an option that would require state Medicaid programs to cover family planning services and supplies for low-income women who are not pregnant. The bill allows each state to make its own decision as to whether to provide such coverage. CBO estimates that the option provided by the Committee bill will save the federal government $700 million in Medicaid outlays over the next ten years.

The arguments cited by CBO in support of its budget option apply with equal force to this section of the bill: "The main argument for this option is that it would reduce the number of unplanned pregnancies while resulting in savings to the states and the federal government. A number of benefits are associated with lowering the rate of unplanned pregnancies. Women with unplanned pregnancies are less likely to recognize early signs of pregnancy and thus delay the use of prenatal services until later in their pregnancies, possibly increase the risk of birth complications. In addition, motherhood among young women tends to result in lower educational attainment and higher reliance on public assistance. Finally, reducing unplanned pregnancies could reduce the adverse health consequences of closely spaced births."

Section 5005: Protections for Indians under Medicaid and CHIP

This section establishes protections for American Indians and Alaska Natives under Medicaid and the State Children's Health Insurance Program (SCHIP). The bill prohibits state Medicaid programs from imposing cost-sharing requirements on Medicaid-eligible American Indians or Alaska Natives when the beneficiary is receiving an item or service directly from an Indian health care provider or through referral from a Contract Health Services (CHS) provider. The bill requires that states disregard certain property in determining the Medicaid or SCHIP eligibility of American Indians or Alaska

Natives. Finally, the bill requires that the procedures used by state Medicaid programs for estate recovery exempt certain income, resources, and property described in manual instructions in effect on April 1, 2003.

Section 5006: Consultation on Medicaid and CHIP

This section requires state Medicaid and SCHIP programs to seek advice on a regular, ongoing basis from Indian Health Programs and Urban Indian Organizations on all matters likely to have a direct effect on such Programs and Organizations, including plan amendments, waiver request, and proposals for demonstration projects.

Section 5007: Temporary Increase in DSH Allotments during Recession

Provides a temporary increase in state allotments for payments to Medicaid disproportionate share (DSH) hospitals. The bill increases the DSH allotment for each state for FY 2009 by 2.5 % above the allotment the state would otherwise receive. Each state's DSH allotment for FY 2010 will be 102.5% of its DSH allotment for FY 2009, as increased by the bill. For FY 2011 and each fiscal year thereafter, each state's DSH allotment will be determined as under current law without regard to the temporary increases for FY 2009 and FY 2010.

EXPLANATION OF AMENDMENTS

During the January 22, 2009, Committee business meeting, the Committee considered five separate Committee prints on the following subjects: (1) broadband; (2) energy; (3) health insurance for the unemployed; (4) health information technology; and (5) Medicaid. The text of these prints was comprised of provisions of the legislation proposed by the House Appropriations Committee known as the "American Recovery and Reinvestment Act" that fund communications, energy, and health-related programs created by and within the jurisdiction of the Committee on Energy and Commerce.

At the conclusion of consideration of these prints, the Committee by unanimous consent agreed to replace the text of H.R. 629 as introduced with the text of the five Committee prints as amended during the Committee business meeting. This section will therefore describe amendments to the five Committee prints.

Broadband

Chairman Waxman offered an Amendment in the Nature of a Substitute ("ANS") that incorporated several technical changes. The ANS changed the funding language of "from money appropriated" to "from amounts authorized." It added a requirement that the NTIA coordinate with the FCC while consulting with other federal agencies. To provide enhanced oversight, the ANS added a requirement that NTIA submit an annual report to Congress for five years assessing the impact of the grants funded under this program and whether the grants are meeting the objectives and criteria described. It also gave the NTIA the explicit authority to prescribe rules as necessary to carry out the

purposes of the section. The ANS modified the definition of eligible entities to make it clear that satellite providers, tower companies, and "backhaul companies" (companies that provide facilities critical for connecting broadband and wireless networks) are all potentially eligible for the funds. Finally the ANS dropped the requirement that applicants provide an "engineering plan." The amendment was adopted by voice vote.

Rep. Stupak offered an amendment that requires the FCC to revise its definitions of "unserved" and "underserved" based on data used by the NTIA to develop and maintain its new national broadband map no later than three months after the map becomes available. This allows the FCC to utilize the best available data for the purpose of defining the terms. The Stupak amendment was accepted by voice vote.

Rep. Stupak offered a second amendment that would add to the list of public policy goals to be considered by the NTIA in making the grants whether a grant application will significantly improve interoperable broadband communications used by public safety. The term "interoperable broadband communications systems" is defined as communications systems which enable public safety agencies to share information using voice or data signals via advanced wireless broadband services. Equipment used would include hardware, software, middleware, or network-based IP solutions. The amendment was accepted by voice vote.

Rep. Rush offered an amendment that would add to the list of public policy goals to be considered by the NTIA in making the grants whether the applicant is a "socially and economically disadvantaged small business concern" as defined under the Small Business Act. The amendment was accepted by voice vote.

Rep. Markey offered an amendment to direct the FCC to submit a National Broadband Plan to the Energy and Commerce Committee within one year after enactment. The amendment was accepted by voice vote.

Rep. Walden offered an amendment to delete the prohibition on a state from identifying more than 20% of the geographic area of that state as an area worthy of grant funds. The Walden amendment was adopted by voice vote.

Rep. Blunt offered an amendment that would have prioritized grant applications for unserved areas over underserved areas based on the number of existing service providers. The amendment was defeated on a 23-to-33 vote.

Rep. Buyer offered an amendment to require the FCC to revise the definitions of "unserved" and "underserved." It would require the FCC to also review the percentage distribution currently allocated to unserved and underserved areas. The amendment was defeated on a 21-to-33 vote.

Ranking Member Barton offered an amendment to disqualify applicants that have received or are scheduled to receive Universal Service Fund under its high-cost program

or from the Rural Utilities Service within 12 months of the date of its application for the grant programs. The amendment was defeated on a voice vote.

Energy

An amendment in the nature of a substitute offered by Mr. Waxman was adopted by a voice vote. The Chairman's amendment in the nature of a substitute included the following changes:

- Adding a condition to smart-grid grants for demonstration projects and qualifying smart-grid investments that requires grantees to utilize open internet-based protocols and standards, if available.
- Allowing the Weatherization Assistance Program to proceed separately if cost-effective on separate elements of weatherizing eligible homes, such as attic insulation.
- Elaboration of the categories of eligible recipients of loan guarantees to limit awardees to renewable energy systems that generate electricity and that favor electric power transmission system projects, including upgrading and reconductoring, that require such guarantees to be viable and that serve reliability and environmental objectives.
- Elaboration of what became Section 2005 of H.R. 629, to assure that assumptions and projections made in the study will be fully explained.

An amendment offered by Mr. Upton was adopted by a voice vote. This amendment required the Secretary of Energy to analyze the extent to which legal challenges are delaying construction of transmission lines necessary to access renewable energy.

An amendment offered by Mr. Upton was defeated by a recorded vote, 21 – 33. This amendment would have expanded the category of eligible projects for loan guarantees to include zero-emission technologies.

An amendment offered by Ms. Baldwin was adopted by a voice vote. This amendment allowed leading edge biofuels to be eligible for loan guarantees.

An amendment offered by Mr. Shadegg was adopted by a voice vote. This amendment clarified that that incremental hydropower projects were eligible for loan guarantees.

An amendment offered by Mr. Inslee was adopted by a voice vote. This amendment ensured that prior to receiving funds for state energy programs; governors would notify the Secretary of Energy that to the extent practicable they would seek to prioritize funding for existing energy efficiency and renewable energy programs.

An amendment offered by Mr. Barton was defeated by a recorded vote, 20 – 33. This amendment sought to eliminate the requirement that governors notify the Secretary

of Energy that they would seek to modify utility policies in favor of allowing utilities to promote energy efficiency.

An amendment offered by Mr. Shimkus was defeated on a recorded vote, 19 – 34. This amendment would have made forestry projects and other carbon sequestration projects eligible for loan guarantees.

An amendment offered by Mr. Stearns was defeated by a division vote, 15 - 29. This amendment would have eliminated the requirement that governors notify the Secretary of Energy that they would seek to update their state building energy codes.

An amendment offered by Mr. Walden was ruled non germane. This amendment would have amended the Clean Air Act.

An amendment offered by Mr. Gingrey was withdrawn. This amendment would have amended a governmentwide contracting standard.

An amendment offered by Mr. Terry was ruled non germane. This amendment would have amended the Federal Power Act to create a new program for the promotion of transmission lines.

Health Insurance for the Unemployed

An amendment in the nature of a substitute offered by Mr. Waxman was agreed to as amended by a voice vote. This amendment made a minor change in the Medicaid assistance provided for those affected by the economic downturn. It consolidated two Medicaid eligibility categories—individuals who are receiving unemployment benefits, and individuals who have exhausted those benefits—into one optional category. It also made conforming technical changes.

An amendment offered by Mr. Barton was not agreed to by a vote of 14 to 30. This amendment would have required individuals seeking temporary assistance for COBRA coverage to meet an income test of $100,000 and an asset test of $1,000,000 to qualify for the COBRA coverage option.

An amendment offered by Mr. Stearns was agreed to by voice vote. This amendment imposed an income limit of $1,000,000 on individuals seeking temporary assistance under the COBRA coverage option.

An amendment offered by Mr. Rogers was not agreed to by voice vote. The amendment would have required states that provide coverage through Medicaid to those affected by the economic downturn to offer premium assistance through a voucher to purchase coverage in the individual market as part of that option.

An amendment offered by Mr. Deal was not agreed to by a vote of 13 to 27. This amendment would have imposed a limit of $1,000,000 for those seeking temporary assistance under the Medicaid coverage option.

Health Information Technology

An amendment in the nature of a substitute offered by Rep. Waxman made certain technical corrections to title IV of the Committee print relating to health information technology, including a clarification that Medicare measures of clinical quality should be selected in parallel fashion for hospitals and eligible professionals. The amendment was further amended to clarify that certain grant activities would be directed towards expanding the use of health information technology. The amendment was adopted, amended, by a voice vote.

An amendment offered by Rep. Whitfield would have modified Medicare's sustainable growth rate formula for updating the Medicare physician fee schedule to require an annual increase in fees equal to the Medicare Economic Index. The amendment was defeated by a recorded vote of 15 – 31.

An amendment offered by Rep. Burgess would have modified Medicare's sustainable growth rate formula for updating the Medicare physician fee schedule. The amendment was defeated by a recorded vote of 15 – 34.

An amendment offered by Rep. Gingrey would have set the update for 2010 to Medicare's physician fee schedule to 0 percent. The amendment was defeated by a division vote of 13 – 27.

An amendment offered by Rep. Barton would have created an exception to self-referral prohibitions in the case of a physician owning an interest in a whole hospital. The amendment was defeated by a division vote of 10 – 30.

An amendment offered by Rep. Rogers would have prohibited enforcement of federal privacy and security laws by state attorneys general. The amendment was defeated by a recorded vote of 15 – 32.

An amendment offered by Rep. Blunt provided that nothing in the privacy subtitle of the HITECH Act shall prevent a pharmacist from collecting and sharing information with a patient in order to improve patient safety. The amendment was withdrawn without prejudice.

An amendment offered by Rep. Rogers would allow providers and health plans to market to individuals using their personal health information so long as any remuneration was disclosed and there was notice of a toll-free number patients could call to opt out of the communications. The amendment was withdrawn without prejudice.

An amendment offered by Rep. Markey would require individually identifiable health information be secured by technology to render it unusable, unreadable, or indecipherable. The amendment was adopted by unanimous consent.

An amendment offered by Rep. Murphy of Pennsylvania required all funds made available pursuant to the HITECH Act for health information technology only purchase technology that is manufactured, engineered, programmed in the United States and made substantially from articles, materials, or supplies mined, produced, or manufactured in the United States. The amendment was adopted by a voice vote.

An amendment offered by Rep. Christensen required that one of the purposes of the Office of the National Coordinator for Health Information Technology and Health Information Technology Policy Committee be to reduce health disparities through the use of health information technology. The amendment was adopted by a voice vote.

An amendment offered by Rep. Burgess would permit the donation of health information technology from one provider to another by rolling back anti-fraud protections that currently exist under Medicare. The amendment was defeated by a recorded vote of 16-32.

An amendment offered by Rep. Rogers would require covered entities to only account for disclosures made for health care operations. The underlying bill requires covered entities to account for disclosures made for treatment, payment and health care operations. The amendment was defeated by a voice vote.

An amendment offered by Rep. Burgess would have prohibited incentives payments to eligible professionals for the use of certified electronic health records in Medicare until the sustainable growth rate formula relating to the physician fee schedule remains is repealed. The amendment was defeated by a voice vote.

An amendment offered by Rep. Gingrey would have accelerated the depreciation of health IT expenses for tax purposes. The amendment was ruled non-germane and withdrawn.

An amendment offered by Mr. Gingrey would accelerate the date in which Medicare incentive payments are made for physicians to acquire and use health information technology and delayed the date in which penalties were applied to physician payments for noncompliance. The amendment was defeated by voice vote.

An amendment offered by Mr. Burgess would have accelerated the date in which Medicare incentive payments are made for physicians to acquire and use health information technology to June 2009. The amendment was defeated by a voice vote.

An amendment offered by Rep. Blunt clarifies that nothing in the privacy subtitle of the HITECH Act shall prevent a pharmacist from collecting and sharing information with a patient in order to reduce medication errors and improve patient safety so long as

any remuneration received for making such communication is reasonable and cost based. The amendment was adopted by unanimous consent.

Medicaid

An amendment in the nature of a substitute offered by Mr. Waxman was agreed to by voice vote. This amendment contained a minor change to the text of the Committee print. It added a section that would temporarily raise the Medicaid DSH allotments for all States in Fiscal Years 2009 and 2010 by 2.5 percent each year.

An amendment offered by Mr. Buyer was withdrawn. This amendment would have imposed stricter requirements on state Medicaid programs relating to formularies and prior authorization for single source drugs within six protected classes.

An amendment offered by Mr. Pitts was not agreed to by a recorded vote of 14 to 29. This amendment would have required any entity determining a minor presumptively eligible for family planning services provide parental notification before providing any services.

An amendment offered by Mr. Deal was not agreed to by a recorded vote of 11 to 32. This amendment would have required states under title XIX to require providers to report prices charged to self-paying (non-Medicaid) patients to the state to report to the Secretary of Health and Human Services. The Secretary would then publish these prices on a publicly available website.

An amendment offered by Mr. Deal was not agreed to by a recorded vote of 11 to 32. This amendment would have required states, as a condition of receiving enhanced federal assistance under title XIX beginning with FY 2010, to pay pharmacies a minimum of $9 per prescription dispensed under XIX.

An amendment offered by Mr. Shadegg was not agreed to by a division vote of 9 to 26. This amendment would have mandated that a state offer a premium assistance program under title XIX to allow individuals to use Medicaid funding to purchase health coverage in the individual market or employer coverage as a condition of receiving enhanced federal assistance under section 5001.

An amendment offered by Mr. Rush was withdrawn. This amendment would have expanded the number of entities that receive federally mandated 340B prices.

An amendment offered by Mr. Stupak was withdrawn. This amendment would have required that managed care organizations providing outpatient prescription drugs to individuals under title XIX receive the same rebate from drug manufacturers as the state receives for such covered drugs, without meeting the same statutory protections relating to formularies and prior authorization as the state must follow.

An amendment offered by Mr. Deal was not agreed to by a recorded vote of 11 to 31. This amendment would have prevented states from receiving certain enhanced federal assistance if the state provided coverage to legal immigrants, such as legal immigrant pregnant women and children.

COMMITTEE CONSIDERATION

On Thursday, January 22, 2009, the Committee met in open session and ordered H.R. 629 to be favorably reported to the House by a voice vote.

ROLL CALL VOTES

Clause 3(b) of Rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. A motion by Mr. Waxman to order H.R. 629 favorably reported to the House, amended, by a voice vote. The following is the recorded votes taken during Committee consideration, including the names of those Members voting for and against:

(Insert Recorded Votes)

COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 03

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Blunt, No. 1C, to the Broadband section to prioritize grant applications for unserved areas over underserved areas based on the number of existing service providers.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 23 yeas to 33 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton	X		
Mr. Boucher				Mr. Stearns	X		
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield	X		
Mr. Rush		X		Mr. Shimkus	X		
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel				Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle		X		Mr. Walden	X		
Ms. Harman		X		Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick	X		
Mr. Inslee		X		Mr. Sullivan	X		
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn	X		
Mr. Matheson		X		Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise	X		
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley							
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 3

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Blunt, No. 1C, to the Broadband section to prioritize grant applications for unserved areas over underserved areas based on the number of existing service providers.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 23 yeas to 33 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton	X		
Mr. Boucher				Mr. Stearns	X		
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield	X		
Mr. Rush		X		Mr. Shimkus	X		
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel				Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle		X		Mr. Walden	X		
Ms. Harman		X		Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick	X		
Mr. Inslee		X		Mr. Sullivan	X		
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn	X		
Mr. Matheson		X		Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise	X		
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley							
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 04

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Buyer, No. 1H, to add a section at the end of section 3102 to require the Federal Communications Commission to revise the definition of "unserved" and "underserved", and review the percentage distribution currently allocated to unserved and underserved.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 21 yeas to 33 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell	X			Mr. Hall	X		
Mr. Markey		X		Mr. Upton	X		
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield	X		
Mr. Rush		X		Mr. Shimkus	X		
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle		X		Mr. Walden	X		
Ms. Harman		X		Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn	X		
Mr. Matheson		X		Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise	X		
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes							
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 05

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Upton, No. 1B, to the Energy provisions in section 5003 to expand the category of eligible projects for loan guarantees to include zero-emission technologies.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 21 yeas to 33 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton	X		
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield	X		
Mr. Rush		X		Mr. Shimkus	X		
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle		X		Mr. Walden	X		
Ms. Harman				Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick	X		
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn	X		
Mr. Matheson		X		Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise	X		
Mr. Melancon							
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 06

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Barton, No. 1F, to the Energy provisions to eliminate the requirement that governments notify the Secretary of Energy regarding modifying utility policies to allow utilities to promote energy efficiency.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 20 yeas to 33 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton	X		
Mr. Boucher				Mr. Stearns	X		
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon				Mr. Whitfield	X		
Mr. Rush		X		Mr. Shimkus	X		
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle		X		Mr. Walden	X		
Ms. Harman		X		Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise	X		
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 07

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Shimkus, No. 1G, to the Energy provisions to make eligible for loan guarantees forestry projects and other carbon sequestration projects.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 19 yeas to 34 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton	X		
Mr. Boucher				Mr. Stearns	X		
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield	X		
Mr. Rush		X		Mr. Shimkus	X		
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle		X		Mr. Walden	X		
Ms. Harman		X		Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey			
Mr. Butterfield		X		Mr. Scalise	X		
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 08

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

MOTION: A Motion by Mr. Waxman to order the Energy provisions of H.R. 629 favorably to the House, amended.

DISPOSITION: AGREED TO by a roll call vote of 34 yeas to 17 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman	X			Mr. Barton		X	
Mr. Dingell	X			Mr. Hall		X	
Mr. Markey	X			Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone	X			Mr. Deal		X	
Mr. Gordon	X			Mr. Whitfield		X	
Mr. Rush	X			Mr. Shimkus			
Ms. Eshoo	X			Mr. Shadegg		X	
Mr. Stupak	X			Mr. Blunt		X	
Mr. Engel	X			Mr. Buyer		X	
Mr. Green	X			Mr. Radanovich		X	
Ms. DeGette	X			Mr. Pitts		X	
Mrs. Capps	X			Ms. Bono Mack		X	
Mr. Doyle	X			Mr. Walden		X	
Ms. Harman	X			Mr. Terry		X	
Ms. Schakowsky	X			Mr. Rogers		X	
Mr. Gonzalez	X			Mrs. Myrick			
Mr. Inslee	X			Mr. Sullivan			
Ms. Baldwin	X			Mr. Murphy of PA		X	
Mr. Ross	X			Mr. Burgess		X	
Mr. Weiner	X			Ms. Blackburn			
Mr. Matheson				Mr. Gingrey		X	
Mr. Butterfield	X			Mr. Scalise		X	
Mr. Melancon	X						
Mr. Barrow	X						
Mr. Hill	X						
Ms. Matsui	X						
Mrs. Christensen	X						
Ms. Castor	X						
Mr. Sarbanes	X						
Mr. Murphy of CT	X						
Mr. Space	X						
Mr. McNerney	X						
Ms. Sutton	X						
Mr. Braley	X						
Mr. Welch	X						

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 09

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act"

AMENDMENT: An amendment by Mr. Whitfield, No. 1A, to title IV of Health Information Technology provision to add Sec. 4315 on permanent annual MEI updates to physician fee schedule.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 15 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell				Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield	X		
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich			
Ms. DeGette		X		Mr. Pitts			
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle		X		Mr. Walden	X		
Ms. Harman				Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise	X		
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill							
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 10

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Burgess, No. 1B, to title IV of Health Information Technology provisions to modify Medicare's sustainable growth rate formula.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 15 yeas to 34 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall			
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield	X		
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts			
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise	X		
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 11

BILL: **H.R. 629,** the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Rogers, No. 1E, to Title IV of Health Information Technology provisions to prohibit enforcement of federal privacy and security laws by state attorneys general.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 15 yeas to 32 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee				Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 12

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Burgess, No. 1K, to title IV of Health Information Technology provisions to modify Medicare's sustainable growth rate formula for updating the Medicare physician fee schedule.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 16 yeas to 32 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns	X		
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack	X		
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry	X		
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee				Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 13

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Pitts, No. 1C, to Title V of the Medicaid portion to require that a minor provide parental notification to receive family planning services.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 14 yeas to 29 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon				Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak	X			Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer			
Mr. Green		X		Mr. Radanovich			
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross	X			Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon	X						
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 14

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Deal, No. 1D, to Title V of the Medicaid portion to authorize the states to require providers to report to the State prices charged to self-paying (non-Medicaid) patients. The State would provide the report to HHS. HHS would publish on a public Web site.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 11 yeas to 32 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon				Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer			
Mr. Green		X		Mr. Radanovich			
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 15

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Deal, No. 1E, to Title V the Medicaid portion to require states, as a condition of receiving enhanced Federal assistance under title XIX beginning with FY2010, to pay pharmacies a minimum of $9 per prescription dispensed under title XIX.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 11 yeas to 32 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon				Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer			
Mr. Green		X		Mr. Radanovich			
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 16

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Gingrey (on behalf of Mr. Stearns), No. 1H, to title V of the Medicaid portion adding at end of section 50001 a section on state ineligibility for failure to satisfy documentation requirement.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 14 yeas to 26 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon				Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer			
Mr. Green		X		Mr. Radanovich			
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross	X			Mr. Burgess	X		
Mr. Weiner				Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon							
Mr. Barrow		X					
Mr. Hill	X						
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space	X						
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 17

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Deal, No. 1I, to Title V of the Medicaid portion to prevent states from receiving certain enhanced Federal assistance if the state provided coverage to legal immigrants.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 11 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon				Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer			
Mr. Green		X		Mr. Radanovich			
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon							
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 18

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

MOTION: A Motion by Mr. Waxman to order the Medicaid provisions of H.R. 629 favorably to the House, amended.

DISPOSITION: **AGREED TO** by a roll call vote of 11 yeas to 32 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon				Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer			
Mr. Green		X		Mr. Radanovich			
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch		X					

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 19

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Barton, No. 1A, to Title III of the Health Insurance for the Unemployed portion to require individuals seeking temporary assistance for COBRA coverage to meet an income test of $100,000 and an asset test of $1,000,000 to qualify for the COBRA coverage option.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 14 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns	X		
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee				Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch							

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 20

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Rogers, No. 1C, to Title III of the Health Insurance for the Unemployed portion to require states that provide coverage through Medicaid to those affected by the economic downturn to offer premium assistance through a voucher to purchase coverage in the individual market as part of that option.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 14 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey		X		Mr. Upton			
Mr. Boucher				Mr. Stearns	X		
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon				Mr. Whitfield			
Mr. Rush		X		Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green		X		Mr. Radanovich	X		
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman		X		Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon		X					
Mr. Barrow		X					
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch							

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 21

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

AMENDMENT: An amendment by Mr. Deal, No. 1E, to Title III of the Health Insurance for the Unemployed portion to impose a limit of $1,000,000 for those seeking temporary assistance under the Medicaid coverage option.

DISPOSITION: **NOT AGREED TO** by a roll call vote of 13 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman		X		Mr. Barton	X		
Mr. Dingell		X		Mr. Hall	X		
Mr. Markey				Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone		X		Mr. Deal	X		
Mr. Gordon		X		Mr. Whitfield			
Mr. Rush				Mr. Shimkus			
Ms. Eshoo		X		Mr. Shadegg	X		
Mr. Stupak		X		Mr. Blunt	X		
Mr. Engel		X		Mr. Buyer	X		
Mr. Green				Mr. Radanovich			
Ms. DeGette		X		Mr. Pitts	X		
Mrs. Capps		X		Ms. Bono Mack			
Mr. Doyle				Mr. Walden	X		
Ms. Harman				Mr. Terry			
Ms. Schakowsky		X		Mr. Rogers	X		
Mr. Gonzalez		X		Mrs. Myrick			
Mr. Inslee		X		Mr. Sullivan			
Ms. Baldwin		X		Mr. Murphy of PA	X		
Mr. Ross		X		Mr. Burgess	X		
Mr. Weiner		X		Ms. Blackburn			
Mr. Matheson				Mr. Gingrey	X		
Mr. Butterfield		X		Mr. Scalise			
Mr. Melancon		X					
Mr. Barrow	X						
Mr. Hill		X					
Ms. Matsui		X					
Mrs. Christensen		X					
Ms. Castor		X					
Mr. Sarbanes		X					
Mr. Murphy of CT		X					
Mr. Space		X					
Mr. McNerney		X					
Ms. Sutton		X					
Mr. Braley		X					
Mr. Welch							

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COMMITTEE ON ENERGY AND COMMERCE – 111TH CONGRESS
ROLL CALL VOTE # 22

BILL: **H.R. 629**, the "Energy and Commerce Recovery and Investment Act".

MOTION: A Motion by Mr. Waxman to order the Health Insurance for the Unemployed provisions of H.R. 629 favorably to the House, amended.

DISPOSITION: **AGREED TO** by a roll call vote of 32 yeas to 12 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Waxman	X			Mr. Barton		X	
Mr. Dingell	X			Mr. Hall		X	
Mr. Markey	X			Mr. Upton			
Mr. Boucher				Mr. Stearns			
Mr. Pallone	X			Mr. Deal		X	
Mr. Gordon	X			Mr. Whitfield			
Mr. Rush	X			Mr. Shimkus			
Ms. Eshoo	X			Mr. Shadegg		X	
Mr. Stupak	X			Mr. Blunt		X	
Mr. Engel	X			Mr. Buyer		X	
Mr. Green	X			Mr. Radanovich			
Ms. DeGette	X			Mr. Pitts		X	
Mrs. Capps	X			Ms. Bono Mack			
Mr. Doyle				Mr. Walden		X	
Ms. Harman	X			Mr. Terry			
Ms. Schakowsky	X			Mr. Rogers		X	
Mr. Gonzalez	X			Mrs. Myrick			
Mr. Inslee	X			Mr. Sullivan			
Ms. Baldwin	X			Mr. Murphy of PA		X	
Mr. Ross	X			Mr. Burgess		X	
Mr. Weiner	X			Ms. Blackburn			
Mr. Matheson				Mr. Gingrey		X	
Mr. Butterfield	X			Mr. Scalise			
Mr. Melancon	X						
Mr. Barrow	X						
Mr. Hill	X						
Ms. Matsui	X						
Mrs. Christensen	X						
Ms. Castor	X						
Mr. Sarbanes	X						
Mr. Murphy of CT	X						
Mr. Space	X						
Mr. McNerney	X						
Ms. Sutton	X						
Mr. Braley	X						
Mr. Welch							

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of P.L. 104-1 requires a description of the application of this bill to the legislative branch where the bill relates to terms and conditions of employment or access to public services and accommodations. H.R. 629 is a generally applicable measure that does not have provisions that uniquely apply to the legislative branch.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 3(c)(1) of Rule XIII and clause (2)(b)(1) of Rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of Rule XIII of the Rules of the House of Representatives, the Committee's performance goals and objectives are reflected in the descriptive portions of this report.

CONSTITUTIONAL AUTHORITY STATEMENT

Under clause 3(d)(1) of Rule XIII of the Rules of the House of Representatives, the Committee must include a statement citing the specific powers granted to Congress to enact the law proposed by H.R. 629. Article I, Section 8, Clause 18 of the Constitution of the United States grants the Congress the power to enact this law.

FEDERAL ADVISORY COMMITTEE ACT

The Committee finds that the legislation does not establish or authorize the establishment of an advisory committee within the definition of 5 U.S.C. App., Section 5(b).

UNFUNDED MANDATES STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104-4) requires a statement on whether the provisions of the report include unfunded mandates. The Congressional Budget Office is conducting the analysis of this matter as part of its review of H.R.1, which incorporates provisions of H.R. 629.

EARMARK IDENTIFICATION

H.R. 629 does not include any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of rule XXI.

COMMITTEE ESTIMATE

Clause 3(d)(2) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison by the Committee of the costs that would be incurred in carrying out H.R. 629. However, clause 3(d)(3)(B) of that rule provides that this requirement does not apply when the Committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act. CBO is conducting a cost estimate of H.R.1, which incorporates provisions of H.R. 629.

BUDGET AUTHORITY AND CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, Congressional Budget Office is conducting a cost estimate of H.R. 1, which incorporates provisions of H.R. 629.

MINORITY AND DISSENTING VIEWS

(Insert Views)

Committee on Energy and Commerce
Report on H.R.629
Minority Views

[Title I] Broadband

This title throws nearly $3 billion into the air and hopes the right people catch it when it falls out of the sky more like manna from heaven than money taken away from working families. If the point of this exercise was to meet the President's call for bipartisan ideas that stimulate broadband deployment and the economy, we do not believe that the inclusion of controversial provisions on open access, minimum speeds, and build-out requirements meets such goals. These provisions are not bipartisan, and they harm rather than advance the stated goal. "Open access" is not even defined in the legislation. The speed requirements are unrealistic at best, and at worst they are neither competitively nor technologically neutral. Possibly worst of all, these conditions combine to discourage companies from participating in the stimulus plan.

This title has its priorities upside down. Why else would it send 75 percent of the grants to "underserved areas" and give totally "unserved areas" the leftovers. Most people know what some service is, and what no service is, and they know the difference. This bill either doesn't know the difference, or gets it exactly backwards. In fact, the fair case can be made that all the money should go to unserved areas. Those are the places that need the most help, since there is apparently no market-based business case to deploy there yet. At least in underserved areas, a market appears to be developing. Moreover, sending money to underserved areas simply subsidizes one set of providers as they compete against others. Government's role is not to put fingers on the scale. The Majority rejected an amendment offered by Mr. Blunt that would have addressed this disparity on a party line vote.

Lastly, this title cedes far too much discretion over a $3 billion program to unelected officials at the Federal Communications Commission (FCC). Not only does the public not know who they are, Congress doesn't know who they are. At the moment, only three of the five seats on the Commission are filled, and two of the sitting members must leave if they are not renominated and reconfirmed in short order. Yet the bill leaves it to the FCC to define what "unserved' and "underserved" areas are. It is irresponsible for Congress to allocate $3 billion in this fashion.

Elsewhere in the stimulus package Congress is apparently considering allocating $650 million to pay for the disaster that delaying the digital television transition will cause. Delaying the transition is not necessary, and will cause more harm than good by confusing consumers and jeopardizing spectrum earmarked for public safety and wireless broadband services. It will also cost government and industry millions of more dollars to change five years worth of previous planning. Ensuring that the DTV transition goes forward on February 17, 2009, is perhaps the nation's quickest, most realistic chance of creating a broadband stimulus and creating jobs. To top it off, legislation delaying the

DTV transition has not even passed, so we may be allocating $650 million with nothing to spend it on.

[Title II] Energy Provisions

The most egregious provision in the energy title is one that attempts to promulgate a policy to preserve utility profits at the expense of energy-saving consumers. In order for a state to receive energy efficiency grants, a governor would have to notify the Secretary of Energy that his state is trying to institute a system in which utilities' fixed costs are covered by consumers, independent of energy usage. Under this concept, consumers who follow our persistent advice to consume less energy will see their bills either stay the same or actually rise. Families who buy appliances rated high for energy stinginess will be punished for their good intentions and expensive investments. We believe that consumers should be rewarded when they save energy, not penalized so that electric utility companies can be supported in the luxe style to which they have become accustomed. Mr. Barton proposed an amendment to remedy this injustice; it was rejected on a party-line vote by the Majority.

The energy title fails to address important sources of energy that are essential to stimulating our economy. This title—which authorizes $22.1 billion in spending for renewable energy, transmission projects, and increased energy efficiency—completely neglects almost 70 percent of our country's electricity supply. Mr. Upton proposed an amendment designed to stimulate zero-emissions energy which did not pass. Mr. Shimkus's amendment to add carbon capture and sequestration for coal-fired generation to the list of energy project categories to the proposed temporary program for rapid deployment of energy projects also was rejected. Republican Members' position is that a true stimulus should stimulate all American energy, a suggestion that the Majority rebuffed as too wide-ranging for the narrow focus of the $22.1 billion in stimulus dollars. The Majority totally failed to address energy from America's most abundant source -- coal -- and its cleanest -- nuclear. The Majority's energy mark-up resulted in a package that overstimulates a small area of our economy and neglects the energy sources that provide the most jobs right now, that ensure energy security, and that will provide clean energy for years to come.

Smart-grid technology is extremely promising. It holds the possibility of increasing efficiency throughout the electricity system and giving consumers more control over their own electricity use. However, language was added in Chairman Waxman's substitute which would limit the grants only to recipients using open internet-based protocols and standards, when available. This language, if passed, would result in Congress picking technology winners and losers, without any hearings or discussions. Smart-grid technology is still developing, and there is more than one standard being tested. Forget about paper versus plastic or VHS versus Betamax—the ramifications of determining the industry standards and protocols for deployment of smart grid technology are monumental in comparison. Given the importance of this issue, the one thing that is clear is that smart-grid standards and protocols should be carefully

considered and not added as a last-minute afterthought to the Chairman's substitute with absolutely no discussion or consideration.

The Majority is equally misguided in their position that stimulating the economy should involve micro-managing state and local building codes. The majority proposes $8.4 billion in energy efficiency grants and loans. Rather than funding states and localities to enforce the currently-existing energy efficiency codes, the Majority insists on micro-managing states and localities by mandating adoption of the most recently published version of the International Energy Conservation Code or its equivalent for residential buildings, and the ANSI/ASHRAE/IESNA Standard 90.1-2007 or equivalent for commercial buildings. Mr. Stearns proposed an amendment that would provide grant funding to empower states and localities to enforce the codes that they have chosen in the best interests of their states. The choices for cost-effective energy efficiency technology should be determined by those closest to the building site, not a wide-sweeping federal code. Nevertheless, the Majority insists that states should be forced to conform to a model code to receive the grants.

The mark-up highlighted the need for changes to the Energy Independence and Security Act of 2007 ("EISA"), as evidenced by the rejection of all Minority-offered amendments, including: Mr. Walden's amendment to correct the definition of renewable biomass so advanced biofuels derived from woody material gathered from federal lands and other private lands can be counted towards the renewable fuels standard; Mr. Gingrey's proposed amendment to strike Section 526 of EISA, which restricts procurement and acquisition of alternative fuels; and Mr. Shadegg's proposed amendment to remove the Davis-Bacon provisions from Section 545 of EISA. While the Majority members agreed with the need for an all-encompassing revision to EISA, they stopped short of actually supporting any of the Minority amendments to make improvements to EISA. We hope the Majority lives up to its commitments to revisit EISA and look forward to working with them, when that time comes.

[Title III] Health Insurance for the Unemployed

This title permanently extends COBRA coverage to any person 55 or older who loses their job or to any person that has worked for a company for at least 10 years. This will lead to greater cost for the employers that currently provide health care coverage to their employees and a reduction in employer sponsored health care.

In addition to the change in length to COBRA eligibility, this title establishes a new government subsidy of 65 percent of COBRA premium costs for the first 12 months of coverage. Unfortunately, the bill lacks the thoughtful approach of legislation that results from regular order. The new program for COBRA subsidies does not contain an income test or an asset test. In tough economic times it is unconscionable that we would ask the average American to have their tax dollars transferred to the wealthiest in this country. An amendment was rejected that would have capped eligibility for the government subsidy at $100,000 in annual income and a total of $1 million in assets on a party line vote.

We are pleased that the Majority accepted an amendment that would have capped eligibility for the new government subsidy at $1 million in annual income. We believe this level is still too high, but as previously mentioned, efforts to impose a lower income threshold were rejected.

The legislation expands the Medicaid program to new groups of individuals. The "temporary" Medicaid option is funded 100 percent by the federal government and has no regard to a person's income or asset levels. An amendment to limit the program to individuals with incomes below $1 million in the previous year was rejected.

Medicaid has historically been administered by the states and funded jointly by the states and the federal government. Although there are significant reports of persistent fraud and abuse in the Medicaid program, as reiterated in a recently released study by the Government Accountability Office (GAO), states had the incentive to protect their investments in the program, and they succeeded in getting more money with less reform. The new Medicaid expansion would provide 100 percent of the financing for the program not just for medical services but also for administrative costs. This is a dangerous precedent that will undermine the already unsustainable Medicaid program. Unless there is significant state investment in the program, there will be little or no incentive for the state to govern the program efficiently and ensure that federal taxpayer dollars are being spent responsibly.

An amendment also was rejected that would have provided a premium subsidy for individuals in the new Medicaid expansion so they could enroll in a health plan of their choice. Individuals in Medicaid should have the same options to receive better heath care as those receiving the new COBRA subsidy. The Committee has repeatedly heard of instances where Medicaid fails patients. Many doctors will not participate in the program. Patients must linger on waiting lists or drive miles to find a doctor who takes Medicaid patients.

[Title IV] Health Information Technology

We support the adoption of health information technology and believe its increased adoption will lead to reduced medical errors and improved patient outcomes. However rushed adoption of non-interoperable health information technology could actually impede its deployment.

Although the legislation purports to be an economic stimulus package, the bonus payments for using electronic health records do not go out until 2011 with penalties for not using electronic health records going into effect in 2016. How these are supposed to stimulate a cure for the present recession is a medical mystery. Given that payment incentives are not distributed until 2011, the legislation should have been considered through regular order to ensure that health information technology is disseminated efficiently and effectively.

[Title V] Medicaid Provisions

In what may be considered a fitting coincidence, on the same day that legislation designed to increase the federal share of the costs of the Medicaid program by $98.5 billion over the next two years was favorably reported by the Energy and Commerce Committee, the Government Accountability Office released a report stating that the Medicaid program remained on GAO's list of "high-risk" programs because of "growing concerns about the quality of fiscal oversight, which is necessary to prevent inappropriate program spending." Unfortunately, GAO's concern about the future stability of the Medicaid program is directly contrasted by the provisions in Title V of the *American Recovery and Reinvestment Act of 2009*, which, other than expanding taxpayer coverage of family planning items and services, only serves to temporarily prop up an unsustainable, broken program.

When Senator Mark Warner (D-VA) was the governor of Virginia and the chairman of the National Governors Association, he correctly stated that the unsustainable growth of Medicaid spending has every state and the federal government "on the road to a meltdown." His solution was to update the severely outdated rules and regulations and allow state governments the flexibility to run their programs with increased levels of innovation, efficiency, and accountability. The Republican Members of the Committee on Energy and Commerce believe that Senator Warner was correct in both his assessment of the problem facing Medicaid as well as its solution. In contrast, the proposed solution put forward by the Majority ignores the impending meltdown of the Medicaid system and places a finger in the leaking dam with a proposal to temporarily shift more of the costs of the Medicaid program onto the federal government in exchange for a commitment from the states that they will not reduce their eligibility criteria below where they were on July 1, 2008. While, states retain the flexibility to cut payment rates to the rapidly decreasing number of health care providers that still participate in the Medicaid program and the flexibility to reduce the number of items and services that are covered in Medicaid, states accepting any of the temporarily increased reimbursement rates are prohibited from reforming their eligibility criteria, unless – of course – a state would like to expand its eligibility.

Proponents of this legislation like to claim that it is necessary because states cannot afford the expenses of their current Medicaid programs. However, simply dumping more federal dollars into an unsustainable status quo is not the answer. State officials must be held accountable for the performance of their programs, and states that continue to administer their programs in the same inefficient manner that created the current crisis should not be rewarded with additional federal funds.

The Republicans on the Energy and Commerce Committee are deeply concerned that this legislation will create a very troubling situation on January 1, 2011, when the temporary increases in reimbursement expire. Under the legislation reported out of the Committee, states will be prevented from making certain necessary reforms to their programs and will have additional federal dollars with which to expand their Medicaid enrollment to new populations. As a result, short-sighted state officials may take the bait

and expand their Medicaid program while blissfully ignoring the fact that the billions of dollars worth of increased reimbursement rates will come to an abrupt halt on December 31, 2010. Clearly, if a state cannot afford its Medicaid program today, it is reasonable to assume that this same state will not be able to afford an even larger, more expensive Medicaid program on January 1, 2011. This is why the Republican approach of reforming the Medicaid program and demanding accountability from state officials is the better approach for the American taxpayers, health care providers, and the current and future generations of Medicaid beneficiaries.

The Minority was disappointed that an amendment offered by Dr. Gingrey requiring all states to verify the identity of all applicants for Medicaid coverage was defeated by the Majority. Given the tens of billions of dollars of state and federal Medicaid funds that are lost each year to criminally fraudulent claims and fraudulently enrolled beneficiaries, this amendment would have been an important provision to enable states to continue their current Medicaid program without making cuts to benefits or eligibility.

Joe Barton
Ranking Member

Roy Blunt

Steve Buyer

George Radanovich

Joe Pitts

Mary Bono Mack

Greg Walden

Lee Terry

Mike Rogers

John Sullivan

Michael Burgess

Marsha Blackburn

Phil Gingrey

Steve Scalise

Nathan Deal

Congress of the United States
Washington, DC 20515

Committee on Energy & Commerce
Report on H.R.X 629

Dissenting Views

In addition to the Minority Views expressed by Ranking Member Barton and our Republican colleagues on the Committee, we have some additional concerns that this legislation fails to address. Several Republican Members offered amendments to ensure Medicare beneficiaries continue to have access to their doctors and that new Medicare beneficiaries would be able to find a doctor that would accept Medicare. Unfortunately, these amendments were all rejected on a party-line vote by the Majority.

Over the last several years, the Sustainable Growth Rate (SGR), the formula that controls Medicare physician payment, has forecast deep cuts to Medicare Part B reimbursement. This has created a high-degree of instability for doctors and threatens the viability of their practices. Including a permanent fix to Medicare physician payment rates would have a profound impact on stimulating the health care sector of the U.S. economy, which constitutes 16.2% of GDP, and ensuring vulnerable seniors have access to their doctors.

Phil Gingrey, M.D.
Member of Congress

Michael Burgess, M.D.
Member of Congress