



National Conference of State Legislatures

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Summary: Selected Health Legislation 109th Congress

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SUMMARY: SELECTED HEALTH LEGISLATION IN THE 109TH CONGRESS - 2ND SESSION

(Copies of the bills, reports and Public Laws referenced here can be obtained from the THOMAS website at: <http://thomas.loc.gov>)
 (Updated April 3, 2006)

ISSUE/TITLE	DESCRIPTION	LEGISLATIVE ACTION	NCSL POSITIONS, ACTIONS, AND PUBLICATIONS
AIDS/HIV			
<p>Ryan White CARE Act Amendments of 2006 (S. 2339, H.R. 5009)</p>	<ul style="list-style-type: none"> ▪ Reauthorizes the Ryan White CARE Act for five years. <p>Funding for Primary Medical Care</p> <ul style="list-style-type: none"> ▪ Requires at least 75 percent of the CARE funds to be spent on primary medical care, including doctor visits and prescription drugs. <p>Formula Changes</p> <ul style="list-style-type: none"> ▪ Ensures that all living individuals with HIV/AIDS are recognized in the funding formulas beginning in FY 2007. Formulas would be updated to prevent duplication in counting cases and eliminate the counting of deceased patients. These changes will be phased in so that states will not experience a loss of funding any greater than five percent in 2007 with an increase each year by five percent until 2010. <p>Treatment</p> <ul style="list-style-type: none"> ▪ Medicaid – Provides a state option to use CARE funds to supplement AIDS-related treatment provided under Medicaid. ▪ Hepatitis B and Hepatitis C - Allows treatment coverage for HIV-positive individuals co-infected with Hepatitis B and/or Hepatitis C 	<ul style="list-style-type: none"> ▪ Introduced in the House. (3/16/06) ▪ Introduced in the Senate. (2/28/06) 	<p><u>NCSL Policy</u></p> <p>Acquired Immune Deficiency Syndrome/HIV-Infection</p> <ul style="list-style-type: none"> ▪ Federal grants supporting state efforts to provide care and treatment to people with AIDS should provide maximum flexibility to states to enable them to develop programs that best meet the needs of their citizens. ▪ NCSL supports continued and adequate funding for states through the Ryan White CARE Act and through cooperative agreements with the CDC. ▪ States should be permitted to demonstrate, in their state plan, that they have addressed the needs of all populations within their boundaries. ▪ NCSL opposes the imposition of state matching or maintenance of effort requirements in these programs. ▪ NCSL urges the federal government to ensure that adequate funding is provided for the AIDS Drug Assistance Program (ADAP). It is important that the funding for this program keep pace with the approval and availability of new drug therapies.

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	<p>seems to increase health care provider' knowledge of co-infection treatment.</p> <p>AIDS Drug Assistance Program (ADAP)</p> <ul style="list-style-type: none"> ▪ Formulary – Requires the establishment of a standard formulary for AIDS drug treatment. ▪ Appropriations – Each authorizes a \$70 million increase annually and provides an additional \$35 million annually to provide assistance to patients living in states with ADAP shortfalls. <p>Authorizes Appropriations</p> <ul style="list-style-type: none"> ▪ Authorizes an increase of \$70 million annually for the AIDS Drug Assistance Program (ADAP), which provides medication to underinsured individuals with HIV. ▪ Designates \$35 million annually for ADAP supplemental grants for needy areas. ▪ Redirects CARE Act funds into ADAP supplemental funds if left unspent for two years. <p>Partner Notification (Grant Condition)</p> <ul style="list-style-type: none"> ▪ Prohibits CARE Act funding to any jurisdiction that prohibits or imposes barriers to partner notification services. ▪ Effective 25 months after date of enactment. <p>Rapid Routine Testing - (Grant Condition)</p> <ul style="list-style-type: none"> ▪ Directs the Secretary to require rapid routine testing of each client at any health facility, provider, clinic or entity receiving funding from the CDC, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, the Centers for Medicare and Medicaid Services, or 		

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	<p>any reproductive health program administered by the Secretary.</p> <ul style="list-style-type: none"> ▪ Routine testing is defined as HIV testing: (1) that is administered automatically to individuals accessing health care services for any reason; and (2) where the individual is notified that he/she will receive a HIV test and that he/she may opt out of the test. Pre-test counseling is not required, but for individuals who test positive, post-test counseling, including referrals for care, must be provided and confidentiality must be protected. ▪ Rapid routine testing is not required if the individual has already been diagnosed with HIV infection. ▪ Directs the Secretary to require health facilities receiving federal funds and federal health care programs to offer pregnant women routine testing and to offer the parents of a newborn rapid routine testing if the mother's HIV status is unknown. ▪ Requires entities that conduct routine testing under the provisions of the Act to provide each individual who tests positive, appropriate counseling and referral into treatment in a timely manner. ▪ Beginning 25 months after enactment, a state or locality that prohibits or imposes significant administrative, statutory, regulatory, or practical barriers to routine testing will be ineligible for CARE funds. <p>Special Projects of National Significance</p> <ul style="list-style-type: none"> ▪ Provides up to \$15 million annually for special projects of national significance which will 		

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	<p>include: (1) pilot programs to evaluate various forms of partner notification; (2) development of a standard electronic client data system to improve coordination of coverage provided to patients under the CARE Act and other federal programs; and (3) study and provide recommendations for best practices for disease management for patients living with HIV/AIDS.</p> <p>Housing Assistance</p> <ul style="list-style-type: none"> ▪ Improves efforts to provide federal housing assistance to those with HIV/AIDS by updating formulas for Housing Opportunities for Persons with HIV/AIDS (HOPWA) to make funding based on living cases rather than cumulative cases of AIDS by FY 2009 and requiring that at least 75 percent of HOPWA funds be utilized for the construction and maintenance of development of housing assistance. 		
APPROPRIATIONS/BUDGET			
<p>FY 2007 Budget Resolution S. Con. Res. 83; H. Con. Res. 376</p>	<p>Senate Budget Resolution (Health Provisions)</p> <ul style="list-style-type: none"> ▪ Calls for \$3 billion in federal entitlement program savings, but assumes no reductions in Medicaid or Medicare. ▪ Restores \$7 billion in funding to programs within the jurisdiction of the Health, Education, Labor and Pensions Committee. ▪ Establishes a number of “deficit neutral” reserve funds including funds for: (1) the uninsured; (2) health information technology; (3) an asbestos injury trust fund; (4) the safe importation of prescription drugs; (5) a chronic care case management; (6) the extension of the Medicare Part D enrollment period; (7) pandemic flu preparedness; (8) the global HIV/AIDS, tuberculosis and malaria program; and (9) to 	<ul style="list-style-type: none"> ▪ House budget resolution was favorably reported by the House Budget Committee. (3/29/06) ▪ Adopted in the Senate by recorded vote 51 yeas – 49 nays. (3/16/06) 	<p><u>NCSL Letter</u></p> <ul style="list-style-type: none"> ▪ Letter to Senate Budget Committee Chairman Gregg (R-NH) and Ranking Member Conrad (D-ND) from NCSL President, Senator Steven Rauschenberger and NCSL President-elect, Senator Leticia Van de Putte expressing support for reducing the federal government’s deficit and urging the senators to: (1) reduce the volume of unfunded federal mandates; (2) close the gap on federal unfunded mandates or relax the requirements that create the mandates; and (3) reinstitute fiscal discipline tools and apply them to both revenue and mandatory/entitlement programs. (3/6/06)

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	<p>provide for an increase in Medicare physician payments.</p> <ul style="list-style-type: none"> ▪ Includes a provision authorizing the Secretary to negotiate prices for the Medicare Part D program. <p>House Budget Resolution (Health Provisions)</p> <ul style="list-style-type: none"> ▪ Calls for \$6.8 billion in federal entitlement program savings, directing more than half of the savings to be found within the jurisdiction of the House Ways and Means Committee (Medicare, welfare, pensions, trade). The chairman noted that no specific instructions were given to reduce spending in either the Medicaid or Medicare programs. <i>[During Budget Committee debate, staff disclosed that FY 2007 funding for Transitional Medical Assistance was not provided for in the budget, but that the House Energy and Commerce Committee indicated that it would find savings within its jurisdiction to fund the program for FY 2007.]</i> ▪ Provides a special exemption from the Congressional budget controls for spending measures to combat avian flu, to increase local preparedness, and to develop a vaccine to inoculate the American population, capped at \$2.3 billion. <p>Increased budget authority for veteran's benefits and services by \$795 million and assumes the Congress will not accept the President's budget proposal to implement enrollment fees and increased drug co-pays for certain veterans.</p>		
HEALTH INFORMATION TECHNOLOGY			
<p>Wired for Health Care Quality Act (S. 1418)</p>	<p>Establishment of the Office of the National Coordinator of Health Information Technology</p>	<ul style="list-style-type: none"> ▪ Adopted in the Senate by unanimous consent. 	<p><u>NCSL Policy</u></p> <ul style="list-style-type: none"> ▪ NCSL has no position.

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[S. Rpt. 109-111]	<ul style="list-style-type: none"> ▪ Amends the Public Health Service Act to establish the Office of the National Coordinator of Health Information Technology to coordinate with relevant federal agencies and private entities and oversee programs and activities to develop a nationwide interoperable health information technology infrastructure. ▪ Requires the National Coordinator to: (1) serve as the principal advisor to the Secretary of Health and Human Services (the Secretary) concerning the development, application, and use of health information technology and to coordinate and oversee the health information technology programs of the Department of Health and Human Services (HHS); (2) facilitate the adoption of a nationwide, interoperable system for the electronic exchange of health information; (3) ensure the adoption and implementation of standards for such exchange; (4) ensure that HHS health information technology policy and programs are coordinated with those of relevant executive branch agencies; (5) coordinate outreach and consultation by the relevant executive branch agencies with public and private parties of interest; and (6) advise the President regarding specific federal health information technology programs. <p>Establishment of the American Health Information Collaborative</p> <ul style="list-style-type: none"> ▪ Requires the Secretary to establish the public-private American Health Information Collaborative to: (1) advise the Secretary and recommend actions to achieve a nationwide interoperable health information technology infrastructure; (2) serve as a forum for the participation of a broad range of stakeholders to provide input on achieving the interoperability of 	(11/18/05)	

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	<p>health information technology; and (3) recommend standards for the electronic exchange of health information by the federal government and private entities.</p> <ul style="list-style-type: none"> ▪ Requires the Collaborative to recommend to the Secretary uniform national policies to support the widespread adoption of health information technology, including: (1) protecting individually identifiable health information through privacy and security practices; (2) preventing unauthorized access to health information; (3) notifying patients if their individually identifiable health information is wrongfully disclosed; (4) facilitating secure patient access to health information; and (5) fostering the public understanding of health information technology. ▪ Deems the standards adopted by the Consolidated Health Informatics Initiative as having been recommended by the Collaborative. ▪ Requires the Collaborative to annually review existing standards, identify deficiencies, omissions, duplication, and overlap, and recommend modifications and/or new standards. ▪ Requires the Secretaries of HHS, Veteran Affairs, and Defense to jointly review the Collaborative's recommendations. Requires the Secretary of HHS to provide for the adoption by the federal government of any recommended standards, if appropriate. ▪ Prohibits any federal agency from expending federal funds to purchase any new health information technology that is inconsistent with adopted standards. Requires all federal agencies collecting health data to comply with the adopted standards within three years. 		

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	<ul style="list-style-type: none"> ▪ Requires the Secretary to develop criteria to: (1) ensure uniform and consistent implementation of any standards voluntarily adopted by private entities; and (2) ensure and certify hardware, software, and support services compliance with applicable adopted standards. <p>Grants</p> <ul style="list-style-type: none"> ▪ Allows the Secretary to award grants to: (1) facilitate the purchase and enhance the utilization of qualified health information technology systems; (2) implement regional or local health information plans; and (3) carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals. <p>State Loan Programs</p> <ul style="list-style-type: none"> ▪ Authorizes the HHS Secretary to award competitive grants to states for establishment of state loan programs for health care providers to facilitate the purchase and enhance the utilization of qualified HIT. ▪ Awardees must: (1) establish a qualified HIT loan fund; (2) submit a strategic plan to the HHS Secretary; (3) require that health care providers receiving loans adopt federal government standards and measurement systems as laid out in the bill. Awardees must also link to the extent practicable the qualified health information system to a local or regional health information network; (4) obtain matching funds in cash equal to not less than \$1 for every \$1 of federal funds. Matching funds can come from private entities can not specify the loan recipient. ▪ Directs the HHS Secretary to give preference in 		

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	<p>awarding grants to states that adopt value-based purchasing programs to improve health care quality.</p> <p>Quality Provisions</p> <ul style="list-style-type: none"> ▪ Requires the Secretary to develop measures of the quality of care patients receive and ensure that the measures: (1) are evidence based, reliable, and valid; (2) are consistent with the purposes of developing a nationwide interoperable health information technology infrastructure; (3) include measures of clinical processes and outcomes, patient experience, efficiency, and equity; and (4) include measures of overuse and underuse of health care items and services. ▪ Requires the Secretary to: (1) adopt and utilize the quality measures; (2) implement procedures to accept the electronic submission of quality measurement data; and (3) disseminate recommendations and best practices derived from the analysis of quality measures. <p>Studies</p> <ul style="list-style-type: none"> ▪ Requires the Secretary to carry out a study that examines the impact that variations among state laws relating to licensure, registration, and certification of medical professionals have on the secure electronic exchange of health information. ▪ Requires the Comptroller General to report on the necessity and workability of requiring health plans, health care clearinghouses, and health care providers who transmit health information in electronic form to notify patients if their individually identifiable health information is wrongfully disclosed. 		

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	<ul style="list-style-type: none"> ▪ Requires the Secretary to study methods to create efficient reimbursement incentives for improving health care quality in federally qualified health centers, rural health clinics, and free clinics. <p>Information Technology Resource Center</p> <ul style="list-style-type: none"> ▪ Requires the Secretary, acting through the Director of the Agency for Healthcare Quality and Research (AHRQ), to develop a Health Information Technology Resource Center to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology. Requires the Secretary to establish a toll-free telephone number or Internet website to provide health care providers and patients with a single point of contact regarding health information technology. 		
<p>Health Information Technology Promotion Act of 2005 H.R. 4157</p>	<p>Establishment of the Office of the National Coordinator of Health Information Technology</p> <ul style="list-style-type: none"> ▪ Establishes within the Department of Health and Human Services an Office of the National Coordinator for Health Information Technology. ▪ Directs the National Coordinator to: (1) maintain, direct, and oversee the continuous improvement of a strategic plan to guide the nationwide implementation of interoperable health information in both the public and private health care sectors; and (2) serve as the coordinator of federal government activities relating to health information technology. <p>Safe Harbor</p> <ul style="list-style-type: none"> ▪ Prescribes conditions under which any nonmonetary remuneration (in the form of health 	<ul style="list-style-type: none"> ▪ Introduced in the House. (10/27/06) 	<p><u>NCSL Policy</u></p> <ul style="list-style-type: none"> ▪ NCSL has no position.

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	<p>information technology and related training services) made by a hospital or a critical access hospital to a physician would not be considered a prohibited payment (subject to civil and criminal penalties) made as an inducement to reduce or limit services to certain individuals.</p> <p>Studies</p> <ul style="list-style-type: none"> ▪ Directs the Secretary of Health and Human Services to study and report to Congress on whether pertinent state laws and current federal standards should be conformed to create a single set of national standards to preserve and protect the security and confidentiality of patient health information. <p>Privacy</p> <ul style="list-style-type: none"> ▪ Amends the Social Security Act to provide for the establishment of uniform confidentiality and security standards with respect to individually identifiable patient health information. <p>Code Upgrades and Coordination</p> <ul style="list-style-type: none"> ▪ Directs the Secretary to: (1) promulgate a final rule for upgrading specified Accredited Standards Committee X12 (ASC X12) and National Council For Prescription Drug Programs (NCPDP) Telecommunications standards and International Statistical Classification of Diseases and Related Health Problems, 9th revision, Clinical Modification (ICD-9-CM) codes; and (2) develop a strategic plan related to the need for coordination in the area of health information technology. 		

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HEALTH LAW			
<p>Federal Consent Decree Fairness Act (S. 489, H.R. 1229)</p>	<ul style="list-style-type: none"> ▪ Authorizes State or local governments and related officials sued in their official capacity to file a motion to modify or vacate a consent decree upon the earlier of: (1) four years after the consent decree is originally entered; or (2) in the case of a civil action in which a State is a party or in which a local government is a party and the surrounding State is not a party, the expiration of the term of office of the highest elected State or local government official authorizing the consent decree. ▪ Places the burden of proof with respect to the motions on the party originally filing the action to demonstrate that continued enforcement is necessary to uphold a Federal right. ▪ Nullifies consent decrees pending a ruling on a motion to modify or vacate if the court fails to rule on the motion within 90 days of filing. ▪ Addresses compensation and termination of special masters overseeing consent decrees. ▪ Makes this Act applicable to all consent decrees regardless of: (1) the date on which the final order of a consent decree is entered; or (2) whether any relief has been obtained before enactment. 	<ul style="list-style-type: none"> ▪ Hearing held in Subcommittee on Administrative Oversight and the Courts, Senate Committee on the Judiciary. (7/19/05) ▪ Hearing held in the House Judiciary Subcommittee on Courts, the Internet, and Intellectual Property. (6/21/05) 	<p><u>NCSL Policy</u></p> <ul style="list-style-type: none"> ▪ State Medicaid dollars are increasingly tied up in costly federal litigation. NCSL urges the Administration and the Congress to work with state officials on developing strategies to reduce the volume of litigation by clarifying and simplifying Medicaid statutory provisions that are too vague or too prescriptive for states to properly administer. NCSL also urges the U.S. Department of Health and Human Services to provide technical assistance to states regarding Medicaid services/issues that are the subject of litigation in several states so that states may find ways to successfully provide the services in question without litigation.

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IMMIGRATION REFORM			
Securing America's Borders Act S. 2454	Health Provisions <ul style="list-style-type: none"> ▪ Permanently authorizes the J-1 visa program.¹ 	<ul style="list-style-type: none"> ▪ S. 2454 is being debated on the Senate floor the week of April 2, 2006. 	<p><u>NCSL Policy</u></p> <p>Continuation of the J-1 Visa Waiver Program for Immigrant Physicians</p> <ul style="list-style-type: none"> ▪ Under current law, immigrants admitted to the United States for education programs receive a J-1 visa, which requires the individual to return home for two years after completing the educational program before he or she can apply for an immigrant visa, permanent residence status or an additional non-immigrant visa. The requirement to return home can be waived. This waiver program has become a critical part of many state's efforts to assure underserved areas in the state have access to physicians. NCSL urges Congress to enact legislation to ensure the continuation of this important program in a timely fashion that will permit states and the immigrant physicians adequate time to plan. NCSL also urges Congress to consider whether the shortages in other health professionals in these underserved areas could benefit from a similar program. NCSL prefers a five-year extension.

¹ Federal law requires that foreign physicians seeking to pursue graduate medical education or training in the United States obtain a J-1 exchange visitor visa. The J-1 visa allows physicians to remain in the U.S. until their studies are completed. However, upon completion of their studies, the physicians must return to their home country for at least two years before they are able to return to the United States. Changes in the Immigration and Nationality Technical Corrections Act (Public Law 103-416), allows each State Department of Public Health or its equivalent to sponsor up to thirty (30) foreign trained physicians each fiscal year. The State 30 program, as it is commonly referred to, affords J-1 visa holders the privilege of waiving their two-year foreign residency requirement in exchange for providing primary medical care in federally designated Health Professional Shortage Areas (HPSAs).

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INSURANCE REFORM			
<p>Small Business Health Fairness Act of 2005 (H.R.525, S.406) [H. Rpt. 109-41]</p>	<p>General Provisions</p> <ul style="list-style-type: none"> ▪ Amends the Employee Retirement Income Security Act of 1974 (ERISA) to provide for the establishment and governance of association health plans (AHPs), which are group health plans whose sponsors are trade, industry, professional, chamber of commerce, or similar business associations, and which meet certain ERISA certification requirements. ▪ Through the ERISA preemption of State laws, certified AHPs are exempted from State regulation of health insurance providers, including State consumer protection laws and State requirements for health care benefits to be offered by such entities, with certain exceptions. <p>Certification/Regulation</p> <ul style="list-style-type: none"> ▪ Establishes rules governing AHPs, including requirements relating to certification, sponsors and boards of trustees, participation and coverage, nondiscrimination, plan documents, contribution rates, benefit options, applications for certification, notice of voluntary termination, corrective actions, and mandatory termination. ▪ Requires all AHPs to provide written notice of certification to any state which at least 25 percent of the participants and beneficiaries under the plan are located <p>Solvency Provisions</p> <ul style="list-style-type: none"> ▪ Requires AHPs which provide health benefits in addition to health insurance coverage to maintain certain reserves and comply with other solvency requirements. 	<ul style="list-style-type: none"> ▪ Adopted in the House by recorded vote 263 yeas – 165 nays. (07/26/2005) 	<p><u>NCSL Letter</u></p> <ul style="list-style-type: none"> ▪ Letter to Speaker Hastert and Minority Leader Pelosi from William Pound, NCSL Executive Director regarding NCSL’s opposition to H.R. 525 (7/26/05). ▪ Letter to Chairman Boehner and Ranking Member Miller from William Pound, NCSL Executive Director regarding NCSL’s opposition to H.R. 525 (3/16/05). <p><u>NCSL Policy</u></p> <p>Principles for Federal Health Insurance Reform</p> <ul style="list-style-type: none"> ▪ Federal health insurance legislation that establishes mandated benefits or uniform standards, should establish a floor, but not a ceiling. The federal government should continue to give deference to state, local and tribal governments regarding the regulation of state, local and tribal government employee health plans. ▪ <u>Health Insurance for Small Employers.</u> NCSL also supports the development of public and private purchasing cooperatives and other innovative ventures that permit individuals and groups to obtain affordable health coverage. However, NCSL strongly opposes preemption of state insurance laws and efforts to expand the ERISA preemption. NCSL strongly opposes proposals that exempt association health plans (AHPs), Health Marts, certain multiple employer welfare arrangements (MEWAs), and similar entities and organizations, from critical state insurance standards. NCSL is particularly concerned that: (1) the impact on state small group and individual insurance markets; and (2)

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	<ul style="list-style-type: none"> ▪ Directs the Secretary of Labor to apply for appointment, and carry out specified duties, as trustee of any insolvent AHPs which provide health benefits in addition to health insurance coverage. ▪ Requires AHPs to include in their summary plan descriptions, in connection with each benefit option, a description of the form of any solvency or guarantee fund protection secured under ERISA or applicable State law. <p>Contribution Taxes</p> <ul style="list-style-type: none"> ▪ Allows a State to impose a contribution tax on any AHP commencing operations in the state after the enactment of the Act. ▪ Establishes limits on the tax, including reduction by the amount of any tax or assessment otherwise imposed by the state on specified other insurance related items maintained by the AHP. <p>Preemption of State Law</p> <ul style="list-style-type: none"> ▪ Allows a certified AHP to exist in a State regardless of any State law that would preclude it. ▪ Preempts State requirements for benefits to be offered by AHPs; but allows a State in which an AHP is domiciled to require the domiciled AHP to cover particular types of diseases and conditions. ▪ Allows health insurance issuers to offer coverage of the same policy type offered in connection with a particular AHP to eligible employers, regardless of whether the employers are members of the particular association and regardless of state law. 		<p>the opportunity inadequate regulation provides for fraud and abuse. These concerns are in addition to larger concerns about the commitment of resources by the federal government to adequately regulate an expanded health insurance market.</p>

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	<ul style="list-style-type: none"> ▪ Deems health insurance coverage policy forms filed and approved in a particular state in connection with an insurer's offering under an AHP as approved in any other state in which coverage is offered when the insurer provides a complete filing in the same form and manner to the authority in the other state. ▪ Makes inapplicable to certified AHPs certain current ERISA provisions which allow state regulation of multiple employer welfare arrangements (MEWAs). ▪ Revises ERISA preemption rules to permit state regulation of self-insured MEWAs providing medical care which do not elect to meet the certification requirements for AHPs. <p>Reports</p> <ul style="list-style-type: none"> ▪ Directs the Secretary to report to specified congressional committees by January 1, 2010, on the effect, if any, AHPs have had on the number of uninsured individuals. <p>Treatment of Single Employer Arrangements</p> <ul style="list-style-type: none"> ▪ Revises requirements for treatment of single employer arrangements. Allows two or more trades or businesses to be deemed a single employer if they are in the same control group offering medical care benefits, under specified conditions. <p>Enforcement/Regulation</p> <ul style="list-style-type: none"> ▪ Provides for enforcement of AHP requirements, including criminal penalties for certain willful misrepresentations, issuance of cease and desist orders, and the responsibility of AHP boards of trustees for certain claims procedures. 		

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	<ul style="list-style-type: none"> ▪ Directs the Secretary, regarding the exercise of authority, to consult only with the recognized primary domicile State for an AHP. ▪ Revises ERISA preemption rules to permit State regulation of self-insured MEWAs providing medical care which do not elect to meet the certification requirements for AHPs. <p>Transition</p> <ul style="list-style-type: none"> ▪ Provides for transitional and other rules relating to treatment of certain existing health benefit programs. ▪ Establishes Association Health Plans (AHPs) authorizing trade, industry, and professional associations to act as group purchasing cooperatives for health insurance. ▪ Permits states to impose by law a contribution tax on AHPs if the plan becomes operational after enactment of the Small Business Health Fairness Act of 2005. ▪ Exempts AHPs from state laws regulating health insurance. AHPs would be regulated by the U.S. Department of Labor (DOL) under ERISA. 		
<p>Health Insurance Marketplace Modernization and Affordability Act of 2005 (S. 1955)</p>	<p>Small Business Health Plans (SBHPs)</p> <ul style="list-style-type: none"> ▪ Requires SBHPs to be fully-insured and offered through licensed insurers. SBHPs are not permitted to self-insure. ▪ Permits SBHPs to pool independently from the underlying small group market. ▪ Retains primary oversight and supervision of insurance coverage at the state level. Requires full licensure of carriers selling to SBHPs in every state in which the plan participates. 	<ul style="list-style-type: none"> ▪ Favorably reported by the Senate Committee on Health, Education, Labor and Pensions by recorded vote 11 yeas – 9 nays. (03/15/06) 	<p><u>NCSL Letter</u></p> <ul style="list-style-type: none"> ▪ Letter to Senate Health, Education, Labor and Pension Committee Chairman Enzi and Ranking Member Kennedy from Carl Tubbesing, NCSL Deputy Executive Director regarding NCSL’s concerns about the preemption of state rating laws and regulations and state mandated benefits and the limited choices for low-wage employees. (3/14/06) <p><u>NCSL Policy</u></p>

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	<ul style="list-style-type: none"> ▪ Associations wishing to establish an SBHP must: <ul style="list-style-type: none"> ▪ have been established for purposes other than health coverage; ▪ have been in existence for at least 3 years; ▪ not condition association membership or coverage on health status; ▪ obtain federal certification; and ▪ must be governed by a board of directors with complete fiscal control. <p>Preemption of State Mandated Benefits</p> <ul style="list-style-type: none"> ▪ Permits the plans to vary from state mandated requirements if they offer an alternative containing the covered benefits offered in a state employee health plan in one of the five most populous states (CA, NY, TX, FL and IL). <p>Provisions Applying to SBHPs and the Small Group Market – Rating Provisions</p> <ul style="list-style-type: none"> ▪ Applies to SBHPs and policies sold to others. ▪ Establishes the National Association of Insurance Commissioners (NAIC) 1993 model rules regarding rating (the amount premiums can vary), the National Interim Model Rating Rules, as the interim standard for rating for all states. <ul style="list-style-type: none"> ▪ The NAIC rules require that the premiums charged when the policy is issued cannot vary more than +/- 25 percent for the base rate, and +/- 15 percent upon renewal. ▪ Insurers licensed in a state will be permitted to use the NAIC standard even if state law differs. ▪ Provides for a graduated transition process for states that currently have rating rules materially different from the NAIC model. <p>Provisions Applying to SBHPs and the Small</p>		<p>Principles for Federal Health Insurance Reform</p> <ul style="list-style-type: none"> ▪ Federal health insurance legislation that establishes mandated benefits or uniform standards, should establish a floor, but not a ceiling. The federal government should continue to give deference to state, local and tribal governments regarding the regulation of state, local and tribal government employee health plans. ▪ <u>Health Insurance for Small Employers</u>. NCSL also supports the development of public and private purchasing cooperatives and other innovative ventures that permit individuals and groups to obtain affordable health coverage. However, NCSL strongly opposes preemption of state insurance laws and efforts to expand the ERISA preemption. NCSL strongly opposes proposals that exempt association health plans (AHPs), Health Marts, certain multiple employer welfare arrangements (MEWAs), and similar entities and organizations, from critical state insurance standards. NCSL is particularly concerned that: (1) the impact on state small group and individual insurance markets; and (2) the opportunity inadequate regulation provides for fraud and abuse. These concerns are in addition to larger concerns about the commitment of resources by the federal government to adequately regulate.

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	<p>Group Market – Lower-Cost Plan Options</p> <ul style="list-style-type: none"> ▪ Mirroring the approach applied to benefit mandates for SBHPs, insurance carriers selling to non-SBHP purchasers may offer coverage that varies from state mandate requirements if they offer an alternative containing the covered benefits offered in a state employee health plan in one of the five most populous states (CA, NY, TX, FL and IL). <p>Health Insurance Regulatory Harmonization/Uniform Insurance Standards</p> <ul style="list-style-type: none"> ▪ Establishes a process to create greater uniformity across the states in the administrative and process requirements in current state health insurance regulation. ▪ Directs the Secretary of Health and Human Services (HHS) to establish, in consultation with the NAIC and the states, the Health Insurance Consensus Standards Board to develop recommendations to “harmonize inconsistent state health insurance laws.” <ul style="list-style-type: none"> ▪ The Board will be composed of the following voting members to be appointed by the Secretary after considering recommendations by professional organizations representing the entities and constituencies described in the Act: four state insurance commissioners as recommended by the NAIC (two democrats, two republicans, one of which will be designated as the Board chair, and one as the Board vice-chair); four representatives of state government consisting of two governors and two state legislators (two democrats, two republicans); four representatives of health 		

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	<p>insurers (one representing insurers providing coverage in each of the following markets: all markets, the small group market, large group market, and the individual market); two representatives of insurance agents and brokers; and two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance. A representative of the Secretary will serve as an ex officio member of the Board.</p> <ul style="list-style-type: none"> ▪ Directs the Secretary to establish an advisory panel to provide advice to the Board after considering the recommendations of professional organizations representing the entities and constituencies identified in the Act. <ul style="list-style-type: none"> ▪ The advisory panel is to include: two representatives of small business health plans; two representatives of employers (one representing small employers, one representing large employers); two representatives of consumer organizations; and two representatives of health care providers. ▪ The areas to be addressed by the Board include: (1) form and rate filing; (2) market conduct review; (3) prompt payment of claims; and (4) internal review. It does not include consumer protection or access standards. <p>Civil Actions against Nonadopting States</p> <ul style="list-style-type: none"> ▪ Gives the United States district courts exclusive jurisdiction over civil actions regarding the provisions in the harmonization title. ▪ Provides that an eligible insurer may bring an action in district courts for injunctive or other 		

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	<p>equitable relief against any officials or agents of a nonadopting state in connection with any conduct or action, by the officials or agents, which violates the harmonization standards.</p> <ul style="list-style-type: none"> ▪ Permits, at the election of the eligible insurer, an action to be brought directly to the United States Court of Appeals for the circuit in which the nonadopting state is located by filing a petition for review in the Court. ▪ Provides for expedited review. In district court, requires the court to complete action, including the issuance of a judgment, prior to the end of 120-day period beginning on the date the action was filed, unless all parties to the proceeding agree to an extension. In the case of the Court of Appeals, the court is directed to complete all action, including the issuance of a judgment, prior to the end of the 60-day period from the date the petition was filed with the Court, unless all parties to the proceeding agree to an extension. ▪ Establishes a standard of review for the court, requiring the court to render a judgment based on a review of the merits of all questions presented in the action and cannot defer to any conduct or action, or proposed conduct or action of a non-adopting state. <p>Transition Process</p> <ul style="list-style-type: none"> ▪ States will have 18 months to adopt the model standards after they are issued by the Board and certified by the Secretary. ▪ If a state fails to adopt the standard within the required timeframe, an insurer, following certain certification requirements, would be permitted to sell insurance in that state following the 		

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	harmonized federal rules, rather than state law.		
Health Care Choice Act of 2005 (H.R. 2355, S. 1015)	<p>General Provisions</p> <ul style="list-style-type: none"> ▪ Amends the Public Health Service Act to provide that the laws of the primary state (as designated by the health insurance issuer) apply to individual health insurance coverage offered by that issuer both in the primary state and in any secondary state if the coverage and issuer comply with this Act. ▪ Exempts health insurance issuers from any laws of the secondary state that would: (1) regulate the operation of the health insurance issuer in the secondary state, except for certain activities, including paying taxes and registering with the state insurance commissioner; (2) require any individual health insurance coverage issued by the issuer to be countersigned by an agent or broker residing in the secondary state; or (3) discriminate against the issuer issuing insurance in both the primary state and any secondary state. <p>Requirements on Insurers</p> <ul style="list-style-type: none"> ▪ Prohibits a health insurance issuer that provides individual health insurance coverage in a primary or secondary state from: (1) upon renewal, taking certain actions based on health-status related factors, including increasing premiums assessed; and (2) offering coverage in a secondary state that is not currently offered for sale in the primary state. ▪ Requires health insurance issuers offering coverage in both primary and secondary states to submit to the insurance commissioner of each state: (1) a copy of a plan of operation, a feasibility study, or similar statement; (2) written notice of any change in designation of its 	<ul style="list-style-type: none"> ▪ Reported as amended by the House Committee on Energy and Commerce. (7/20/05) ▪ Introduced in the House and Senate. (5/12/05) 	<p><u>NCSL Policy</u></p> <p>Principles for Federal Health Insurance Reform</p> <ul style="list-style-type: none"> ▪ Federal health insurance legislation that establishes mandated benefits or uniform standards, should establish a floor, but not a ceiling. The federal government should continue to give deference to state, local and tribal governments regarding the regulation of state, local and tribal government employee health plans. ▪ <u>Health Insurance for Small Employers.</u> NCSL also supports the development of public and private purchasing cooperatives and other innovative ventures that permit individuals and groups to obtain affordable health coverage. However, NCSL strongly opposes preemption of state insurance laws and efforts to expand the ERISA preemption. NCSL strongly opposes proposals that exempt association health plans (AHPs), Health Marts, certain multiple employer welfare arrangements (MEWAs), and similar entities and organizations, from critical state insurance standards. NCSL is particularly concerned that: (1) the impact on state small group and individual insurance markets; and (2) the opportunity inadequate regulation provides for fraud and abuse. These concerns are in addition to larger concerns about the commitment of resources by the federal government to adequately regulate.

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	<p>primary state; and (3) quarterly financial statements.</p> <ul style="list-style-type: none"> ▪ Sets forth requirements (regarding determination of capital and an independent review process) that must be met by primary states in order for an issuer to provide insurance in a secondary state. ▪ Prohibits the insurer from taking action upon renewal of policy against the insured based on health status related factors, including increasing premiums. ▪ Prohibits a health insurer from offering a different plan of coverage in a secondary state which isn't currently offered in their primary state. <p>Solvency</p> <ul style="list-style-type: none"> ▪ Requires the state insurance commissioner to use a risk-based capitol formula for determination of the insurer's fiscal solvency. <p>Preemption of State Law</p> <ul style="list-style-type: none"> ▪ Gives sole jurisdiction to primary states to enforce the covered laws in primary and secondary states. ▪ Allows states to require brokers to obtain a license from that state, but not to impose any requirements that discriminate against nonresident brokers. <p>State Requirements</p> <ul style="list-style-type: none"> ▪ Establishes base federal standards which a state must meet in order for an insurer to designate them as a primary state: ▪ Requires the states to have legislation or regulations in place establishing an independent 		

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	<p>review process for the individual insurance market unless the state has a independent review mechanism that is functionally equivalent to the one prescribed in the “Health Carrier External Review Model Act” of the National Association of Insurance Commissioners (NAIC).</p>		
<p>Genetic Nondiscrimination Act of 2005 (S.306, H.R. 1227)</p>	<p>Genetic Nondiscrimination in Health Insurance</p> <ul style="list-style-type: none"> ▪ Amends the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act, affecting both the group and individual markets, by adding provisions which prohibits: <ul style="list-style-type: none"> ▪ health discrimination on the basis of genetic information ² or services. ▪ health insurers from using genetic information to impose enrollment restrictions or adjust group premiums. ▪ insurers from denying coverage or pricing coverage out of reach of consumers based on their genetic information. ▪ requests for genetic testing or results except as necessary for treatment, payment, or health care operations. ▪ a health care professional from requiring an individual to undertake a genetic test, but does not prohibit the health professional from requesting that their patients have a genetic test and health care professionals employed by or affiliated with a health plan are not prohibited from informing an individual about the availability of a genetic test if it is part of a bone fide wellness program. ▪ Bars the use or disclosure of genetic information 	<ul style="list-style-type: none"> ▪ Introduced in the House. (3/10/05) ▪ Adopted in the Senate by recorded vote 98 yeas—2 nays. (2/17/05) 	<p><u>NCSL Policy</u></p> <p>Principles for Federal Health Insurance Reform</p> <ul style="list-style-type: none"> ▪ Federal health insurance legislation that establishes mandated benefits or minimum standards, should establish a floor, but not a ceiling. In addition, the federal government should give deference to state, local, and tribal governments regarding the regulation of state, local and tribal government employee health plans.

² Genetic information includes information about an individual’s genetic tests, genetic tests of members of the individual’s family, and the occurrence of a disease of disorder in family members of the individual, but excludes information about the age and sex of an individual.

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	<p>for enrollment, premium rating, or the creation, renewal or replacement of an insurance plan.</p> <ul style="list-style-type: none"> ▪ Grants enforcement powers to the Secretary and establishes penalties for administrative and discovered failures of compliance. Penalties imposed are not allowed to exceed the amount equal. ▪ Final rules are to be published within a year of enactment and to become effective 18 months after enactment. <p>Prohibiting Employment Discrimination on the Basis of Genetic Information</p> <ul style="list-style-type: none"> ▪ Bars public (state, federal and Congressional) and private sector employers, employment agencies, labor organizations, and joint labor-management training programs from making employment-related decisions based on genetic information of their employees or of job applicants. ▪ Prohibits employers from requesting, requiring or purchasing genetic information except in limited circumstances. <p>Preemption of State Law</p> <ul style="list-style-type: none"> ▪ Preempts some state laws that establish confidentiality standards for genetic information. ▪ Restricts how state and local governments use genetic information in employment practices and in the provision of health care for employees. 		

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MISCELLANEOUS HEALTH			
<p>National Uniformity for Food Act of 2005 (H.R. 4167) [H. Rpt. 109-197]</p>	<p>General Provisions</p> <ul style="list-style-type: none"> ▪ Amends the Federal Food, Drug, and Cosmetic Act to expand current uniform labeling requirements to include food adulteration. It also adds a new section that specifically requires uniformity in food safety warning notification requirements. ▪ Provides that no state or political subdivision may directly or indirectly establish or continue in effect any notification requirement for food that provides for a warning concerning the safety of the food unless the state or political subdivisions' requirement is identical to the notification requirement under the FFDCA. The Committee reiterates that the term `identical' means substantially similar and does not result in a materially different requirement. ▪ Provides that nothing in this Act is to be construed to prevent a state or political subdivision of a state from establishing, enforcing, or continuing in effect a requirement relating to: freshness dating, open date labeling, grade labeling, religious dietary labeling, organic or natural designation, returnable bottle labeling, or a statement of geographic origin. ▪ Provides that the Act will not prevent a State or political subdivision of a state from establishing, enforcing, or continuing in effect a requirement relating to a consumer advisory relating to food sanitation that is imposed on a food establishment, or that is recommended by the Secretary under part 3-6 of the Food Code issued by the Food and Drug Administration. ▪ Clarifies that the uniformity in notification 	<ul style="list-style-type: none"> ▪ Adopted in the House by recorded vote 283 yeas – 139 nays. (3/08/06) 	<p><u>NCSL Letter</u></p> <ul style="list-style-type: none"> ▪ Letter to Representative Phil Gingrey and Representative Louise Slaughter from Carl Tubbesing, NCSL Deputy Executive Director expressing NCSL's concerns regarding H.R. 4167. (03/08/06) ▪ Letter to the House Energy and Commerce Committee Chairman, Joe Barton and Ranking Member, John Dingell, from NCSL Deputy Executive Director, Carl Tubbesing expressing NCSL's concerns regarding preemption of state laws and expressing NCSL's desire to provide testimony and work with proponents of the legislation to address these concerns. (12/15/05) <p><u>NCSL Policy</u></p> <p>Federalism</p> <ul style="list-style-type: none"> ▪ <u>Preemption</u>. NCSL believes that state laws should never be preempted without substantial justification. Preemption may be warranted in specific instances when it is clearly based upon provisions of the U.S. Constitution authorizing such preemption and only when it is clearly shown (1) that the exercise of authority in a particular area by individual states has resulted in widespread and serious conflicts imposing a severe burden on national economic activity or other national goals; (2) that solving the problem is not merely desirable, but necessary to achieve a compelling national objective; and (3) that preemption of state laws is the only reasonable means of correcting the problem.

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	<p>requirements for warnings does not apply to dietary supplements and ensures that states can set tolerance levels for substances in food when the federal government has not.</p> <ul style="list-style-type: none"> ▪ Provides that the Act does not affect any state law, regulation, proposition or other action that establishes a notification requirement regarding the presence or potential effects of mercury in fish and shellfish. ▪ A rule of construction provides that this section shall not be construed to prohibit a state from conducting notification, disclosure, or other dissemination of information, or prohibit any action taken relating to a mandatory recall, civil administrative order, embargo, detention order, or court proceeding involving food adulteration under a State statutory requirement identical to a food adulteration requirement under the FFDCA. <p>Clarification of Terms</p> <ul style="list-style-type: none"> ▪ Provides that in the new section regarding uniformity provisions for food adulteration and food safety warning notification requirements, that the term `identical' means that the language in state law or regulation is substantially the same language as the comparable provision of the Act, and that any difference does not result in the imposition of materially different requirements. For the purposes of this section it is the Committee's intention that `identical' not be construed to mean the language of the states' food safety laws must be exactly the same. Rather, the language need only be substantially the same and not lead to materially different results. ▪ Clarifies that the term `any requirement for food.' does not include the procedures a state utilizes to 		

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	<p>enforce its laws, but rather to the substantive requirements imposed on the product.</p> <ul style="list-style-type: none"> ▪ Defines `notification requirement' to include any mandatory disclosure requirement relating to the dissemination of information about a food by a manufacturer or distributor. ▪ Defines the term `warning' as any statement, vignette, or other representation that indicates, directly or indirectly, that the food presents or may present a hazard to health or safety. <p>Petition Process - State Notification Requirement in Effect on the Date of Enactment</p> <ul style="list-style-type: none"> ▪ Provides for a petition process for states to receive an exemption for notification requirements that do not meet the uniformity requirements of this Act. ▪ Provides that a state notification requirement that was in effect on the date of enactment of the Act will remain in effect for 180 days after the date of enactment. ▪ Provides that for a state notification requirement that was in effect on the date of enactment of the Act, a state may submit a petition to the Secretary to provide by regulation an exemption to the uniformity requirements or for the Secretary to establish a new national standard. If the state submits a petition within 180 days of enactment of this Act, the state notification requirement will remain in effect until the Secretary either denies the petition, or if the petition is approved, the effective date of the final rule that is promulgated to provide the exemption or national standard. There is no ending date for a state requirement if the final rule does not establish any condition for the 		

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	<p>requirement in the final rule.</p> <ul style="list-style-type: none"> ▪ Directs the Secretary, no later than 270 days after the enactment of the Act, to publish a notice in the <i>Federal Register</i> concerning any petition submitted for an exemption or new national standard for an existing state notification requirement. The Secretary must provide 180 days for the public to comment on the petition. The Secretary must take action on the petition not later than 360 days after the end of the public comment period. ▪ The Secretary may provide for an exemption, under conditions as the Secretary imposes, for a requirement that: <ul style="list-style-type: none"> ▪ protects an important public interest that would otherwise be unprotected in the absence of the exemption; ▪ would not cause the food to be in violation of any applicable requirement or prohibition under Federal law; and ▪ would not unduly burden interstate commerce, balancing the public interest of the state or political subdivision against the impact on interstate commerce. ▪ The failure of the Secretary to comply with any timeframe set forth in this subsection will constitute final agency action. For the purpose of judicial review, the remedy is an order by the court to the Secretary to comply with a time period to take action. The court will determine that time period. If the Secretary fails to take action under any time frame established in the Act, the state notification shall remain in effect. <p>Petition Process - State Notification Requirement Not in Effect on the Date of Enactment</p> <ul style="list-style-type: none"> ▪ Provides for a separate process for a petition for 		

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	<p>an exemption or national standard for a notification requirement that was not in effect on the date of enactment of this Act. The state may petition the Secretary to provide by regulation an exemption, under such conditions as the Secretary may impose, for a requirement that: protects an important public interest that would otherwise be unprotected in the absence of the exemption; would not cause the food to be in violation of any applicable requirement or prohibition under Federal law; and would not unduly burden interstate commerce, balancing the public interest of the state or political subdivision against the impact on interstate commerce.</p> <ul style="list-style-type: none"> ▪ The state may also petition the Secretary to establish by regulation a national standard regarding any requirement under the FFDCA or the Fair Packaging and Labeling Act relating to the regulation of a food. ▪ The Secretary is required to publish the petition in the <i>Federal Register</i> within 30 days of its receipt. The Secretary must allow for public comment on the petition for a time period determined by the Secretary. Not later than 60 days after the end of the comment period, the Secretary must take final agency action on the petition. If final agency action is not possible within 60 days, the Secretary must inform the petitioner why final agency action is not possible, the date final action will be taken, and the final action that will be taken or likely will be taken. In any event, the Secretary must take final action within 120 days after the end of the comment period. ▪ The failure of the Secretary to comply with any time frame in this subsection will constitute final 		

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	<p>agency action. For the purpose of judicial review, the remedy available under this section is an order by the court to the Secretary to comply with a time period to take action. The court will determine that time period.</p> <p>State Petitions – Expedited Consideration</p> <ul style="list-style-type: none"> ▪ Provides for expedited consideration of state petitions that seek adoption of national warning requirements or exemptions from uniformity for state warning requirements in cases where the requested warning: <ul style="list-style-type: none"> ▪ relates to cancer-causing agents; ▪ is related to reproductive effects or birth defects; and ▪ is intended to provide information that will allow parents or guardians to understand, monitor, or limit a child’s exposure to cancer causing agents or reproductive or developmental toxins. hazard authority if the requirement <p>Imminent Hazard Authority</p> <ul style="list-style-type: none"> ▪ Permits states to respond to an imminent hazard even if the action would violate the uniformity requirements. Allows a state to take action under imminent hazard authority if the requirement is necessary to address an imminent hazard that is likely to result in serious health consequences or death. In addition, the state must have notified the Secretary about the matter involved, and the Secretary must not have already initiated enforcement action on the matter. ▪ Requires the state to submit a petition for an exemption or for a new national standard not later than 30 days after the state establishes the requirement, and the state must have taken enforcement action with respect to compliance 		

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	<p>with the state law within 30 days of establishing the standard.</p> <ul style="list-style-type: none"> ▪ Directs the Secretary to take final agency action on a petition on an imminent hazard within 7 days of receiving the petition. The failure of the Secretary to comply with this time frame will represent final agency action for the purposes of judicial review. The remedy available for judicial review under this section will be a court order for the Secretary to take action on the petition within a time period determined by the court. It is the Committee's intention that the state requirement under the imminent hazard authority remain in effect until final agency action is taken on the petition. <p>Impact on State Product Liability Laws</p> <ul style="list-style-type: none"> ▪ Provides that there is nothing in this section that is to be construed to modify or affect state product liability law. <p>Homeland Security</p> <ul style="list-style-type: none"> ▪ Provides that changes of law made by the Act will not take effect until the HHS Secretary certifies to Congress, after consultation with the Secretary of Homeland Security, that the implementation of the Act will pose no additional risk to the public health or safety from terrorist attacks related to the food supply. 		
PENSION REFORM			
<p>Pension Protection Act of 2005 H.R. 2830</p>	<p>Health Provisions</p> <ul style="list-style-type: none"> ▪ <u>Tax Treatment of Combined Annuity or Life Insurance Contracts with a Long Term Care Insurance Feature</u> – Provides for favorable tax treatment applicable to long-term care insurance 	<ul style="list-style-type: none"> ▪ Pending in House/Senate Conference Committee. 	<p><u>NCSL Policy</u></p> <ul style="list-style-type: none"> ▪ NCSL supports the provisions regarding Flexible Spending Accounts (FSAs) and the provision to permit tax-free distributions from governmental retirement plans for premiums for health and

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	<p>that is provided by a rider on or as part of an annuity contract, and modifies the tax rules applicable to long-term care insurance coverage provided by a rider on or as part of a life insurance contract. Designed to increase the number of individuals purchasing long-term care insurance products.</p> <ul style="list-style-type: none"> ▪ <u>Disposition of Unused Health Benefits in Flexible Spending Arrangements (FSAs)</u> - Allows up to \$500 of unused health benefits³ in an employee's health FSA to be carried forward to the employee's health FSA for the next plan year. An employee's unused health benefit is the excess of the maximum amount of reimbursement allowable to the employee over the actual amount of reimbursement made during the year. In the case of employees who are eligible individuals under Health Savings Accounts (HSA) rules, the provision also allows up to \$500 of unused health benefits in an employee's health FSA to be contributed on the employee's behalf to an HSA maintained for the benefit of the employee. Amounts contributed to an HSA are treated as employer contributions for purposes of HSA rules, including limits on contributions. As in the case of other amounts contributed to a HSA through a cafeteria plan, the amounts are not subject to the requirement that, in the case of employer contributions, comparable contributions must be made on behalf of all employees. Effective for taxable years after December 31, 2005. ▪ <u>Permit Tax-Free Distributions from Governmental Retirement Plans for Premiums for Health and Long-Term Care Insurance for Public Safety Officers</u> – Provides that certain pension distributions from an eligible retirement plan used to pay for qualified health insurance 		<p>long-term care insurance for public safety officers. NCSL has no policy on combined annuity or life insurance contracts with a long-term care insurance feature.</p>

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	premiums are excludable from income.		
PHARMACEUTICAL ISSUES			
Pharmaceutical Market Access and Drug Safety Act of 2005 (S. 334)	<ul style="list-style-type: none"> ▪ Amends the Federal Food, Drug, and Cosmetic Act by permitting a qualifying drug⁴ imported or offered for import into the United States from a registered exporter, importer or individual in a permitted country⁵. ▪ Requires a qualifying exporter to be registered with the Secretary of Health and Human Services and must meet certain qualifying standards such as the country must have statutory and regulatory standards equivalent to those in the United States and Canada with respect to the training and practice of pharmacists, and the protection of the privacy of personal medical information. ▪ Provides for the process of registration as a qualified importer or exporter. ▪ Requires the importer or exporter, as a condition of registration, to agree that a qualifying drug must be manufactured in an establishment meeting criteria outlined in the act and inclusive 	<ul style="list-style-type: none"> ▪ Adopted as an amendment to S. 1392, the FTC Reauthorization Act of 2005, which was favorably reported as amended by the Senate Committee on Commerce, Science and Transportation. (7/21/05) 	<p><u>NCSL Policy</u></p> <p>Drug Reimportation, Regulation of Internet Pharmacies and Drug Safety</p> <ul style="list-style-type: none"> ▪ <u>Drug Reimportation</u>. NCSL believes that it should be a national priority to expand access to affordable prescription drugs. NCSL urges the U.S. Department of Health and Human Services to complete its study on drug reimportation and to make its findings public. In addition, NCSL urges the Food and Drug Administration (FDA) to clarify its “personal use” policy and how the policy is to be enforced. NCSL also urges Congress to make it a priority to explore alternatives in order to: (1) increase the number of individuals with health insurance, thereby increasing access to prescription drug coverage; and (2) increase the affordability of prescription drugs.

4 A “qualifying drug” is defined as one which has a corresponding U.S. label drug.

5 A “permitted country” means—(i) Australia, (ii) Canada, (iii) a member country of the European Union, but does not include a member country with respect to: (I) the country’s Annex to the Treaty of Accession to the European Union 2003 includes a transitional measure for the regulation of human pharmaceutical products that has not expired; or (II) the Secretary determines that the requirements described in sub-clauses (I) and (II) of clause (vii) will not be met by the date on which such transitional measure for the regulation of human pharmaceutical products expires; (iv) Japan ; (v) New Zealand; (vi) Switzerland; and (vii) a country in which the Secretary determines the following requirements are met: (I) The country has statutory or regulatory requirements—(aa) that require the review of drugs for safety and effectiveness by an entity of the government of the country; (bb) that authorize the approval of only those drugs that have been determined to be safe and effective by experts employed by or acting on behalf of such entity and qualified by scientific training and experience to evaluate the safety and effectiveness of drugs on the basis of adequate and well-controlled investigations, including clinical investigations, conducted by experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs; (cc) that require the methods used in, and the facilities and controls used for the manufacture, processing, and packing of the drugs in the country to be adequate to preserve their identity, quality, purity, and strength; (dd) for the reporting of adverse reactions to drugs and procedures to withdraw approval and remove drugs found not to be safe or effective; (ee) that require the labeling and promoting of drugs to be in accordance with the approval of the drug. (II) The valid marketing authorization system in the country is equivalent to the system in the countries described in clauses (i) through (vi). (III) The importation of drugs to the United States from the country will not adversely affect public health.

6 A “qualifying medical relationship” with respect to issuing a prescription drug for a patient exists if, (i). at least one in-person medical evaluation of the patient has been conducted by the practitioner; or (ii). the practitioner conducts a medical evaluation of the patient as a covering practitioner.

ISSUE/TITLE	DESCRIPTION	LEGISLATIVE ACTION	NCSL POSITIONS, ACTIONS, AND PUBLICATIONS
	<p>of permitting the Secretary to conduct onsite inspections.</p> <ul style="list-style-type: none"> ▪ Requires the exporter or importer to notify the Secretary within eight hours and five days of the shipment of qualifying drugs. Such notification must include but is not limited to the identity of the drug, the manufacturer information, anticipated arrival information, and a summary of the chain of custody. ▪ Imposes registration and inspection fees to cover costs administrative costs. ▪ Provides that the Secretary should treat any difference of a qualifying drug from that of a U.S. label drug as if it were a manufacturing change to the U.S. label drug and conduct a review in accordance with that change. ▪ Prohibits any unfair or discriminatory acts on the part of a manufacturer inclusive of but not limited to charging a higher price for a prescription drug sold to a registered exporter, importer or other persons in a permitted country, denying or restricting supplies, or refuse to allow an inspection authorized by this act. ▪ Grants authority for enforcement of this act with the Federal Trade Commission. ▪ Authorizes the state attorneys general to bring civil action on behalf of their state residents for violations of this act that have adversely affected their state in a district court of the United States. ▪ Establishes requirements for the internet sale of pharmaceuticals inclusive of standards for the content of an internet site, a prohibition on dispensing a prescription drug without the existence of an appropriate medical relationship⁶, 		

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	<ul style="list-style-type: none"> ▪ Provides that the requirements of this act should not be construed to affect state law concerning the practice of medicine or to prohibit a state official from proceeding in state court on the basis of violations of any civil or criminal statute of the state. ▪ Directs the Secretary of Health and Human Services to award a grant or to contract with the National Clearinghouse on Internet Prescribing to identify internet sites that appear in violation of federal or state law, to report these sites to state medical licensure boards and state pharmacy licensing boards, and to the attorney general and the secretary for further investigation. Appropriates \$100,000 for FY 2005 through 2007 to carry out these actions. 		
PUBLIC HEALTH			
Trauma Care Systems Planning and Development Act of 2005 (S. 265)	<ul style="list-style-type: none"> ▪ Amends the Public Health Service Act to direct the HHS Secretary to collect, compile, and disseminate information regarding problems experienced by state and local agencies and private entities in providing trauma care and emergency medical services with special consideration for rural areas. ▪ Amends provisions concerning matching funds for modifications of the trauma care part of state emergency services plans, including to modify the matching requirements to not less than \$1 for each \$1 of federal funds in the third year of payments and not less then \$2 for each \$1 of federal funds in the fourth and fifth years (currently the amount is set at not less than \$3 for each \$1 of federal funding in the third year and subsequent years). ▪ Amends requirements with respect to carrying out the purpose of allotments, including 	<ul style="list-style-type: none"> ▪ Favorably reported by the Senate Health, Education, Labor and Pensions Committee. (2/9/05) 	<u>NCSL Policy</u> <ul style="list-style-type: none"> ▪ NCSL has no position.

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	<p>requiring a state plan for emergency medical services to coordinate planning for trauma systems with state disaster emergency planning and bioterrorism hospital preparedness planning.</p> <ul style="list-style-type: none"> ▪ Requires states to submit to the Secretary the trauma care part of their emergency services plans in FY 2005 and years following to 2007 to include changes and improvements made and plans to address deficiencies. ▪ Provides a self-evaluation mechanism to assist states in assessing and improving their trauma care systems ▪ Directs the Secretary to enter into a contract with the Institute of Medicine (IOM) of the National Academy of Sciences, or another appropriate entity, to conduct a study on the state of trauma care and trauma research. ▪ Authorizes appropriations \$12,000,000 through FY2009, doubling the funding available for this program. 		
RESEARCH			
<p>Stem Cell Research Enhancement Act of 2005 (S. 471, H.R. 810)</p>	<ul style="list-style-type: none"> ▪ Amends the Public Health Service Act to require the HHS Secretary to conduct and support research that utilizes human embryonic stem cells, regardless of the date on which the stem cells were derived from a human embryo. ▪ Limits the research to stem cells that meet the following ethical requirements: <ul style="list-style-type: none"> ▪ the stem cells were derived from human embryos donated from in vitro fertilization clinics for the purpose of fertility treatment 	<ul style="list-style-type: none"> ▪ Adopted in the House by recorded vote 238 yeas—194 nays (5/24/05). ▪ Introduced in the Senate (2/28/05). 	<p><u>NCSL Policy</u></p> <ul style="list-style-type: none"> ▪ NCSL has no position.

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	<p>and were in excess of the needs of the individuals seeking such treatment;</p> <ul style="list-style-type: none"> ▪ the embryos would never be implanted in a woman and would otherwise be discarded; and ▪ such individuals donate the embryos with written informed consent and receive no financial or other inducements. 		
<p>Cord Blood Stem Cell Act of 2005 (S. 681, H.R. 596)</p>	<ul style="list-style-type: none"> ▪ Amends the Public Health Service Act to direct the HHS Secretary, acting through the Administrator of the Health Resources and Services Administration (HRSA), to enter into contracts with qualified cord blood stem cell banks to assist in establishing and maintaining a National Network of Cord Blood Stem Cell Banks to: <ul style="list-style-type: none"> ▪ acquire, tissue type, test, cryopreserve, and store donated units of human cord blood acquired with the informed consent of the donor; ▪ make cord blood units available to transplant centers for stem cell transplantations; and ▪ allocate up to 10 percent of the cord blood inventory each year for peer-reviewed research. Requires the Secretary to provide for the establishment of a Board of Directors to administer the Network. ▪ Directs the Secretary, acting through the Administrator, to establish as part of the Network a National Cord Blood Stem Cell Registry to: <ul style="list-style-type: none"> ▪ operate a system for identifying, acquiring, and distributing donated units of cord blood; ▪ provide health care professionals with the ability to search the registry for suitable matches for patients; and ▪ maintain a database to document the 	<ul style="list-style-type: none"> ▪ Introduced in the Senate (3/17/05). ▪ Introduced in the House (2/25/05). 	<p><u>NCSL Policy</u></p> <ul style="list-style-type: none"> ▪ NCSL has no position.

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	<p>collection, storage, distribution, and transplantation of cord blood units and the clinical outcomes of Network transplantations.</p> <ul style="list-style-type: none"> ▪ Requires the Administrator to report to the Secretary regarding the safety, efficacy, and cost-effectiveness of the clinical, research, and education activities of the Network. ▪ Requires the Board to ensure that: (1) the Network donor banks meet confidentiality and privacy requirements; and (2) the Network and their birthing hospital collection sites are geographically distributed throughout the United States. 		
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)			
<p>The Covering Kids Act of 2005 (S. 1049)</p>	<ul style="list-style-type: none"> ▪ Makes grant funding available to states, local communities, schools, faith-based organizations, Indian tribes, safety net providers, and groups to enroll more children into Medicaid and the State Children's Health Insurance Program (SCHIP). ▪ Requires the HHS Secretary to give priority to grantees that target areas with high numbers of children who are eligible for Medicaid or SCHIP, but not enrolled. ▪ Sets aside 10 percent of the funding to the Indian Health Service (IHS), tribal organizations and urban Indian programs to enroll more Native American children in Medicaid or SCHIP. ▪ Authorizes \$50 million in FY 2006 and in FY 2007. 	<ul style="list-style-type: none"> ▪ Introduced in the Senate (5/17/05). 	<p><u>NCSL Policy</u></p> <ul style="list-style-type: none"> ▪ NCSL has no position.
VETERANS HEALTH			
<p>Veterans Health Care Improvements Act of 2005 (S. 1182)</p>	<ul style="list-style-type: none"> ▪ Authorizes the Secretary of Veterans Affairs to provide up to 14 days of care following birth for the newborn child of a woman veteran receiving 	<ul style="list-style-type: none"> ▪ Adopted in the Senate by unanimous consent. (12/21/05) 	<p><u>NCSL Position</u></p> <ul style="list-style-type: none"> ▪ NCSL has no position.

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	<p>maternity care furnished by the Department of Veterans Affairs if the child was delivered in a Department facility or a Department-contracted facility.</p> <ul style="list-style-type: none"> ▪ Provides that, if payment made by the Secretary for health care furnished to children of Vietnam veterans born with spina bifida or to children of women Vietnam veterans born with certain birth defects, is less than the amount billed, then the health care provider may seek payment of the difference from a responsible third party insurer. Prohibits the provider from imposing any additional charge on the beneficiary for any service or item for which the Secretary has made payment. ▪ Includes marriage and family therapists and mental health counselors within authorized Department mental health providers. Outlines professional requirements for such positions. Requires a report from the Department's Under Secretary for Health to the congressional veterans' committees on the provision of post-traumatic stress disorder (PTSD) treatment by marriage and family therapists. ▪ Provides a Senior Executive Service pay level adjustment for the Chief Nursing Officer, Office of Nursing Services. ▪ Authorizes the Secretary to conduct studies comparing costs of private contractor versus Department provision of commercial and industrial products and services for the Veterans Health Administration (VHA). Authorizes appropriations. Requires a report from the Secretary to the veterans' committees. ▪ Directs the Secretary, within the Department, to: <ul style="list-style-type: none"> (1) expand the number of clinical treatment 		

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	<p>teams principally dedicated to the treatment of PTSD; (2) expand and improve substance abuse services; (3) expand and improve tele-health initiatives; (4) improve education programs for primary care delivery professionals; (5) expand the delivery of mental health services in community-based outpatient clinics; and (6) expand and improve Mental Health Intensive Case Management Teams. Authorizes appropriations. Requires the Under Secretary for Health to take appropriate steps and provide necessary incentives to: (1) prioritize the provision of mental health services to veterans in need; (2) foster collaborative working environments for the provision of such services; and (3) conduct mental health consultations during primary care appointments.</p> <ul style="list-style-type: none"> ▪ Directs the Secretary to ensure that each community-based outpatient clinic has the capacity to provide mental health services to veterans in need. Requires a report from the Secretary to Congress concerning such services. ▪ Requires a memorandum of understanding between the Secretary and the Secretary of Defense: (1) to ensure that separating service members receive standardized individual mental health and sexual trauma assessments as part of separation exams; and (2) that includes the development of shared guidelines on the conduct of the assessments. Requires such Secretaries to: (1) establish a joint workgroup on mental health, which shall conduct a study of mental health services and assessments provided by each department; and (2) report jointly to Congress on workgroup recommendations. ▪ Directs the Under Secretary for Health to: (1) establish system-wide guidelines for screening 		

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	<p>primary care patients for mental health disorders and illnesses; and (2) conduct appropriate training for Department clinicians to carry out mental health consultations.</p> <ul style="list-style-type: none"> ▪ Requires the National Center on Post Traumatic Stress Disorder to collaborate with the Secretary of Defense to: (1) enhance the clinical skills of military PTSD clinicians; and (2) promote pre-deployment resilience and post-deployment readjustment among service members serving in Operations Iraqi Freedom and Enduring Freedom. Authorizes appropriations. ▪ Authorizes the Secretary to disclose to an organ procurement organization the name and address of a member or former member of the Armed Forces, and his or her dependents, in order for such organization to determine whether such individual is, or after death will be, a suitable organ, tissue, or eye donor, if: (1) the individual is near death or deceased; and (2) the disclosure is permitted under provisions of the Health Insurance Portability and Accountability Act of 1996. ▪ Directs the Secretary to increase the number of Readjustment Counseling Service facilities capable of providing health services and counseling through tele-health linkages with facilities of the Veterans Health Administration. Requires the Secretary to submit to the veterans' committees a plan to implement such requirement. ▪ Requires a report from the Secretary to such committees describing the mental health data maintained by the Department. ▪ Directs the Secretary to publish a strategic plan 		

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	<p>for long-term care.</p> <ul style="list-style-type: none"> ▪ Requires the Secretary, within 30 months after the enactment of this Act, to establish an additional blind rehabilitation outpatient specialist position at no fewer than 35 additional Department facilities, giving priority to facilities with large numbers of enrolled legally blind veterans. Authorizes appropriations. ▪ Extends through 2006 (currently, 2004) a report requirement concerning the Secretary's compliance with departmental capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans. ▪ Directs the Secretary to provide necessary medical and health care services to any veteran affected by Hurricane Katrina as if such veteran was enrolled in the Department's annual patient enrollment system. Prohibits the collection of payments from such veterans for such care (including co-payments for medications). ▪ Authorizes the Secretary to reimburse certain veterans for expenses resulting from emergency treatment furnished in a non-Department facility for which the veteran remains personally liable. 		

NCSL Federal Health Policy website at: <http://www.ncsl.org/statefed/health/fedhealthissues.htm>.

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