HR 3162

Children's Health and Medicare Protection Act of 2007

Congress: 110 (2007–2009, Ended)
Chamber: House
Policy Area: Health
Introduced: Jul 24, 2007
Current Status: Received in the Senate. Read twice. Placed on Senate Legislative Calendar under General Orders. Cale
Latest Action: Received in the Senate. Read twice. Placed on Senate Legislative Calendar under General Orders. Calendar No. 338. (Sep 4, 2007)
Official Text: https://www.congress.gov/bill/110th-congress/house-bill/3162

Sponsor

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Party: Democratic • **State:** MI • **Chamber:** House

Cosponsors (12 total)

Cosponsor	Party / State	Role	Date Joined
Rep. Pallone, Frank, Jr. [D-NJ-6]	D · NJ		Jul 24, 2007
Rep. Rangel, Charles B. [D-NY-15]	D · NY		Jul 24, 2007
Rep. Stark, Fortney Pete [D-CA-13]	D · CA		Jul 24, 2007
Rep. Baldwin, Tammy [D-WI-2]	D · WI		Jul 27, 2007
Rep. Cuellar, Henry [D-TX-28]	D · TX		Jul 27, 2007
Rep. Engel, Eliot L. [D-NY-17]	D · NY		Jul 27, 2007
Rep. Hirono, Mazie K. [D-HI-2]	D · HI		Jul 27, 2007
Rep. Waxman, Henry A. [D-CA-30]	D · CA		Jul 27, 2007
Rep. Wynn, Albert Russell [D-MD-4]	D · MD		Jul 27, 2007
Rep. Allen, Thomas H. [D-ME-1]	D · ME		Jul 31, 2007
Rep. DeGette, Diana [D-CO-1]	D · CO		Jul 31, 2007
Rep. Green, Gene [D-TX-29]	D · TX		Jul 31, 2007

Committee Activity

Committee	Chamber	Activity	Date
Energy and Commerce Committee	House	Referred to	Jul 24, 2007
Ways and Means Committee	House	Reported By	Aug 1, 2007

Subjects & Policy Tags

Policy Area:

Health

Related Bills

Bill	Relationship	Last Action
110 HR 976	Related bill	**Oct 18, 2007:** The Chair announced that the message and the accompanying bill would be referred to the Committees on Energy and Commerce and Ways and Means and that the Clerk would be directed to notify the Senate of the actions of the House.
110 HRES 594	Procedurally related	**Aug 1, 2007:** Motion to reconsider laid on the table Agreed to without objection.
110 S 1893	Companion bill	**Jul 27, 2007:** Placed on Senate Legislative Calendar under General Orders. Calendar No. 288.

Summary (as of Aug 1, 2007)

Children's Health and Medicare Protection (CHAMP) Act of 2007 - **Title I: Children's Health Insurance Program** - (Sec. 100) States that it is the purpose of this title to provide dependable and stable funding for children's health insurance under titles XXI (Children's Health Insurance Program) (CHIP) (also known as SCHIP) and XIX (Medicaid) of the Social Security Act (SSA) in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today.

Subtitle A: Funding - (Sec. 101) Prescribes formulae for new base CHIP allotments for states and territories beginning with FY2008.

(Sec. 102) Makes CHIP allotments for FY2008 and each following fiscal year available for two years only (currently three years).

(Sec. 103) Provides for redistribution of unused allotments to address state funding shortfalls.

(Sec. 104) Increases from 20% to 100% the percentage of any CHIP allotment that a state may use for Medicaid payments after FY2007.

Subtitle B: Improving Enrollment and Retention of Eligible Children - (Sec. 111) Directs the Secretary of Health and Human Services (HHS) to make performance bonus payments to states to offset the additional Medicaid and CHIP child enrollment costs resulting from enrollment and retention efforts.

Directs the Comptroller General to study and report to Congress on the effectiveness of such performance bonus payment program: (1) on the enrollment and retention of eligible children under the Medicaid and CHIP programs; and (2) in reducing the rate of uninsurance among such children.

(Sec. 112) Gives states the option to provide that, in determining a child's Medicaid eligibility, it may rely on a finding made within a reasonable period from an Express Lane agency. Requires the state to use its regular procedures to determine Medicaid eligibility, however, if the Express Lane finding is negative.

Authorizes a federal or state agency or private entity possessing sources of data potentially pertinent to Medicaid eligibility determinations to convey such data to the state agency administering the state Medicaid plan, subject to specified requirements.

(Sec. 113)Applies Medicaid outreach procedures to all children and pregnant women.

(Sec. 114) Requires payments to states to cover translation or interpretation services in connection with the enrollment and retention under Medicaid of children of families for whom English is not the primary language.

Provides for the use of community health workers for outreach activities.

(Sec. 115) Requires a state child health plan providing child health assistance through a means other than Medicaid to provide for the 12-months continuous eligibility option for targeted low-income children whose family income is below 200% of the poverty line.

Subtitle C: Coverage - (Sec. 121) Requires the child health assistance provided to a targeted low-income child to cover dental services, federally-qualified health center (FQHC) services, and rural health clinic (RHC) services.

(Sec. 122) Revises the definition of both CHIP and Medicaid: (1) Secretary-approved coverage, relating to child health assistance to a targeted low-income child, to require the health benefits coverage to be at least equivalent to the coverage in a benchmark benefit package; and (2) state employee benchmark coverage to be that selected most frequently by employees seeking dependent coverage in either of the previous two plan years.

(Sec. 123) Establishes a 30-day premium grace period for state child health plans.

Subtitle D: Populations - (Sec. 131) Provides for optional coverage of older children, up to age 21, under Medicaid and CHIP.

(Sec. 132) Provides for optional coverage of legal immigrants under Medicaid and CHIP.

(Sec. 133) Gives states the option to expand or add coverage of targeted low-income pregnant women under CHIP.

(Sec. 134) Prohibits the Secretary, through exercise of waiver authority, from providing for federal financial participation to a state for CHIP health care services for individuals who are not targeted low-income children or pregnant women, unless the Secretary determines that no eligible targeted low-income child in the state would be denied such coverage because of such eligibility.

(Sec. 135) Declares that nothing in this Act allows federal payment for individuals who are not legal residents.

(Sec. 136) Requires each state to audit a statistically-based sample of cases of individuals whose eligibility for medical assistance (or child health assistance) is determined under specified requirements for satisfactory documentary evidence of citizenship or nationality, in order to demonstrate to the Secretary's satisfaction that federal Medicaid or SCHIP funds are not unlawfully spent for benefits for individuals who are not legal residents.

Requires a state to remit to the Secretary the federal share of any unlawful expenditures for benefits, for aliens who are not legal residents, which are identified under such an audit.

Subtitle E: Access - (Sec. 141) Amends SSA title XIX (Medicaid) to establish as an agency of Congress the Children's Access, Payment, and Equality Commission to review federal and state payment policies of the Medicaid and CHIP programs and make pertinent recommendations to Congress.

(Sec. 142) Directs the Comptroller General to develop, and report to Congress on, a model process for the coordination of Medicaid and CHIP enrollment, retention, and coverage of children who, because of migration of families, emergency evacuations, educational needs, or otherwise, frequently change their state of residency or otherwise are temporarily located outside of the state of their residency.

(Sec. 143) Gives states the option to require children to present satisfactory documentary evidence of proof of U.S. citizenship or nationality for Medicaid eligibility purposes.

(Sec. 144) Directs the Secretary to develop a program to deliver oral health educational materials that inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within their newborn's first year of life.

Prohibits a state from preventing an FQHC from contracting with private practice dental providers in the provision of FQHC services.

(Sec. 145) Prohibits the Secretary from approving any new health opportunity account demonstration programs.

Subtitle F: Quality and Program Integrity - (Sec. 151) Requires the Secretary to establish a child health care quality measurement program to develop and implement pediatric quality measures for children's health care, as well as overall program performance measures, that may be used by public and private health care purchasers.

(Sec. 152) Requires any state child health plan to apply to CHIP coverage, state agencies, enrollment brokers, and managed care entities and organizations certain managed care quality safeguards that apply to such coverage and entities under Medicaid.

(Sec. 153) Directs the Secretary to conduct an independent subsequent evaluation of 10 states with approved child health plans.

(Sec. 154) Grants access to CHIP records for Inspector General and General Accounting Office audits and evaluation.

Title II: Medicare Beneficiary Improvements - Subtitle A: Improvements in Benefits - (Sec. 202) Amends SSA title XVIII (Medicare) to provide coverage of, and waiver of cost-sharing for, specified preventive services. Eliminates coinsurance in outpatient hospital settings and waives application of any deductible for all preventive services, as well as medical nutrition therapy services.

(Sec. 202) Revises requirements for payments from the Federal Supplementary Medical Insurance Trust Fund. Waives the deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.

(Sec. 203) Eliminates the 62 1/2% limitation on payments for outpatient treatment of mental disorders (thus requiring parity of payments for mental health coinsurance).

Subtitle B: Improving, Clarifying, and Simplifying Financial Assistance for Low Income Medicare Beneficiaries - (Sec. 211) Provides that, beginning in 2009, the maximum resources level shall be the same for both part D low-income subsidy (LIS) groups. Sets such level in 2009 at $17,000 for an individual and $34,000 for a couple, and in subsequent years at the previous year's level increased by the annual percentage increase in the consumer price index. Applies such maximum resource levels also to eligibility determination for Medicare Savings programs.

(Sec. 212) Revises requirements for the program under which individuals qualifying for Medicare (QIs) also qualify for Medicaid. Repeals the termination date for the QI program to make the program permanent. Eliminates the funding limitation, thereby expanding eligibility to all persons meeting the income and resource criteria. Provides a 100% federal medical assistance percentage (FMAP) for payments under the QI program. Sets the resources standard for the QI program at 150% of the federal poverty level.

(Sec. 213) Requires that individuals applying for the part D LIS program be permitted to apply on the basis of self-certification of income and resources. Subjects matters attested to in the application to appropriate methods of verification without the individual's need to provide additional documentation, except in extraordinary situations as determined by the Commissioner.

Requires that a subsidy eligible individual (or particular class, such as a full or partial subsidy individual) be deemed to continue to be eligible without the need for any annual or periodic application (automatic reenrollment), unless and until the individual notifies a responsible federal or state official that the eligibility conditions have changed so that the individual is no longer subsidy eligible.

Requires the Secretary to take all reasonable steps to encourage states to provide, under the Medicare Savings Program (MSP), for such administrative verification of income and automatic reenrollment.

Directs the Commissioner of Social Security to provide Medicare part A benefit applicants information describing the MSP and the LIS program (LISP), applications for LISP for medical assistance for Medicare cost-sharing, as well as information on how to obtain assistance in completing such applications.

Requires the Commissioner to: (1) make such application forms available at local Social Security Administration (SS Admin) offices; and (2) provide training to SS Admin employees in assisting applicants in completing an MSP application.

Requires the state Medicaid agency to accept MSP applications and act on them in the same manner, and subject to the same deadlines, as if they had been submitted directly by the applicant.

Requires the Secretary to translate the Model Form used for MSP applications into at least 10 languages that are most often used by persons applying for Social Security or Medicare part A benefits.

Amends the Internal Revenue Code to provide for the disclosure of tax return information to SS Admin officers and employees for purposes of providing low-income subsidies under Medicare.

(Sec. 214) Prohibits any estate recovery of Medicaid correctly paid for Medicare cost-sharing or related benefits on behalf of an individual who was 55 years of age or older when the individual received such medical assistance.

(Sec. 215) Eliminates part D cost-sharing for certain non-institutionalized full-benefit dual eligible mentally retarded individuals.

(Sec. 216) Excludes from calculation of income and resources for LIS eligibility the value of any life insurance policy or any balance in a pension or retirement plan.

(Sec. 217) Limits the aggregate cost-sharing per year for LIS-eligible individuals to 5% of income.

(Sec. 218) Prohibits the automatic enrollment of a part D eligible individual in a prescription drug plan unless the plan meets specified formulary, pharmacy network, quality, and low cost requirements.

Subtitle C: Part D Beneficiary Improvements - (Sec. 221) Revises requirements for the annual out-of-pocket threshold that part D beneficiaries must meet for any costs incurred by AIDS drug assistance programs and the Indian Health Service.

(Sec. 222) Permits a special enrollment period in the case of an individual enrolled in a prescription drug plan (PDP) or Medicare Advantage-Prescription Drug (MA-PD) plan who has been prescribed a covered part D drug while so enrolled, if the formulary of the plan is materially changed (in midyear, and other than because of a Food and Drug Administration recall or withdrawal) in a way to reduce the drug coverage (or increase the cost-sharing).

(Sec. 223) Repeals the exclusion of benzodiazepines from required part D drug coverage (thus extending coverage to such drugs).

(Sec. 224) Authorizes the Secretary to apply to part D the same process for updating drug compendia as used under Medicare part B.

(Sec. 225) Requires PDP formularies to include all or substantially all covered part D drugs in the therapeutic classes: (1)

anticonvulsants; (2) antineoplastics; (3) antiretrovirals; (4) antidepressants; (5) antipsychotics; and (6) immunosuppressants.

(Sec. 226) Eliminates part D late enrollment penalties for LIS-eligible individuals.

(Sec. 227) Creates a special enrollment period for LIS-eligible individuals, together with automatic enrollment for those who fail to enroll in a PDP or MA-PD plan during such period.

Subtitle D: Reducing Health Disparities - (Sec. 231) Directs the Secretary to: (1) collect data on the race, ethnicity, and primary language of each Medicare benefits applicant and recipient; (2) analyze and report on such data annually to the Director of the Office for Civil Rights and specified congressional committees; and (3) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, and primary language data.

(Sec. 232) Directs the Secretary to study and report to the appropriate congressional committees on ways that Medicare should develop payment systems for language services using the results of Sec. 233 demonstration programs to improve effective communication between Medicare service providers and Medicare beneficiaries who are limited English proficient.

(Sec. 233) Directs the Secretary, acting through the Centers for Medicare & Medicaid Services, to award 24 three-year grants to eligible Medicare service providers to conduct such demonstration programs, especially for providers and beneficiaries living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to culturally and linguistically appropriate services.

(Sec. 234) Directs the Secretary to establish a demonstration project to determine the greatest needs and most effective methods of outreach to Medicare beneficiaries who were previously uninsured.

(Sec. 235) Directs the Inspector General of the Department of Health and Human Services to report on: (1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding the Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, and the Office of Minority Health's Culturally and Linguistically Appropriate Service Standards in health care; and (2) a description of the costs associated with or savings related to the provision of language services. Directs the Department of Health and Human Services to implement changes responsive to any deficiencies identified in the report.

(Sec. 236) Requires the Secretary to seek to arrange with the Institute of Medicine to report on the impact of language access services on the health and health care of limited English proficient populations.

Title III: Physicians' Service Payment Reform - (Sec. 301) Amends SSA title XVIII (Medicare) to require establishment of: (1) separate target growth rates for service categories; (2) separate conversion factors for each service category; and (3) updates for such conversion factors.

(Sec. 302) Directs the Secretary to: (1) establish an expert panel to identify misvalued physicians' services; and (2) conduct a five-year review of physicians' services in conjunction with the five-year review by the American Medical Association/Specialty Society Relative Value Update Committee (RUC), particularly for services that have experienced substantial changes in length of stay, site of service, volume, practice expense, or other factors that may indicate changes in physician work.

Gives the Secretary the authority to reduce the work component for services with accelerated growth without using the RUC process.

(Sec. 303) Requires the Secretary to develop a mechanism to measure resource use on a per capita and an episode basis in order to provide confidential feedback to physicians in the Medicare program on how their practice patterns compare to physicians generally, both in the same locality as well as nationally.

(Sec. 304) Creates incentive payments under the Medicare program for participating physicians practicing in an efficient area.

(Sec. 305) Directs the Comptroller General to analyze and report to Congress on: (1) codes paid under the Medicare physician fee schedule to determine whether the codes for procedures that are commonly furnished together should be combined; and (2) those procedures under the same schedule for which no global payment methodology is applied but for which a "bundled" payment methodology would be appropriate.

(Sec. 306) Directs the Secretary to establish: (1) an expanded medical home demonstration project; and (2) a process for selection of a qualified standard setting and certification organization to establish standards for medical practices to qualify as medical homes or as HIT-enhanced medical homes.

Requires the Secretary to provide for payment to the personal physician of each participating beneficiary of a monthly medical home care management fee.

(Sec. 307) Repeals the Physician Assistance and Quality Initiative Fund.

(Sec. 308) Requires the Secretary to revise the fee schedule areas for California for services furnished on or after January 1, 2008 using a specified proposed county-based geographic adjustment factor.

(Sec. 309) Requires diagnostic imaging services to be furnished at an accredited facility in order to be covered by the part B physicians' services fee schedule.

Provides for the adjustment in practice expenses to reflect a higher presumed utilization of such imaging services. Requires the Secretary to adjust the number of practice expense relative value units for imaging services to reflect a 75%, rather than a 50%, presumed rate of utilization.

Directs the Secretary to increase from 25% to 50% the reduction in expenditures ("discount") attributable to the multiple procedure payment reduction applicable to the technical component for single-session imaging involving consecutive body parts under a specified final rule published by the Secretary in the Federal Register.

Directs the Secretary, in computing the practice expense component for imaging services, to change the interest rate assumption for capital purchases of imaging devices to reflect the prevailing rate in the market, but in no case higher than 11%.

Prohibits the Secretary from accepting or paying a claim for imaging unless it is made separately for each component of such services. (Thus disallows global billing.)

(Sec. 310) Reduces the frequency of meetings of the Practicing Physicians Advisory Council from once each quarter to once a year.

Title IV: Medicare Advantage Reforms - Subtitle A: Payment Reform - (Sec. 401) Revises requirements for Medicare Advantage (MA) rates for monthly capitation payments to the MA plans, currently set by a process based on county level benchmarks and MA plan bids.

Requires phase-out of payments to MA plans in excess of 100% of the average Fee-for-Service (FFS) costs in each county over four years to 100% of the FFS cost in the county in 2011. Prescribes a formula for blended county benchmarks and FFS to accomplish this goal. Excludes indirect medical education (IME) costs from the calculation of the 100% FFS for an MA plan in a county area.

Provides that, if a MA plan bid exceeds 106% of the county FFS amount for 2009 or 103% of the FFS amount in 2010, then that MA plan may not enroll any new enrollees for that year during the annual, coordinated election period or during the year (if the enrollment becomes effective during the year).

Requires FFS rates to be rebased annually beginning in 2009.

Repeals the regional Preferred Provider Organization (PPO) stabilization fund.

Subtitle B: Beneficiary Protections - (Sec. 411) Requests the National Association of Insurance Commissioners (NAIC) to develop and submit to the Secretary model regulations regarding Medicare plan marketing, enrollment, broker and agent training and certification, agent and broker commissions, and market conduct by plans, agents and brokers. Prescribes general guidelines for such regulations.

Declares that any contract with an MA organization shall require it to meet all marketing and enrollment standards adopted pursuant to such NAIC model regulations, subject to specified sanctions.

Doubles the civil monetary penalties that may be imposed on an MA organization that violates its contract.

Requires the Secretary to: (1) disclose on the HHS public website all market and advertising contract violations and imposed sanctions; and (2) develop standard definitions of benefits and formats for use in marketing materials.

Specifies funding to support Medicare part C and part D (Voluntary Prescription Drug Benefit Program) counseling and assistance provided by State Health Insurance Assistance Programs (SHIPs).

(Sec. 412) Requires Medicare part C (private) plans to offer benefits under the original Medicare FFS program option with cost-sharing requirements no greater than those imposed under the traditional Medicare program. States that nothing shall be construed as prohibiting Medicare part C plans from using flat co-payments or per diem rates in lieu of part A or part B cost-sharing amounts, as long as they do not exceed the level of cost-sharing under traditional Medicare.

Prohibits Medicare part C plans from imposing cost-sharing for dual-eligible individuals or qualified Medicare beneficiaries enrolled in a Medicare part C plan that exceeds the cost-sharing amounts permitted under the Medicare and Medicaid statutes.

(Sec. 413) Authorizes continuous open enrollment in Medicare part C plans for full benefit dual-eligible individuals and qualified Medicare beneficiaries (QMBs). Changes the continuous open enrollment period to allow institutionalized, dual-eligible individuals and QMBs to disenroll from MA plans and return to traditional Medicare at any time.

Authorizes special election periods for specified low-income Medicare beneficiaries and beneficiaries enrolled in

Medicare part C plans in which enrollment has been suspended for not meeting the terms of their contracts.

Requires the Secretary to take into account the health or well-being of the individual when determining the exceptional conditions in which individuals may be allowed to take advantage of a special election period.

Increases from one year to two years the length of time certain categories of individuals who leave Medicare part C plans have to enroll in a Medigap plan.

Prohibits the Secretary from enrolling Medicaid-eligible individuals (automatically) as dual-eligibles or QMBs in a Medicare part C plan without the individual's affirmative enrollment application.

(Sec. 414) Directs the Secretary to publish for each Medicare part C plan: (1) its medical loss ratio in the previous year: (2) the per enrollee payment to the plan, as adjusted to reflect a risk score of 1.0; and (3) the average risk score (as so based).

Prescribes requirements for preparation of the data necessary for such information, including standardized data elements and definitions.

Requires a contract with a Medicare part C organization to provide the Secretary with the right to audit and inspect any pertinent book or record.

Provides that, beginning in 2010, if an MA plan fails to have a medical loss ratio of at least .85, it will be subject to the following sanctions: (1) reduction of the blended benchmark amount; (2) no new enrollees for a specified period of time; and (3) termination of the plan contract if the plan fails to have such a medical loss for five consecutive contract years.

Directs the Secretary to publish monthly the actual enrollment in each Medicare part C plan by contract and county.

Requires the Medicare Payment Advisory Commission (MEDPAC) to study and report to Congress on the need and feasibility of providing for different minimum medical loss ratios for different types of Medicare part C plans.

Subtitle C: Quality and Other Provisions - (Sec. 421) Requires any Medicare Advantage organization offering a private fee-for-service plan or an MSA plan for contract year 2009 to submit to the Secretary the same information on the same performance measures for which such information must be submitted for Medicare part C plans that are PPO plans for that year. Requires any such Medicare Advantage organization for contract year 2010 to submit to the Secretary the same performance measure information for which such information must be submitted for coordinated Medicare part C plans for that year.

Requires employer-sponsored Medicare part C plans to have 90% of the Medicare beneficiaries enrolled in the plan reside in a county in which the organization offers a Medicare part C local plan.

(Sec. 422) Requires the Secretary to develop quality measures for Medicare part C plans that measure disparities in the amount and quality of health services provided to racial and ethnic minorities.

Requires the Secretary to provide for Medicare part C organizations to submit data that permits analysis of such disparities, together with biennial reports to Congress on how quality assurance programs measure and report on them.

(Sec. 423) Requires Medicare Advantage plan audits to cover plan information submitted for risk adjustment purposes.

Authorizes the Secretary to take actions, including pursuit of financial recoveries, necessary to address deficiencies

identified in an audit or other activities.

Applies such authority of the Secretary to PDPs under Medicare part D.

(Sec. 424) Directs the Secretary to report to Congress on the adequacy of the Medicare Advantage risk adjustment system.

(Sec. 425) Eliminates the providers' ability to bill enrollees in private fee-for-service plans more than the Medicare fee schedule amount.

Repeals the exemption of private FFA plans from the Secretary's authority to review and negotiate Medicare Advantage plan bid amounts. (Thus authorizes the Secretary to review and negotiate the bid amounts for private FFS plans in the same manner as with other Medicare part C plans.)

(Sec. 426) Renames the Medicare Advantage program as the Medicare part C program.

Subtitle D: Extension of Authorities - (Sec. 431) Extends the authority to limit enrollment in special needs plans (SNPs) to only special needs beneficiaries for periods before January 1, 2012.

Redefines a special needs plan to require that at least 90% of enrollees: (1) are institutionalized as determined under regulation in effect as of July 1, 2007; (2) are also entitled to Medicaid and are full-benefit dual eligible individuals for Medicare and Medicaid or qualified Medicare beneficiaries; or (3) have a severe or disabling chronic condition of the type that the plan is committed to serve as indicated by the data submitted for the risk-adjustment of plan payments. Requires special needs plans to meet additional requirements for enrollment.

Requires special needs plans for institutionalized individuals to: (1) have an agreement with the state regarding cooperation on the coordination of care for such individuals; (2) have contracts with long-term care facilities and other area providers sufficient to provide proper care; and (3) report to the Secretary on additional quality measures.

Requires special needs plans for dual eligible individuals to have agreements with the state Medicaid agency regarding cooperation on the coordination of the financing of care for such individuals, certain payment requirements, and capitation payments. Limits out-of-pocket costs for part A and part B services charged to enrollees to maximum Medicaid out-of-pocket costs.

Requires special needs plans for severe or disabling chronic conditions to serve Medicare beneficiaries with one or more of the following specific severe or disabling chronic conditions: (1) cardiovascular; (2) cerebrovascular; (3) congestive health failure; (4) diabetes; (5) chronic obstructive pulmonary disease; or (6) HIV/AIDS. Requires the plan also to have: (1) an average risk score of 1.35 or greater; (2) an established and actively managed chronic care improvement program for each of the conditions that it serves that significantly exceeds the features and results of such programs established and managed by non-SPN Medicare Part C plans; and (3) a network of a sufficient number of primary care and specialty physicians, hospitals, and other health care providers under contract so that the plan can clearly meet the routine and specialty needs of the severely ill and disabled enrollees throughout the plan service area.under section 1853(a)(1)(C)

Requires the Secretary to develop new quality measures appropriate to meeting the needs of special needs plan beneficiaries who are institutionalized or dually eligible individuals, or individuals with severe or disabling chronic conditions.

(Sec. 432) Extends for three additional years the length of time a cost-based plan may continue operating in an area

where either two local or two regional Medicare Advantage plans had entered.

Applies certain Medicare Advantage requirements to reasonable cost contract extended or renewed after enactment of this Act.

Title V: Provisions Relating to Medicare Part A - (Sec. 501) Amends SSA title XVIII (Medicare part A (Hospital Insurance Benefits for Aged and Disabled)) to set the following inpatient hospital payment updates for acute hospitals and for other hospitals: (1) for acute hospitals, for FY2007, the market basket percentage increase for hospitals in all areas, and for FY2008, the market basket percentage increase minus .25 percentage points for hospitals in all areas; and (2) for other hospitals, for FY2003-FY2007, the market basket percentage increase, and for FY2008, the market basket percentage increase minus .25 percentage point.

(Sec. 502) Sets the payment update factor for FY2008 at 1% for payments for inpatient rehabilitation facility (IRF) services.

Amends the Deficit Reduction Act of 2005 to require the IRF compliance rate to remain at a maximum of 60% for cost reporting periods beginning on or after July 1, 2006. Requires the Secretary to continue to consider comorbidities as qualifying conditions.

Creates a special payment rule for patients in IRFs admitted for three applicable medical conditions: (1) unilateral knee replacement; (2) unilateral hip replacement; and (3) unilateral hip fracture.

Directs the Secretary to examine and report to Congress on: (1) Medicare beneficiaries' access to medically necessary rehabilitation services; (2) alternatives or refinements to the 75% rule policy for determining exclusion criteria for IRF designation; and (3) any condition for which individuals are commonly admitted to IRFs to determine the appropriate setting of care, and any variation in patient outcomes and costs, across settings of care, for treatment of such conditions.

(Sec. 503) Creates cross-references to the Medicare, Medicaid, and CHIP Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and CHIP Benefits Improvement and Protection Act of 2000 for the prospective payment of long-term care hospitals (LTCHs). Makes the LTCH base rate for rate year 2008 the same as the one used for discharges in the previous rate year.

Defines LTCH and establishes new patient criteria for prospective payment to LTCHs.

Requires the Secretary to approve distinct part rehabilitation units in certain LTCHs if rehabilitation services are not included within one of the major diagnostic categories.

Directs the Secretary to contract with one or more appropriate fiscal intermediaries or Medicare administrative contractors to review the medical necessity of long term care admissions and continued stays for individuals entitled to benefits under Medicare part A.

Directs the Secretary to impose a four-year moratorium, with certain exceptions, on certification of new LTCHs (and satellite facilities) and new LTCH and satellite facility beds.

Creates a separate classification for a certain long-stay cancer hospital.

(Sec. 504) Raises the disproportionate share hospital (DSH) adjustment cap for small urban hospitals and rural hospitals to 16% for discharges occurring in FY2008 and to 18% for discharges in FY2009. Makes the adjustment cap for

discharges on or after October 1, 2009, revert to 12%.

Prescribes a special rule for computing the DSH percentage for hospitals in Puerto Rico.

(Sec. 505) Authorizes the Secretary to compute the target amount for the hospital's 12-month cost reporting period beginning during FY2008 in the case of certain cancer hospitals exempt from the inpatient prospective payment system (IPPS) that: (1) received payment for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1999; and (2) request a rebasing.

Establishes three additional IPPS-exempt cancer hospitals for cost reporting periods beginning after January 1, 2006.

Directs MEDPAC to evaluate and report to the Secretary and Congress on: (1) measures of payment adequacy and Medicare margins for PPS-exempt cancer hospitals; (2) the margins of a PPS-exempt cancer hospital and another hospital with which it was previously affiliated as separate entities, as well as their margins when affiliated; and (3) payment adequacy for cancer discharges under the Medicare IPPS.

(Sec. 506) Eliminates the skilled nursing facility market basket update for FY2008.

(Sec. 507) Revokes the deeming authority granted to the Joint Commission of Healthcare Organizations to accredit hospitals for participation in Medicare.

(Sec. 508) Amends the Medicare Improvements and Extension Act of 2006 (MIEA) and Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MPDIMA) to extend through FY2009 the geographic reclassification of certain hospitals otherwise unable to qualify for administrative reclassification to areas with higher wage index values.

(Sec. 509) Amends MPDIMA to enable Minnesota to designate one hospital in Cass County as a necessary provider of health care on or after January 1, 2006.

Designates a hospital located in Butler County, Alabama, as a critical access hospital.

Title VI: Other Provisions Relating to Medicare part B - Subtitle A: Payment and Coverage Improvements - (Sec. 601) Amends SSA title XVIII (Medicare part B (Supplementary Medical Insurance Benefits for Aged and Disabled)), as amended by MIEA, to extend through calendar 2009 the process for exceptions from beneficiary payment limits for Medicare part B outpatient physical therapy services.

Directs the Secretary to study and report to Congress on refined and alternative payment systems to the Medicare payment cap for physical therapy, speech-language pathology, and occupational therapy services.

(Sec. 602) Establishes a separate definition for outpatient speech language pathology services to permit speech language pathologists practicing independently to bill part B, subject to the same conditions applicable to physical and occupational therapists in independent practice.

(Sec. 603) Removes the limitation on the fee schedule amount for a service furnished by a certified nurse midwife to 65% of the fee amount for a physician.

(Sec. 604) Sets the outpatient hospital fee schedule increase factor for services furnished in 2008 as the market basket increase reduced by .25 percentage points.

(Sec. 605) Creates an exception to the 60-day limit on Medicare reciprocal billing arrangements in the case of physicians ordered to active duty in the armed forces.

(Sec. 606) Excludes clinical social worker services from the skilled nursing facility PPS.

(Sec. 607) Includes marriage and family therapist services and mental health counselor services within the definition of medical and other heath services covered under Medicare part B. Excludes such services, however, from the skilled nursing facility PPS.

(Sec. 608) Eliminates the option to purchase a power-driven wheelchair with a lump sum payment at the time a purchase agreement has been entered into. (Does not, however, eliminate the lump-sum purchase option for a replacement wheelchair.)

(Sec. 609) Decreases from 36 continuous months to 18 continuous months the length of time Medicare will make rental payments for oxygen equipment before transferring title to the beneficiary. Maintains the 36-month rule, however, for oxygen generating portable equipment (concentrators or transfilling systems).

Directs the Secretary to study and report to Congress on the service component and equipment component of the provision of oxygen to Medicare beneficiaries.

(Sec. 610) Increases by 5% the part B payment for applicable mental health services.

(Sec. 611) Extends cost reimbursement for brachytherapy services until January 1, 2009.

(Sec. 612) Requires the Secretary to use a specified formula to assure consistent volume-weighting in the computation of the average sales price (ASP) payable for drugs and biologicals furnished on or after July 1, 2008.

Modifies the Competitive Acquisition Program (CAP), permitting continuous open enrollment and appropriate delivery and transport by a selecting physician of drugs to the site of administration.

Requires the Secretary to: (1) conduct an outreach and education program on the CAP; and (2) provide for the rebidding of CAP contracts only for periods on or after the expiration of the contract in effect on the date of enactment of this Act, except in the case of a contractor terminated for suspension or revocation of the license to deliver drugs or bioligicals, or for specified program-related crimes.

Establishes a special rule for the payment calculation for each single source inhalaton drug or biological furnished through items of DME, as well as certain multiple source inhalation drugs.

Subtitle B: Extension of Medicare Rural Access Protections - (Sec. 621) Extends the floor on Medicare work geographic adjustment through December 31, 2009.

(Sec. 622) Amends the Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000, as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and other specified law, to extend through December 31, 2009, the special treatment of certain physician pathology services under Medicare.

(Sec. 623) Extends until July 1, 2009, reasonable cost reimbursement for certain clinical diagnostic laboratory services

provided by qualified rural hospitals.

(Sec. 624) Extends through December 31, 2009, the Medicare incentive payment program for physician scarcity areas.

(Sec. 625) Reinstates the ground ambulance bonus payments for rural areas for the period beginning on January 1, 2008, and ending on December 31, 2009.

(Sec. 626) Extends a specified hold harmless for small rural hospitals under the hospital outpatient department PPS, by maintaining through calendar year 2009 the calendar year 2007 payment of 90% of the difference between PPS payments and payments that would have been made under the prior reimbursement system.

Subtitle C: End Stage Renal Disease Program - (Sec. 631) Directs the Secretary, acting through the Director of the National Institutes of Health, to establish demonstration projects to: (1) increase public and medical community awareness about the factors that lead to chronic kidney disease, how to prevent it, how to diagnose it, and how to treat it; (2) increase screening and use of prevention techniques for chronic kidney disease for Medicare beneficiaries and the general public; and (3) enhance surveillance systems and expand research to better assess the prevalence and incidence of chronic kidney disease.

(Sec. 632) Extends Medicare coverage to kidney disease patient education services.

Requires the Comptroller General to report to Congress on the chronic kidney disease Medicare program.

(Sec. 633) Requires training for patient care dialysis technicians.

(Sec. 634) Requires MEDPAC to report to the Secretary and Congress on the barriers that exist to increasing the number of individuals with end-stage renal disease who elect to receive home dialysis services under Medicare.

(Sec. 635) Sets the payment amounts for erythropoietin and darbepoetin alfa furnished during 2008 or 2009 to an individual with end stage renal disease (ESRD) by a large dialysis facility.

(Sec. 636) Makes the payment for providers of dialysis services furnished by hospital-based facilities the same as the rate for services furnished by renal dialysis facilities that are not hospital-based (site neutral composite rate), with an exception for the application of the labor share of the geographic index to hospital-based facilitates.

(Sec. 637) Requires the Secretary to implement a bundled ESRD payment system under which a single payment is made for Medicare renal dialysis services.

Requires quality incentive payments for ESRD services meeting certain performance standards that are furnished during specified periods during 2008 through 2011.

(Sec. 638) Directs MEDPAC to report to Congress on the implementation of the ESRD bundling payment system.

(Sec. 639) Requires the Inspector General of the Department of Health and Human Services to study and report to Congress on dosing guidelines, standards, protocols, and alogorithims for erythropoietin stimulating agents (ESAS) recommended or used by providers of services and renal dialysis facilities.

Subtitle D: Miscellaneous - (Sec. 651) Prescribes new requirements for hospitals to qualify for the hospital exception to the general prohibition against physician referral (self-referral) of Medicare patients for certain services to facilities in which they (or their immediate family members) have financial interests.

Title VII: Provisions Relating to Medicare Parts A and B - (Sec. 701) Eliminates the market basket update for home health payments for 2008.

(Sec. 702) Amends the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended by the Deficit Reduction Act of 2005, to extend through calendar 2009 the temporary Medicare payment increase for home health services furnished in a rural area.

(Sec. 703) Amends SSA title XVIII to extend from 30 to 42 months the coordination period for ESRD Medicare Secondary Payer requirements under which any third-party group health plan coverage beneficiaries receive through their employer or their spouse's employer is the primary payer.

Applies this extended coordination period, however, only to those individuals who receive group coverage through a large group health plan (one offered by an employer that normally employed at least 100 employees on a typical business day during the preceding calendar year)

(Sec. 704) Directs the Secretary to develop a plan to implement, beginning in FY2010, a policy to reduce or eliminate payments under Medicare for never events.

Defines "never event" as an event involving the delivery of (or failure to deliver) physicians' services, inpatient or outpatient hospital services, or facility services furnished in an ambulatory surgical facility in which there is an error in medical care that: (1) is clearly identifiable, usually preventable, and serious in consequences to patients; and (2) indicates a deficiency in the safety and process controls of the services furnished with respect to the physician, hospital, or ambulatory surgical center involved.

(Sec. 705) Provides for redistribution of residency slots (including those for osteopaths and allopaths) if one or more hospitals with approved medical residency training programs, located within the same metropolitan statistical area as of January 1, 2001, closes.

Requires the Secretary, in the event of such a closure, to increase by no more than 10 the otherwise applicable resident limit for each hospital within the same metropolitan statistical area that meets specified criteria, including a maximum of 400 beds.

Requires the Secretary shall increase by two the otherwise applicable limit on osteopathic and allopathic residents for any hospital located in Peoria County, Illinois, that has more than 500 beds.

Prescribes an adjustment for any hospital with a dual accredited osteopathic and allopathic family practice program that had its resident limit reduced under certain residency redistribution requirements using a cost report subsequently revised between September 1 and 15, 2006.

(Sec. 706) Directs MEDPAC to study and report to Congress on Medicare beneficiaries utilizing home health care services.

(Sec. 707) Directs the Secretary to make grants to eligible entities for demonstration projects to assist home health agencies to better serve their Medicare populations while aiming to reduce costs to the Medicare program through utilization of technologies, including telemonitoring and other telehealth technologies, health information technologies, and specified telecommunications technologies.

Makes FY2008 appropriations for such grant program.

Title VIII: Medicaid - Subtitle A: Protecting Existing Coverage - (Sec. 801) Amends SSA title XIX (Medicaid) to extend through FY2011 certain requirements for state provision of transitional medical assistance to recipient families who lose their Medicaid eligibility for certain reasons.

Authorizes a state to opt to: (1) substitute a 12-month, in lieu of the current six-month, initial eligibility period for extended transitional Medicaid; and (2) waive the minimum three-month receipt of medical assistance requirement for eligibility for transitional Medicaid.

Requires each state to collect and submit to the Secretary information on: (1) average monthly enrollment and average monthly transitional Medicaid participation rates for adults and children; and (2) the number and percentage of children who become ineligible for transitional Medicaid whose medical assistance is continued under another eligibility category or who are enrolled under the state's child health plan under title XXI (State Children's Health Insurance Program) (SCHIP).

(Sec. 802) Authorizes state Medicaid plans to: (1) cover a specified categorically needy group, whose medical assistance shall be limited to family planning services and supplies, including medical diagnosis or treatment services; and (2) provide for such assistance during a presumptive eligibility period.

(Sec. 803) Prohibits the Secretary, between November 3, 2005, and March 1, 2009, from denying federal financial participation in any adult day health services approved under a state Medicaid plan.

(Sec. 804) Revises requirements for treatment of the income and resources of certain institutionalized spouses by redefining "institutionalized spouse" to specify one who is receiving medical assistance for home and community-based services.

(Sec. 805) Amends the Consolidated Omnibus Budget Reconciliation Act of 1959 to exempt Medicaid health insuring organizations operated by public entities in Ventura and Merced Counties, California, from the requirement that they be Medicaid managed care organizations meeting certain criteria.

Declares that such exemption shall not apply with respect to any period for which the number of Medicaid beneficiaries enrolled with such health insuring organizations exceeds 16% (currently 14%) of the number of such beneficiaries in California.

Subtitle B: Payments - (Sec. 811) Increases Medicaid payments to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for FY2009-FY2012.

Removes the federal matching payments for improving data reporting systems from the over-all limit on payments to such territories for any territory.

(Sec. 812) Increases from 15.1% to 22.1% after December 31, 2007, the minimum Medicaid drug rebate percentage drug manufacturers must agree to for covered outpatient drugs.

(Sec. 813) Requires the disregard of any significantly disproportionate employer pension contribution (whose aggregate allocation exceeds 25% of the total increase in personal income in the state) in calculating the state's per capita income for purposes of computing its federal medical assistance percentage (FMAP) for a fiscal year.

(Sec. 814) Places a one-year moratorium on any federal action, policy, or practice to restrict Medicaid coverage or

payment for rehabilitation services, or school-based administration, transportation, or medical services, if such restrictions are more restrictive in any aspect than those applied to such coverage or payment as of July 1, 2007.

(Sec. 815) Deems the DSH allotments for Tennessee for each fiscal year beginning with FY2008 to be $30,000. Permits the Secretary to impose a limitation on the total amount of payments made to hospitals under the TennCare Section 1115 waiver only to the extent that it is necessary to ensure that a hospital does not receive payment in excess of certain amounts or as necessary to ensure that the waiver remains budget neutral.

(Sec. 816) Addresses construction of certain requirements for reduction in state medical assistance expenditures for federal Medicaid payment purposes by the amount of specified donations and taxes.

States that nothing in such requirements shall be construed as prohibiting a state's use of funds as the nonfederal share of Medicaid expenditures where they are transferred from or certified by a publicly-owned regional medical center located in another state, as long as the Secretary determines that the use of funds is proper and in the interest of the Medicaid program.

(Sec. 817) Directs the Secretary to provide for the application to Medicaid asset eligibility determinations of the automated, secure, web-based asset verification request and response process being applied for determining SSI benefits eligibility under a certain demonstration project.

Subtitle C: Miscellaneous - (Sec. 821) Amends SSA title XXI (SCHIP) to direct the Secretary to establish a demonstration project under which up to 10 states may provide under the state child health plan for a five-year period for child health assistance in relation to family coverage for children who would be targeted low-income children but for coverage as beneficiaries under a group health plan as the children of participants by virtue of a qualifying employer's contributions.

(Sec. 822) Requires a transfer of certain FY2009 SCHIP funds for diabetes grants.

Title IX: Miscellaneous - (Sec. 901) Establishes MEDPAC as an agency of Congress.

(Sec. 902) Repeals subtitle A of title XVIII of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MPDIMA), which requires the board of trustees of the Hospital Insurance and Supplemental Medical Insurance trust funds to determine annually for Congress whether or not general revenue financing will exceed 45% of total Medicare outlays within the next seven years.

(Sec. 903) Repeals the Comparative Cost Adjustment (CCA) program, as added by the Medicare Prescription, Drug, Improvement, and Modernization Act of 2003.

(Sec. 904) Directs the Secretary to establish within the Agency of Health Care Research and Quality a Center for Comparative Effectiveness Research.

Requires the Center to conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which disease, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

Directs the Secretary to establish: (1) an independent Comparative Effectiveness Research Commission to oversee and evaluate the Center's activities; and (2) a Coordinating Council for Health Services Research.

Amends the Internal Revenue Code to establish in the Treasury a Health Care Comparative Effectiveness Research Trust Fund, to be financed in part by fair share per capita fees.

Imposes on each specified health insurance policy for each policy year a fee, payable by the policy issuer, which shall be equal to the fair share per capita amount multiplied by the average number of lives covered under the policy.

Imposes a similar fee on self-insured plans.

(Sec. 905) Directs the Secretary to report to Congress: (1) a plan to develop and implement a health information technology (health IT system) for all health care providers under Medicare; and (2) an analysis of the impact, feasibility, and costs associated with the use of health information technology in medically undeserved communities

(Sec. 906) Directs the Secretary to designate and arrange with a single organization meeting specified requirements (such as the National Quality Forum) for advice and recommendations to the Secretary on \the key elements and priorities of a national system for establishing health care measures.

(Sec. 907) Directs the Secretary to provide for implementation of the changes in the NAIC model law and regulations (for improvements to the Medigap program) recommended by the National Association of Insurance Commissioners (NAIC) in its Model #651 on March 11, 2007, as modified to reflect the changes made under this Act.

Requires issuers of Medicare supplemental (Medigap) policies to offer, in addition to the core package, at least benefit packages classified as "C" or "F."

(Sec. 908) Directs the Secretary, in order to implement the first nine titles of this Act, to provide for the transfer of $40 million from the Federal Supplementary Health and Human Services Trust Fund to the Centers for Medicare & Medicaid Services Program Management Account for FY2008.

(Sec. 909) Requires the Secretary, upon request by a congressional support agency, to provide it with prescription drug data collected under part D.

(Sec. 910) Revises requirements for the separate program for abstinence education under SSA title V (Maternal and Child Health Services).

Prohibits the use of funds to provide abstinence education: (1) that includes information that is medically and scientifically inaccurate; or (2) unless the program is based on a model demonstrated to be effective in preventing unintended pregnancy, or in reducing the transmission of a sexually transmitted disease, including the human immunodeficiency virus.

Authorizes appropriations for FY2008 and FY2009.

Title X: Revenues - (Sec. 1001) Amends the Internal Revenue Code to increase the excise taxes on: (1) cigars; (2) cigarettes; (3) cigarette papers; (4) cigarette tubes; (5) smokeless tobacco; (6) pipe tobacco; and (7) roll-your-own tobacco.

Imposes a floor stocks tax on certain domestic or imported cigarettes, including those located in a foreign trade zone, except cigarettes in vending machines. Allows a credit of $500 against such increased excise taxes.

(Sec. 1002) Exempts from federal excise tax any liquid fuel sold for use in any ambulances providing transportation for emergency medical services.

Entitles the ultimate purchaser of such fuel to a rebate of any excise taxes paid.

Actions Timeline

- **Sep 4, 2007:** Received in the Senate. Read twice. Placed on Senate Legislative Calendar under General Orders. Calendar No. 338.
- **Aug 1, 2007:** Reported (Amended) by the Committee on Ways and Means. H. Rept. 110-284, Part I.
- **Aug 1, 2007:** Rules Committee Resolution H. Res. 594 Reported to House. Rule provides for consideration of H.R. 3162 with 2 hours of general debate. Previous question shall be considered as ordered without intervening motions except motion to recommit with or without instructions. Measure will be considered read. Bill is closed to amendments.
- **Aug 1, 2007:** Rule H. Res. 594 passed House.
- **Aug 1, 2007:** Considered under the provisions of rule H. Res. 594. (consideration: CR H9302-9414; text of measure as introduced: CR H9302-9349)
- **Aug 1, 2007:** Rule provides for consideration of H.R. 3162 with 2 hours of general debate. Previous question shall be considered as ordered without intervening motions except motion to recommit with or without instructions. Measure will be considered read. Bill is closed to amendments.
- **Aug 1, 2007:** DEBATE - Pursuant to the provisions of H. Res. 594, the House proceeded with 2 hours of debate on H.R. 3162.
- **Aug 1, 2007:** DEBATE EXTENSION - Mr. Barton asked unanimous consent that the time for debate be extended by one hour, equally divided and controlled. Agreed to without objection.
- **Aug 1, 2007:** The previous question was ordered pursuant to the rule. (consideration: CR 8/2/2007 H9499)
- **Aug 1, 2007:** Ms. Granger moved to recommit with instructions to Energy and Commerce and Ways and Means. (consideration: CR 8/2/2007 H9499-9502; text: CR H9499-9500)
- **Aug 1, 2007:** Floor summary: DEBATE - The House proceeded with 10 minutes of debate on the Granger motion to recommit with instructions. The instructions contained in the motion seek to report the same back to the House forthwith with the following amendments pertaining to Title I-Extension of State Children's Health Insurance Program (SCHIP).
- **Aug 1, 2007:** The previous question on the motion to recommit with instructions was ordered without objection. (consideration: CR 8/2/2007 H9501)
- **Aug 1, 2007:** On motion to recommit with instructions Failed by the Yeas and Nays: 202 - 226 (Roll no. 786). (consideration: CR 8/2/2007 H9501-9502)
- **Aug 1, 2007:** Passed/agreed to in House: On passage Passed by the Yeas and Nays: 225 - 204 (Roll no. 787).
- **Aug 1, 2007:** On passage Passed by the Yeas and Nays: 225 - 204 (Roll no. 787).
- **Aug 1, 2007:** Motion to reconsider laid on the table Agreed to without objection.
- **Jul 27, 2007:** Committee Consideration and Mark-up Session Held.
- **Jul 26, 2007:** Ordered to be Reported (Amended) by the Yeas and Nays: 24 - 17.
- **Jul 26, 2007:** Committee Consideration and Mark-up Session Held.
- **Jul 24, 2007:** Introduced in House
- **Jul 24, 2007:** Referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
- **Jul 24, 2007:** Referred to the Subcommittee on Health.