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Summary: Selected Health Legislation 110th Congress

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

TABLE OF CONTENTS

SUMMARY: SELECTED HEALTH LEGISLATION IN THE 110TH CONGRESS

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
APPROPRIATIONS/BUDGET			
FY 2009 Budget Resolution (H Con Res 312 ; S Con Res 70)	**Description** ▪ Sets the blueprint for federal expenditure for FY 2009. The funding levels established for FY 2009 resolution provide guidance to the authorizing and appropriating committees.	▪ Conference report adopted in the House by recorded vote, 214 yeas– 210 nays. (6-5-08) ▪ Conference report adopted in the Senate by recorded vote, 48 yeas– 45 nays. (6-4-08) ▪ Conference report filed (H. Rpt. 110-659). (5/20/08) ▪ Senate conferees appointed[1]. (5/15/08) ▪ House appointed conferees[2] ▪ Adopted in the House as amended pursuant to H. Res. 1190. (5/14/08)	**NCSL Policy** ▪ NCSL supported funding for the state fiscal relief, Medicare reform and for the establishment of a Medicare prescription drug program, and the reinstatement of SCHIP funds. NCSL supported Medicaid reform, but did not support a specific proposal

[1] Senate appointed conferees; Senators Conrad, Murray, Wyden, Gregg, and Dominici.
[2] House appointed conferees; Representatives Spratt, DeLauro, Edwards, Ryan (WI), and Barrett (SC).

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
		▪ Adopted in the Senate as amended by recorded vote, 51 yeas– 44 nays. (3/14/08)	
COMMUNITY HEALTH CENTERS			
Health Center Renewal Act of 2007 (H.R. 1343; S. 901) *Sponsors: Representative Green (D-TX); Senator Kennedy (D-MA)*	**Description** ▪ Reauthorizes the Community Health Center program for five years. **State Issues** ▪ Community health centers are an important part of the health care safety net. **Summary** ▪ Reauthorizes the Community Health Center program for five years. ▪ Sets authorization levels at: $2,188, 745,000 for FY 2008; $2,451,394,000 for FY 2009; $2,757,818,700 for FY 2010; $3,116,335,131 for FY 2011; and $3,537,040,374 for FY 2012.	▪ Adopted in the House by a 2/3 majority recorded vote, 393 yeas– 24 nays. (6/4/08) ▪ Ordered to be reported with an amendment in the nature of a substitute by the House Committee on Energy and Commerce. (5/7/08) ▪ Report filed (S. Rpt. 110-274) by the Senate Committee on Health, Education, Labor and Pensions. (3/12/08) ▪ Hearing held in Health Subcommittee of the Energy and Commerce Committee. (12/4/07)	**NCSL Policy** **Federal Funding to Assist States with Health Profession Shortages and to Assist Underserved Areas** ▪ **Community Health Centers, Rural Health Centers and Federally Qualified Health Centers**. Community health centers, Rural Health Centers and Federally Qualified Health Centers and similar and related facilities play critical role in the health care safety net. NCSL urges Congress to continue to support these facilities.
HEALTH INFORMATION TECHNOLOGY			
The PRO(TECH)T Act of 2008 (H.R. 6357) *Sponsors: Representative Dingell (D-MI)*	**Description** ▪ Encourages the widespread adoption of electronic health record systems by authorizing $575 million annually through fiscal year 2013 to provide grants and loans to health care providers to purchase health information technology systems. **State Issues**	▪ Subcommittee on Health markup held. Forwarded to full committee. (6/25/08) ▪ Introduced. (6/24/08)	**NCSL Policy** **Health Information Technology** ▪ NCSL strongly supports the development of an interoperable system of electronic health information for the United States. Such a system has the potential to: (1) facilitate the coordination of health care

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Authorizes grants to states and Indian Tribes. ▪ May preempt some state laws. **Summary** *Office of the National Coordinator of Health Information Technology(IT)* ▪ Codifies the creation of the Office of the National Coordinator of Health Information Technology (ONCHIT) within the U.S. Department of Health and Human Services. ▪ Directs the National Coordinator to maintain and update a national strategic plan to achieve the goals for the development of policies and standards to allow for the secure electronic exchange of health information, and to develop a program of voluntary certification of health IT. ▪ Establishes a HIT Policy Committee consisting of public and private stakeholders to make recommendations to the National Coordinator relating to the implementation of a nationwide health IT infrastructure, including an implementation of the strategic plan. ▪ Establishes a HIT Standards Committee consisting of public and private stakeholders for the purpose of making standard recommendations to the National Coordinator. ▪ Directs the National Coordinator to establish a HIT Resource Center to provide technical assistance, develop best practices, and provide a forum for the exchange of ideas. ▪ Requires federal agencies implementing, acquiring, or upgrading HIT systems for the use of exchanging		regardless of patient location; (2) improve both the quality and efficiency of care; (3) provide easy access to health care information to both patients and health care providers, which can contribute to more informed decision-making on the part of patients; and (4) reduce medical errors and some of the fraud and abuse that plagues our health care system. ▪ The potential of benefits of an interoperable health information system cannot be realized unless: (1) consumers trust the system and want to participate in it; (2) the full range of health care providers trust the system and find it affordable and easy to use; and (3) employers support the system and believe that it is cost-efficient and improves quality of care. ▪ NCSL urges Congress and the Administration to continue to move forward on the development of this important system. It is imperative that states be involved in all stages of the development. The system should be based on a set of common, but not necessarily uniform values and technical standards. NCSL supports a system that: (1) guarantees that patients and their authorized health professionals jointly make decisions regarding the sharing of health information; (2) stores health information locally, where the services are being rendered, not in a centralized national or regional database; (3) creates a nationwide capability for health

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	identifiable health information to only use products meeting standards adopted in accordance with this act. *Competitive Grants for Health Care Providers* ▪ Establishes a competitive grant program for eligible entities, principally providers of healthcare, for the purchase of qualified health IT. ▪ Requires matching funds contribution of one non-federal dollar for every three federal dollars provided in the grant *Competitive Grants to States and Indian Tribes* ▪ Establishes a competitive grant program for states and Indian Tribes to enable them to establish a loan fund to health care providers for the purchase of qualified health IT. ▪ Requires one for one match on funds for a state or Indian Tribe to qualify. ▪ Requires that the conditions for receipt of funds by health care providers meet certain criteria which requires them to link to a local or regional health information network and that they consult with the IT Resource Center to implement an effective system. They must also report any breach of identifiable health information from their system, and develop a plan for how they will maintain and support their system. ▪ States would be permitted to use up to four percent of the funds received in the grant per year to cover reasonable costs in the administration of the program. ▪ Permits the loan fund to accept contributions from private sector entities, but prohibits the contributing		information exchange building on existing systems; (4) facilitates communication among the full range of information networks, states and communities; and (5) allows participating entities to use a wide range of different software and hardware. ▪ The key to the development of a successful interoperable electronic health information system is the development of a system that is secure and protects patient privacy. The Health Insurance Portability and Accountability Act (HIPAA) set important privacy standards that must be retained in such a system. It is critical that the current HIPAA law and regulations and subsequent laws and regulations enacted to facilitate an interoperable electronic health information system continue to establish a floor, but not a ceiling when it comes to protecting patient privacy and to the permissible use of stored data. ▪ Interoperability, not uniformity should be the focus of initiatives to get this important system in place. The security of the data must be a priority. Severe penalties should be established for individuals or entities that compromise information in the system. Every effort must be made to make the system available and affordable to the widest range of providers and consumers. ▪ NCSL supports the establishment of a Health Information Technology Resource Center to identify best practices and to provide technical

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	entity from specifying the recipient. All contributions would be available to the public. *Competitive Grants to Eligible Entities for the Implementation of Health IT Plans* ▪ Provides grant funding to support local and regional organizations in the development of health IT plans. ▪ Preference will be given to small health care providers in medically underserved or rural areas and other who may have difficulty acquiring electronic health records on their own. ▪ Authorizes the appropriations of $115 million for all three competitive grant programs for each year from fiscal years 2009 through 2013. *Demonstration Program to Integrate IT Into Clinical Education* ▪ Creates a demonstration project for the development of academic curricula which integrates qualified health IT into the clinical education of health professionals. ▪ Eligible recipients include schools of health professions who are required to submit a strategic plan which integrates health IT in the clinical education with a goal to reduce medical errors and enhance health care quality. ▪ Requires matching funds to be provided by grant recipients of not less than one dollar for every two federal dollars provided under the grant. ▪ The purchase of hardware, software or services is not permitted with grant funds. ▪ Authorizes the appropriations of $10 million for each of fiscal years 2009 through 2011.		assistance to interested parties. NCSL also supports the establishment of grant, loan and demonstration programs to provide financial and technical support to health care providers, state and local governments, and other entities that will play a key role in the development and successful operation of an interoperable health information system. Finally, it is critical that publicly financed programs such as Medicaid and Medicare be active participants in the system and that creating this capacity be a priority within the federal budget.

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	Privacy and Security Standards ▪ Applies the security safeguards required within the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the penalties for violations to the business associates of the providers who were initially considered covered entities in the act. Business associates include those individuals who perform routine business functions for covered health care providers. ▪ Requires notification of a breach of unencrypted Protected Health Information (PHI) to each individual whose information was affected within 60 days of discovery. ▪ Requires vendors who maintain electronic medical records working with a provider of health service to not only report breaches of information to the affected individual, but also to the Federal Trade Commission (FTC). ▪ Requires the secretary to annually report to congress on complaints and alleged violations and to implement an education programs designed to enhance public awareness regarding the use of health information. *Limitation on Disclosures* ▪ Permits a patient to request that their PHI regarding specific healthcare issues and expenditures remain undisclosed by the provider to the health plan for payment, unless required by law, if the patient has paid out-of-pocket for the services. ▪ Also permits an individual to request an accounting of disclosures from a provider for a period of six years if they employ the use of electronic medical		

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	records in their delivery system. ▪ Requires providers to obtain a patients' consent to use or disclose PHI for health care operations if the provider is utilizing an electronic medical record. *Business Associate Contracts* ▪ Requires health care providers employing the services of an organization where an exchange of Protected Health Information is required on a regular basis to enter into a written contract with that organization. *Preemption of State Law* ▪ Preempts state laws requiring that health or medical records (including billing information) be maintained or transmitted in written rather than electronic form.		
Healthcare Information Technology Enterprise Integration Act (H.R. 2406) *Sponsor: Representative Gordon (R-TN)*	**Description** ▪ Authorize the National Institute of Standards and Technology to increase its efforts in support of the integration of the healthcare information enterprise in the United States. **State Issue** ▪ Supports efforts to advance the use of health information technology. **Summary** ▪ Requires the Director of the National Institute of Standards and Technology (NIST) to establish an initiative for advancing health care information enterprise integration within the United States. ▪ Allows the Director to assist health care representatives and organizations and federal	▪ Report filed, (H. Rpt. 110-451) from the House Committee on Science and Technology. (11/15/07) ▪ Ordered to be favorably reported by voice vote by the House Committee on Science and Technology. (10/24/07)	**NCSL Policy** **Health Information Technology** ▪ NCSL strongly supports the development of an interoperable system of electronic health information for the United States. Such a system has the potential to: (1) facilitate the coordination of health care regardless of patient location; (2) improve both the quality and efficiency of care; (3) provide easy access to health care information to both patients and health care providers, which can contribute to more informed decision-making on the part of patients; and (4) reduce medical errors and some of the fraud and abuse that plagues our health care system.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	agencies in the development of technical roadmaps that identify the remaining steps needed to ensure that standards will be in place. ▪ Requires the Director to develop or adopting existing technology-neutral information technology infrastructure guidelines and standards to enable federal agencies to effectively select and utilize health care information technologies in a manner that is: (1) sufficiently secure and provides adequate privacy to meet needs; and (2) interoperable, to the maximum extent possible. ▪ Requires the Undersecretary of Commerce for Technology to establish a Senior Interagency Council on Federal Healthcare Information Technology Infrastructure to coordinate: (1) the development and deployment of health care information technology solutions; (2) the associated technology transfer to and from the private sector; and (3) federal funding and participation in private, voluntary standards development organizations as related to electronic health care records system. ▪ Requires the Director to establish a program of assistance to institutions of higher education to establish multidisciplinary Centers for Healthcare Information Enterprise Integration in order to: (1) generate innovative approaches to health care information enterprise integration; and (2) develop and use information technologies and other complementary fields. ▪ Directs the National High-Performance Computing Program to coordinate federal research and development programs related to the development and deployment of health information technology.		▪ The potential of benefits of an interoperable health information system cannot be realized unless: (1) consumers trust the system and want to participate in it; (2) the full range of health care providers trust the system and find it affordable and easy to use; and (3) employers support the system and believe that it is cost-efficient and improves quality of care. ▪ NCSL urges Congress and the Administration to continue to move forward on the development of this important system. It is imperative that states be involved in all stages of the development. The system should be based on a set of common, but not necessarily uniform values and technical standards. NCSL supports a system that: (1) guarantees that patients and their authorized health professionals jointly make decisions regarding the sharing of health information; (2) stores health information locally, where the services are being rendered, not in a centralized national or regional database; (3) creates a nationwide capability for health information exchange building on existing systems; (4) facilitates communication among the full range of information networks, states and communities; and (5) allows participating entities to use a wide range of different software and hardware. ▪ The key to the development of a successful interoperable electronic health information system is the development of

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			a system that is secure and protects patient privacy. The Health Insurance Portability and Accountability Act (HIPAA) set important privacy standards that must be retained in such a system. It is critical that the current HIPAA law and regulations and subsequent laws and regulations enacted to facilitate an interoperable electronic health information system continue to establish a floor, but not a ceiling when it comes to protecting patient privacy and to the permissible use of stored data. ▪ Interoperability, not uniformity should be the focus of initiatives to get this important system in place. The security of the data must be a priority. Severe penalties should be established for individuals or entities that compromise information in the system. Every effort must be made to make the system available and affordable to the widest range of providers and consumers. ▪ NCSL supports the establishment of a Health Information Technology Resource Center to identify best practices and to provide technical assistance to interested parties. NCSL also supports the establishment of grant, loan and demonstration programs to provide financial and technical support to health care providers, state and local governments, and other entities that will play a key role in the development and successful operation of an interoperable health information system. Finally, it is critical that publicly financed programs

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			such as Medicaid and Medicare be active participants in the system and that creating this capacity be a priority within the federal budget.
Wired for Health Quality Act (S.1693) *Sponsor: Senator Kennedy (D-MA)*	**Description** ▪ A bill to enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the costs of health care in the United States. **State Issues** ▪ Sets standards for developing a nationwide interoperable health information technology system. ▪ Provides grants to states. ▪ May preempt some state laws. **Summary** ***Encourages the development of standards for health IT*** ▪ Codifies the role of the National Coordinator for Health Information Technology in coordinating the policies of federal agencies regarding health IT. ▪ Establishes a public–private partnership known as the Partnership for Health Care Improvement to provide recommendations to the Secretary with regard to technical aspects of interoperability, standards, implementation specifications, and certification criteria for the exchange of health information. The National Coordinator will serve as a liaison to the Partnership. ▪ Requires the Secretary to publish a schedule for assessment of standards for significant use cases after consulting with the Partnership.	▪ Report filed (S. Rpt. 110-187) by the Senate Committee on Health, Education, Labor and Pensions. (10/01/07) ▪ Ordered to be favorably reported by the Senate Committee on Health, Education, Labor and Pensions Committee. (6/27/07)	**NCSL Policy** **Health Information Technology** ▪ NCSL strongly supports the development of an interoperable system of electronic health information for the United States. Such a system has the potential to: (1) facilitate the coordination of health care regardless of patient location; (2) improve both the quality and efficiency of care; (3) provide easy access to health care information to both patients and health care providers, which can contribute to more informed decision-making on the part of patients; and (4) reduce medical errors and some of the fraud and abuse that plagues our health care system. ▪ The potential of benefits of an interoperable health information system cannot be realized unless: (1) consumers trust the system and want to participate in it; (2) the full range of health care providers trust the system and find it affordable and easy to use; and (3) employers support the system and believe that it is cost-efficient and improves quality of care. ▪ NCSL urges Congress and the Administration to continue to move forward on the development of this important system. It is imperative that states be involved in all stages of the

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	▪ Requires all federal IT purchases conform to the standards recommended by the Partnership and adopted by the President. Adoption of these standards is voluntary for private entities. ▪ Establishes the American Health Information Community as a body providing recommendations to the Secretary regarding policies to promote the development of a nationwide interoperable health information technology infrastructure. These include recommendations regarding patient privacy, information security, and appropriate uses of health information. *Privacy Protections for Electronic Health Information* ▪ Requires that the national strategy on health IT includes strong privacy protections, including methods to notify patients if their medical information is wrongfully disclosed. *Encourages The Adoption Of Qualified Health IT To Improve The Quality And Efficiency Of Care* ▪ Provides grants for the purchase of health IT systems to providers demonstrating financial need. ▪ Provides grants to states to establish low interest loan programs to help providers acquire health IT systems that will improve the quality and efficiency of health care. ▪ Provides grants to facilitate the implementation of regional or local health information plans to improve health care quality and efficiency through the electronic exchange of health information. ***Helps Providers Use IT To Improve Quality***		development. The system should be based on a set of common, but not necessarily uniform values and technical standards. NCSL supports a system that: (1) guarantees that patients and their authorized health professionals jointly make decisions regarding the sharing of health information; (2) stores health information locally, where the services are being rendered, not in a centralized national or regional database; (3) creates a nationwide capability for health information exchange building on existing systems; (4) facilitates communication among the full range of information networks, states and communities; and (5) allows participating entities to use a wide range of different software and hardware. ▪ The key to the development of a successful interoperable electronic health information system is the development of a system that is secure and protects patient privacy. The Health Insurance Portability and Accountability Act (HIPAA) set important privacy standards that must be retained in such a system. It is critical that the current HIPAA law and regulations and subsequent laws and regulations enacted to facilitate an interoperable electronic health information system continue to establish a floor, but not a ceiling when it comes to protecting patient privacy and to the permissible use of stored data. ▪ Interoperability, not uniformity should be the focus of initiatives to get this

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	▪ Provides grants to integrate qualified health IT in the clinical education of health professionals and encourage the use of decision support software to reduce medical errors. ▪ Requires the Secretary to designate a single organization to develop healthcare performance measures. ▪ Establishes a Health Information Technology Resource Center where IT users can learn from the previous experience of others who have implemented qualified health IT.		important system in place. The security of the data must be a priority. Severe penalties should be established for individuals or entities that compromise information in the system. Every effort must be made to make the system available and affordable to the widest range of providers and consumers. ▪ NCSL supports the establishment of a Health Information Technology Resource Center to identify best practices and to provide technical assistance to interested parties. NCSL also supports the establishment of grant, loan and demonstration programs to provide financial and technical support to health care providers, state and local governments, and other entities that will play a key role in the development and successful operation of an interoperable health information system. Finally, it is critical that publicly financed programs such as Medicaid and Medicare be active participants in the system and that creating this capacity be a priority within the federal budget.
HEALTH PROFESSIONS			
A Bill to Extend for 5 Years the Program Relating to Waiver of the Foreign Country Residence Requirement with Respect to International Medical Graduates (H.R. 5571)	▪ Extends for two years, the J-1 visa waiver program for foreign physicians who receive their medical training in the United States.[3]	▪ Adopted in the House as amended by a 2/3 majority voice vote. (5/21/08) ▪ Ordered to be reported by the House	**NCSL Policy** **Federal Funding to Assist States with Health Profession Shortages** ▪ NCSL urges Congress to enact legislation to ensure the continuation of this important program in a timely

[3] Normally these physicians are required to leave the United States and return to their home country for at least two years after they have completed their medical training. J-1 visa waiver recipients may remain in the United States after the completion of their medical training provided they agree to practice medicine for at least three years in a medically underserved area. These physicians are granted nonimmigrant H-1B status (temporary worker in specialty occupation). The current waiver authority expired June 1, 2008

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Sponsor: Representative Zoe Lofgren (D-CA)		Committee on the Judiciary and report filed [H. Rpt. 110-646]. (4/02/08) ▪ Introduced. (3/10/08)	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 urges Congress to permanently authorize this program and to provide for a periodic review and evaluation of the program's goals and objectives . .
Consistency, Accuracy, Responsibility, and Excellence in Medical Imaging and Radiation Therapy Act of 2007 (S. 1042) *Sponsor: Senator Enzi (R-WY)*	**Description** ▪ Amends the Public Health Service Act to make provision of technical services for medical imaging examinations and radiation therapy treatment. **State Issues** ▪ Preempts some state laws. **Summary** ▪ Directs the Secretary of Health and Human Services to establish basic safety standards for medical imaging studies and radiation therapy treatments and to impose those standards on personnel who perform, plan, evaluate, or verify patient dose for medical imaging studies. ▪ Exempts physicians, nurse practitioners and physician assistants from application of the standards. ▪ Directs the secretary to ensure personnel performing these procedures have successfully completed certification through some official process as determined appropriate by the secretary. ▪ Provides for a process to deem individuals for	▪ Ordered to be reported by the Senate Committee on Health, Education, Labor, and Pensions. (3/13/08)	**NCSL Policy** **Federalism** ▪ **Preemption** Congress must allow states flexibility to shape public policy. Creative solutions to public problems can be achieved more readily when state laws are accorded due respect. State legislators believe that state laws should never be preempted without substantial justification. Inordinate reliance upon the central government is not the solution to the nation's problems. Uniformity for uniformity's sake does not justify preemption. A federal system contemplates diversity among states. Our federalism anticipates diversity; our unity does not anticipate uniformity. By definition, every preemptive law diminishes other expressions of self-government and should be approved only where compelling need and broad consensus exist. While proponents of preemption may claim expected benefits, these must be balanced against the potential loss of accountability, innovation and responsiveness.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	licensure or certification if their experience and training is equal to or in excess of those who have graduated from an accredited program in a specific specialty. ▪ Provides the secretary with the authority to certify qualified nonprofit organizations as approved bodies to provide accreditation to individuals and to establish operational standards for those bodies. ▪ Establishes a process of deeming for state licensure and certification processes based on the approval of the secretary. ▪ Directs the secretary to establish an appeals process for states to respond to an adverse determination by the secretary. ▪ States are not prohibited from establishing education and training standards above and beyond those set by the secretary. ▪ Allows for alternative standards for rural and underserved areas unless the state executive officer submits a statement declaring this to be inappropriate in their state to the secretary. ▪ Authorizes the secretary to withhold federal assistance for payment of medical imaging or radiation therapy covered by all programs under the authority of the secretary. ▪ Requires the Agency for Healthcare Research and Quality (AHRQ) to report to congress the types and numbers of providers for who the standards apply, the impact, and the availability and cost of services within five years of implementation of this act.		
HEALTH PROMOTION/DISEASE PREVENTION			
Stroke Treatment and Ongoing	**Description**	▪ Adopted in the House	**NCSL Policy**

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
Prevention Act (H.R. 477) *Sponsor: Representative Capps (D-CA)*	▪ Amends the Public Health Service Act to strengthen education, prevention, and treatment programs relating to stroke. **State Issues** ▪ Authorizes grants to states. **Summary** ▪ Amends the Public Health Service Act to direct the Secretary of Health and Human Services to carry out a national education campaign to promote stroke prevention and increase the number of stroke patients who seek immediate treatment. ▪ Requires the Secretary, acting through the Centers for Disease Control (CDC), to maintain the Paul Coverdell National Acute Stroke Registry and Clearinghouse by collecting specific data points and benchmarks for stroke care analysis and by compiling and disseminating information on state, local, and private care system achievements and problems. ▪ Defines "stroke" as an attack in which blood flow to the brain is interrupted or in which a blood vessel or aneurysm in the brain breaks or ruptures. ▪ Includes stroke and traumatic injury prevention, diagnosis, and treatment within the grant program for emergency medicine residency training. ▪ Authorizes the Secretary, through the Administrator of the Health Resources and Services Administration (HRSA), to make grants to qualified entities for education programs for health care professionals in the use of diagnostic approaches, technologies, and therapies for stroke and traumatic injury prevention, diagnosis, treatment, and rehabilitation. Gives	by voice vote. House report filed (H. Rpt. 110-75). (3/27/07)	**Public Health** ▪ **Preventive Health Screenings and Check-Ups** NCSL urges Congress to increase support for initiatives that promote regularized preventive health screenings and check-ups. NCSL is particularly supportive of efforts that provide information about and promote screening for: cardiovascular disease, dental disease; obesity, asthma, diabetes, cancer. We also support efforts to ensure that children receive age appropriate check-ups and screenings that include recommended childhood immunizations; and dental, vision and hearing screenings; and recommended treatment.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	preference to qualified entities that will train professionals that serve areas with a significant incidence of stroke or traumatic injuries. ▪ Authorizes the Secretary, through the Director of the Office for the Advancement of Telehealth, to make up to seven grants to states and to consortia of public and private entities in any non-grantee state to conduct a five-year pilot project to improve stroke patient outcomes by coordinating health care through telehealth networks.		
INSURANCE REFORM			
Michelle's Law (S. 400; H.R. 2851) *Sponsor: Senator Sununu (R-NH); Representative Hodes (D-NH)*	**Description** ▪ Allows a student attending a post secondary institution who is insured with their parents' health coverage to take a medical leave of absence from school or attend classes part time without losing their health insurance. **State Issues** ▪ May preempts some state laws. **Summary** ▪ Amends the Employee Retirement Income Security Act of 1974, provisions in the Public Health Service Act pertaining to group market reforms and provisions in the Internal Revenue Code relating to group health plan requirements by adding new language which allows for a medical leave of absence for a dependent child from a postsecondary educational institution. ▪ The dependent child may be allowed a leave of absence when they are suffering from a severe illness or injury, the absence is medically necessary, even though it may cause the child to lose full-time student status under the terms of their medical insurance.	▪ Ordered to be reported as amended by the House Committee on Energy and Commerce. (7/16/08)	**NCSL Policy** ▪ NCSL has no policy.

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	▪ Prohibits a group or individual market health plan from terminating coverage before one year after the first day of a medically necessary leave of absence of the date on which the coverage otherwise would have terminated according to the terms of the plan. ▪ In order for these restrictions to apply, an attending physician must certify to the plan that the dependent child is suffering from a severe illness or injury and that the leave is medically necessary. ▪ Requires group health plans to include information concerning continued coverage during a medically necessary leave of absence with any notice to the insured regarding a requirement for certification of student status for coverage. ▪ Prohibits a plan from making any change in covered benefits during a medically necessary leave of absence. ▪ Provides that any changes by a plan sponsor of a group health plan would require the new group health plan will be subject to the same requirements as their predecessor.		
Small Business Health Options Program (SHOP) Act (S. 2795) *Sponsor: Senator Durbin (D-IL)*	**Description** ▪ Establishes a national health insurance purchasing pool for small businesses and the self employed which offers a choice of affordable private health coverage. **State Issues** ▪ Preempts some state laws.	▪ Introduced. (4/02/08)	**NCSL Policy** **Federal health Insurance Reform** ▪ NCSL believes that states should regulate insurance and should continue to set and enforce solvency standards and to provide oversight on insurance matters. NCSL opposes any proposals that would expand the preemption of state laws and regulations beyond those already

[4] The term "preexisting condition exclusion" is defined in the IRS code as meaning a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Rates charged and premiums paid for health benefits will be determined by applicable state rating requirements, except that rates for coverage may not vary based on health status related factors. ▪ State mandated benefit laws will continue to apply, except in the case of a nationwide plan. ▪ Provides a state-opt out option if certain criteria are met. **Summary** ▪ Establishes a national health insurance purchasing pool for small businesses and the self employed which offers a choice of affordable private health coverage. ▪ Applies to employers who employ an average of at least 1 but not more than 100 employees who work at least 35 hours per week, and self-employed individuals with at least $5,000 in net earnings or $15,000 in gross earnings. *Program Oversight* ▪ Provides for the oversight of the small business health insurance pools through an administrator within the Department of Health and Human Services (HHS). ▪ Provides for the duties of the administrator. ▪ Establishes a Small Business Health Board to monitor implementation of the program and make recommendations to the administrator. *Contracts with Health Insurance Issuers* ▪ Authorizes the administrator to enter into contracts with qualified health insurance issuers without		established in the ERISA. Absent changes that would permit states to regulate ERISA plans, Congress should impose requirements on ERISA plans that closely track state legislative and regulatory initiatives. In addition, federal remedies, that more closely resemble remedies available at the state level, should be adopted for consumers in ERISA plans. Federal health insurance legislation that establishes mandated benefits or uniform standards, should establish a floor, 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.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	regard to statutory requirements for competitive bidding. ▪ Requires state licensure in each state where health benefit plans are offered. ▪ Requires that all issuers provide options to individuals terminated from their group plan to enroll in a nongroup policy without evidence of insurability. Provides for exceptions to this provision. *Employer Participation* ▪ Requires that each employer ensure that employees are aware of their opportunity to participate in the plan and prohibits employers from offering other comprehensive coverage outside the plan or supplemental insurance. ▪ The HHS administrator is directed to establish an open enrollment period beginning October 1 and ending on December 1 of each year commencing in calendar year 2010 for coverage beginning in calendar year 2011. ▪ Provides that employees who have either been terminated or voluntarily separated from the eligible employer may continue their coverage for the remainder of the calendar year if they pay 100 percent of their monthly premium. *Health Coverage Available within the Small Business Pool* ▪ Preexisting Condition Exclusion-Permits all contracts to contain a preexisting condition exclusion as defined under section 9801(b) (1) of the Internal Revenue Service (IRS) code of 1986[4]. Requires that the preexisting condition exclusion provide for coverage of the preexisting condition to begin not later than six months after the date the		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	coverage began. ▪ Rates and Premiums-Provides that rates charged and premiums paid for health benefits will be determined by applicable state rating requirements, except that rates for coverage may not vary based on health status related factors. ▪ Preemption of State Law- Preempts state laws or regulation which allows premium rates to vary based on health-status related factors. Amends the Employee Retirement Income Security Act (ERISA) to reflect this prohibition. ▪ State Mandated Benefits- Provides that state mandated benefit laws will continue to apply, except in the case of a nationwide plan. *Ratings Study* ▪ Directs the administrator to contract with the National Association of Insurance Commissioners (NAIC) beginning in 2009 to conduct a study of the rating requirements used in the program and those that apply to health insurance purchased in the small group markets in the states, and to submit recommendations to congress by calendar 2011. ▪ Directs NAIC to make recommendations concerning; ▪ Rating requirements for health insurance coverage under this act for calendar year 2013 and subsequent years, and ▪ The maximum permissible variance between state rating requirements and those for coverage under this act that will allow state flexibility without causing significant adverse selection for health insurance coverage.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Provides for the rating rules which will apply beginning calendar year 2013 if congress should fail to act on recommendations submitted through the NAIC study. *Employee Choice* ▪ Beginning in calendar years 2011 and 2012, in states that apply community rating or adjusted community rating where any age bracket does not exceed 300 percent of the lowest age bracket, employees of an employer within the state may elect to enroll in any health plan offered under this act. ▪ Beginning in calendar year 2013, all participating employees may elect to enroll in any health plan offered under this act. *Benefits for Nationwide plans* ▪ Requires contracts with nationwide plans to include a benefit package as established by the administrator. ▪ Directs the secretary to contract with the Institute of Medicine (IOM) to develop a minimum set of benefits to be offered by nationwide plans. *Premium for Delayed Enrollment* ▪ Provides that self-employed individuals residing in states where they are ineligible to enroll in a small group plan, will be assessed an additional premium if they elect not to enroll in coverage under this act in the first year. *State Enforcement of Provisions* ▪ Authorizes but does not require states to enforce the provisions of this act which supersede state law applying to the following;		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Prohibitions on varying premium rates based on health-status, ▪ The implementation of rating requirements that apply under the program, and ▪ Benefit requirements for nationwide health plans. ▪ In the event that the secretary determines a state is not providing enforcement, the secretary will retain enforcement authority. *State Opt Out* ▪ Authorizes states to prohibit small employers and self-employed individuals from participation in the program if the state; ▪ Defines its small group market to include groups of one, ▪ Prohibits the use of health-status related factors, ▪ Has rating rules which comply with the provisions in this act, and ▪ Maintains a state-wide purchasing pool. *Risk Adjustments Incentives* ▪ Establish a contingency fund for risk corridors which will serve to compensate health plans for a percentage of allowable expenditures over 103 percent of the targeted amounts for calendar years 2011 and 2013. *Regional Administration of Premiums* ▪ Directs the administrator to contract with eligible regional entities to conduct activities in the receipt and disbursement of premiums between employers and health insurance issuers.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	Small Business Employee Health Insurance Tax Credits ▪ Amends the IRS code to establish a tax credit for qualified small employers. ▪ Credit amounts will be determined on the following variables: ▪ An employer size factor percentage with 100 percent provided for businesses with 10 or fewer full time employees; 80 percent with 10-20 employees; 60 percent with 30 employees; 40 percent with 40 employees; 20 percent with 50 employees; and zero percent for more than 50 employees, and ▪ The number of months during the year the employer paid for expenses divided by 12, and ▪ The applicable amount will be equal to; ▪ $1000.00 for each employee who receives self-only coverage, ▪ $2000.00 for each employee who receives family coverage, ▪ $1500.00 for each employee who receives coverage for two adults or one adult and one child, ▪ Creates a bonus for each additional 10 percent of an employee's premium above 60 percent covered by the qualified small employer.		
Mental Health Parity Act of 2007 (S. 558) *Sponsor: Senator Domenici (R-NM)*	**Description** ▪ Amends the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to prohibit a group health plan or group health coverage that provides both medical and surgical	▪ Adopted in the Senate by unanimous consent. (9/18/07)	**NCSL Policy** **Principles for Federal Health Insurance Reform** ▪ Federal health insurance legislation that establishes mandated benefits or uniform

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	benefits and mental health benefits from imposing treatment limitations or financial requirements on the mental health benefits unless comparable limitations or requirements are imposed on medical and surgical benefits. ▪ Current federal law requires benefits-parity only for annual and lifetime dollar limits. This bill requires benefits parity with respect to all treatment limitations and financial requirements. **State Issues** ▪ Retains current law "HIPAA standard" which permits states to enact requirements that are more protective of insured individuals. **Summary** *Definitions* ▪ Defines mental health services to include treatment for substance use disorders. ▪ Provides that state law may continue to define the benefits a fully-insured plan is required to cover. As under current law, states would not be permitted to establish similar requirements for self-insured plans. *Coverage Requirements* ▪ Parity in financial requirements. The plan or coverage must ensure that any financial requirements applied to mental health benefits are no more restrictive or costly than the financial requirements applied to substantially all medical and surgical benefits that the plan covers. Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket expenses. The plan may not establish separate cost-sharing requirements that are applicable only to mental health benefits.		standards, should establish a floor, 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.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Parity in treatment limits. The plan or coverage must also ensure that the treatment limitations applied to such benefits are no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits that the plan covers. Such treatment limitations include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope and duration of treatment. ▪ In and out-of-network coverage. If the plan or coverage provides both medical/surgical benefits and mental health benefits on both an in and out-of-network basis, then it must provide out-of-network mental health benefits on par with out-of-network medical and surgical benefits. ▪ Plan Options. Permits health plans to: (1) negotiate separate reimbursement or provider payment rates and service delivery systems for different benefits; (2) manage the provision of mental benefits in order to provide medically necessary treatments under the plan (as a means to contain costs and monitor and improve the quality of care); and (3) take into consideration similar treatment settings or similar treatments when applying the provisions of this section. *Scope of Coverage Small Business and Individual Market Exemption* ▪ The mental health parity requirements apply only to group health plans with more than 50 employees. Employers with less than 51 employees are exempt from the Act. The bill does not apply to the individual insurance market. *Cost Exemption* ▪ If as a result of the parity requirements a health plan		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	experiences increased actual total costs of coverage that exceed 2% during the first plan year or 1% in subsequent years (as certified by a qualified actuary), it is exempt from the parity requirements for the following plan year. In the year following its exemption, the plan would again need to comply. *Federal Oversight* ▪ Ombudsman. The Secretaries of Labor and Health and Human Services are to designate an individual in each department to serve as an ombudsman, with responsibility to provide information and assistance to individuals concerning coverage of mental health services. ▪ Audits. Requires the Secretaries Health and Human Services (HHS) and Labor (DOL) to provide for random audits of health plans and insurance coverage to ensure compliance with the Act. ▪ Government Accountability Study (GAO). GAO is to conduct a study to evaluate implementation of the Act on issues including health-insurance cost, access to insurance coverage, quality of care, and impact on benefits and coverage of mental health and substance-use disorders.		
Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424) *Sponsor: Representative Kennedy (D-RI)*	**Description** ▪ Amends the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to prohibit a group health plan or group health coverage that provides both medical and surgical benefits and mental health benefits from imposing treatment limitations or financial requirements on the mental health benefits unless comparable	▪ Adopted in the House as amended by recorded vote 268 yeas–148 nays and referred to the Senate[6]. (3/5/08) ▪ Report filed from the House Committee on Energy and Commerce,	**NCSL Policy** **Principles for Federal Health Insurance Reform** ▪ Federal health insurance legislation that establishes mandated benefits or uniform standards, should establish a floor, not a ceiling. The federal government should continue to give deference to state, local

[5] The Diagnostic and Statistical Manuel of Mental Disorders (DSM) is a handbook for mental health professionals with recognized standards for categories of mental disorder and the criteria for diagnosing them, developed by the American Psychiatric Association.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	limitations or requirements are imposed on medical and surgical benefits. ▪ Current federal law requires benefits-parity only for annual and lifetime dollar limits. This bill requires benefits parity with respect to all treatment limitations and financial requirements. ▪ Amends the Mental Health Parity Act of 1996 to require equity in the provision of mental health and substance-related disorder benefits under group health plans. ▪ Prohibits discrimination on the basis of genetic information with respect to health insurance and employment. **State Issues** ▪ Preempts some state laws. ▪ Provides some protection against genetic discrimination in the individual and group health insurance market and in the workplace. **Description** *Definitions* ▪ Defines mental health services to include treatment for substance use disorders and requires that the benefit include the same benefits and services as provided in the plan offered to federal employees with the highest average enrollment. All plans offered to federal employees are required to provide benefits for all mental health and substance abuse disorders listed in the diagnostic manual for those conditions (DSM-IV manual). [5]	H. Rpt. 110-374p3. (3/4/08) ▪ Ordered to be reported by the House Energy and Commerce Committee. (10/16/07) ▪ House Energy and Commerce Committee markup held. (10/16/07) ▪ Report filed from the House Committee on Ways and Means, H. Rpt. 110-374p2. (10/15/07) ▪ Report filed from the House Committee on Education and Labor, H. Rpt. 110-374p1. (10/15/07) ▪ Ordered to be reported with an amendment in the nature of a substitute by the House Committee on Education and Labor. (7/18/07) ▪ Introduced in the House. (3/9/07)	and tribal governments regarding the regulation of state, local and tribal government employee health plans.

▪ [6] Incorporates the text of H.R. 493, the Genetic Information Nondiscrimination Act of 2007, as passed by the House on 4/30/07. (3/05/08)

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	Coverage Requirements ▪ Minimum Scope of Coverage. Requires that all plans providing any mental health or substance abuse-related disorder benefits to include benefits for those conditions included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association. ▪ Parity in financial requirements. Stipulates that a group health plan (or health insurance coverage offered in connection with a group plan) must ensure that the financial requirements that are applied to mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits that the plan covers, including: (1) deductibles; (2) copayments; (3) coinsurance; (4) out-of-pocket expenses; and (5) annual and lifetime limits. Prohibits group health plans from establishing separate cost sharing requirements directed only at mental health benefits. ▪ Parity in treatment limits. The group health plan (or health insurance coverage offered in connection with the plan) must also ensure that the treatment limitations applied to mental health benefits are no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits that the plan covers, including: (1) limits on the frequency of treatment; (2) number of visits; (3) days of coverage; or (4) other similar limits on the scope or duration of treatment. ▪ Parity in out-of-network coverage. Requires that if a group health plan provides both medical and surgical benefits and mental health benefits (including substance abuse treatment), and provides the benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), then		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	the plan must ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits. Does not require a group health plan to eliminate, reduce or provide out-of-network coverage. ▪ Plan Options. Permits health plans to: (1) negotiate separate reimbursement or provider payment rates and service delivery systems for different benefits; (2) manage the provision of mental benefits in order to provide medically necessary treatments under the plan (as a means to contain costs and monitor and improve the quality of care); and (3) take into consideration similar treatment settings or similar treatments when applying the provisions of this section. *Scope of Coverage Small Business and Individual Market Exemption* ▪ Does not apply to any group health plan for any plan year of any small employer. Small employers are those who employ 50 or less employees. ▪ The bill does not apply to the individual insurance market. *Cost Exemption* ▪ A group health plan may elect to be exempt from parity under this act for the following plan year if it is projected that the group health plan will experience increased actual total costs of coverage with respect to medical and surgical benefits and mental health benefits under the plan that exceed 2 percent of the actual total plan costs during the first plan year or exceed 1 percent of the actual total plan costs each subsequent year. It should be noted that		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	the exemption under this section only applies for one plan year and that an employer may still elect to continue to apply mental health parity even if it meets the threshold for cost exemption. ▪ Requires that a qualified actuary who is a member in good standing in the American Academy of Actuaries to determine the increases in costs under a plan. The determinations must be certified by the actuary and be made available to the general public. ▪ Stipulates that group health plans that desire an exemption for meeting the threshold for cost exemption can only do so after they have complied with this section for the first 6 months of the plan year involved. ▪ If the plan elects to modify its coverage of mental health benefits, then it will be treated as a significant modification in the terms of the plan and will have to give appropriate notice to plan members when required. *Effect on State Laws* ▪ Amends the Employee Retirement Income Security Act of 1974 (ERISA) to provide that the provisions of this act relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan supersedes any provision of state law that establishes, implements, or continues in effect any standard or requirement which does not provide greater consumer protection, benefits, methods of access to benefits, rights or remedies than provided in this Act. ▪ Provides that state insurance laws relating to the individual insurance market or to small employers are not preempted. ▪ With respect to a State, this law will be effective the		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	same date as it is effective with respect to group health plans. [With respect to group health plans this law must take effect beginning in the first plan year that begins on or after January 1 of the first calendar year that begins more than 1 year after the date of the enactment of this act.] *Federal Administration* ▪ Requires both the Secretary of Labor and the Secretary of Health and Human Services to designate a person within their respective agencies to serve as the group health plan ombudsman. The primary duties of the ombudsman is to serve as an initial point of contact to permit individuals to obtain information and provide assistance concerning their coverage of mental health services under group health plans or under health insurance coverage issued in connection with group health plans. ▪ Requires that the Secretaries of Labor and Health and Human Services each ensure that random audits of group health plans and health insurance coverage offered in connection with group health plans are conducted in order to determine whether group health plans are in compliance with this act. ▪ Requires the Comptroller General to conduct a study and prepare and submit a report within 2 years of enactment of this act to the appropriate committees of Congress, which evaluates the effect that the implementation of this Act has on: (1) the cost of health insurance coverage; (2) access to health insurance coverage (including the availability of in-network providers); (3) the quality of health care; (4) impact on benefits and coverage for mental health and substance abuse; (5) the impact of any additional costs or savings to the plan; (6) the impact on out-of-network coverage for mental health benefits (including substance abuse treatment); (7) the impact		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	on State mental health benefit mandate laws; (8) other impact on the business community and the Federal Government and, (9) other issues as determined appropriate by the Comptroller General. ▪ Provides that, except as otherwise provided in this act, enforcement of the act follows the enforcement structure contained in the Mental Health Parity Act of 1996, which requires the Department of Labor, Department of the Treasury, and the Department of Health and Human Services to share enforcement jurisdiction. ▪ Requires the Secretaries of Labor and Health and Human Services to promulgate regulations within 1 year after the date that the act is enacted. *Effective Date* ▪ **S**tipulates that with respect to group health plans or health insurance coverage offered in connection with such plans--this law will take effect beginning in the first plan year that begins on or after January 1 of the first calendar year that begins more than one year after the date of enactment. *Genetic Information Nondiscrimination* ▪ Amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, and Title XVIII of the Social Security Act to prohibit the use of genetic information by employers in employment decisions, and by small group or group health plans in making enrollment determination or setting insurance premiums. ▪ Prohibits plans from requesting or requiring genetic testing. ▪ Establishes that a beneficiary has the right to take civil action for violations of the prohibitions.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Establishes penalties for violations. ▪ Amends Medicare to prohibit issuers of Medicare supplemental policies from discriminating on the basis of genetic information. ▪ Extends medical privacy and confidentiality (HIPPA) rules to the disclosure of genetic information. ▪ Makes it an unlawful employment practice for an employer, employment agency, labor organization, or training program to discriminate against an individual or deprive such individual of employment opportunities because of genetic information. Prohibits the collection and disclosure of genetic information, with certain exceptions. ▪ Establishes a Genetic Nondiscrimination Study Commission to review the developing science of genetics and advise Congress on the advisability of providing for a disparate impact cause of action under this Act.		
LONG TERM CARE			
Fairness in Nursing Home Arbitration Act of 2008 (H.R. 6126; S. 2838) *Sponsor : Representative Sanchez (D-CA); Senator Martinez (R-FL)*	**Description** ▪ Invalidates pre-dispute arbitration agreements between a long-term care facility and a resident of that facility or the person acting on behalf of the resident which would. **State Issues** ▪ May preempt some state laws. **Summary** ▪ Invalidates pre-dispute arbitration agreements between a long-term care facility and a resident of that facility or the person acting on behalf of the	▪ Introduced in the House. (5/22/08) ▪ Introduced in the Senate. (4/09/08)	**NCSL Policy** ▪ NCSL has no policy.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	resident entered into at any time during or after the admission process. ▪ Applies to any all public or proprietary long-term care facilities or the facility of a private nonprofit corporation.		
MEDICAID			
Temporary Increase of the Federal Medical Assistance Percentage (FMAP) Under the Medicaid Program (H.R. 5268) *Sponsor : Representative Pallone (D-NJ)*	**Description** ▪ Provides for a temporary increase of the Medicaid federal medical assistance percentage (FMAP) to states. **State Issues** ▪ Temporarily increases the Medicaid FMAP payments to state beginning April 2008 until June 30, 2009. **Summary** ▪ Provides for a temporary increase in the Medicaid FMAP to states by 2.95 percent for five quarters including the last two quarters of FY 2008 and the first three quarters of FY 2009. Provides for a temporary increase of the Medicaid FMAP to territories by 5.9 percent for the same period. ▪ Increases in the FMAP will not apply to any of the following: ▪ Disproportionate share hospital payments, ▪ Temporary Assistance for Needy Families (TANF), or ▪ The State Children's Health Insurance Program. ▪ Requires that for states to qualify for the temporary increase in their FMAP they must maintain their Medicaid eligibility at current levels.	▪ Introduced. (2/07/08)	**NCSL Policy** ▪ NCSL urges the Congress to study options to include a provision establishing emergency assistance to states within the Medicaid statute. The provision would upon some triggering event, such as an economic downturn, natural disaster, act of terrorism, pandemic or other public health emergency, provide additional financial assistance to states through an enhanced federal match or some other mechanism that would revert back to the regular federal-state cost sharing formula when the when the triggering event has been resolved. This is a complex, but critical component to fiscal security for the Medicaid program. NCSL looks forward to working with Congress and the Administration to identify options and to establish and implement a program.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ States requiring local and county contributions toward the non-federal share of expenditures may not require those political subdivisions to pay a greater percentage of the non-federal share for expenditures during the temporary increase period. ▪ Adjusts the computation of Medicaid FMAP to disregard an employer pension contribution exceeding 25 percent of the total increase in personal income in that state for the year involved when computing the per capita income of a state.		
The Indian Health Care Improvement Act of 2007 (S. 1200) Sponsor: Senator Baucus (D-MT);	[See Native American Health Care – The Indian Health Improvement Act of 2007 (S. 1200) p.23]		
MEDICARE			
Medicare Improvements for Patients and Providers Act 2008 (S. 3101) *Sponsor: Senator Baucus (D-MT)*	[See NCSL Side-by-Side Summary Document http://www.ncsl.org/print/health/DocFix.pdf Contained in this booklet]		
The Indian Health Care Improvement Act of 2007 (S. 1200) *Sponsor: Senator Baucus (D-MT)*	[See Native American Health Care – The Indian Health Improvement Act of 2007 (S. 1200) p.23]		
MEDICARE PRESCRIPTION DRUG COVERAGE			
Medicare Prescription Drug Price Negotiation Act of 2007 (H.R. 4) Sponsor: Representative Dingell (D-MI)	**Description** ▪ Amends Medicare to require the HHS Secretary to negotiate lower covered part D drug prices on behalf of Medicare beneficiaries. **State Issues** ▪ Interest in expanding access to affordable prescription drugs.	▪ Adopted in the House by recorded vote 255 yeas – 170 nays and referred to the Senate. (1/12/07)	**NCSL Policy** ▪ NCSL has no policy.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ States provide funding for the Medicare Part D program. **Summary** ▪ Amends Medicare to require the HHS Secretary to negotiate with pharmaceutical manufacturers the prices that may be charged to prescription drug plan sponsors and Medicare Advantage organizations for covered part D drugs for part D eligible individuals enrolled under a prescription drug plan or under a Medicare Advantage prescription drug (MA-PD) plan.		
MENTAL HEALTH			
Mental Health Parity Act of 2007 (S. 558) *Sponsor: Senator Domenici (R-NM)*	[See "Insurance Reform" – Mental Health Parity Act of 2007 (S. 558) on page 19]		
Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424) *Sponsor: Representative Kennedy (D-RI)*	[See Insurance Reform – Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R.1424) on page 22]		
NATIVE AMERICAN HEALTH CARE			
Indian Health Improvement Act Amendments of 2007 (H.R. 1328) *Sponsors: Senator Dorgan (D-ND); Representative Pallone (D-NJ)*	**Description** ▪ Amends the Indian Health Care Improvement Act to revise requirements for health care programs and services for Indians, Indian tribes, tribal organizations, and urban Indian organizations. **State Issues** ▪ Places new requirements on state Medicaid and State Children's Health Insurance Programs, resulting in additional spending of approximately $85 million from FY 2008 – FY 2017. ▪ Exempts employees Tribal Health Program from	▪ Discharged from the House Committee on Energy and Commerce. (6/06/08) ▪ Report filed from the House Committee on Natural Resources, H. Rpt. 110-564p. (4/04/08) ▪ Ordered to be favorably reported by voice vote by the Health Subcommittee of the	**NCSL Policy** ▪ NCSL has no policy.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	state licensing requirements. **Summary** ▪ Reauthorizes the Indian Health Care Improvement Act as amended through FY2017. ▪ Provides continue funding for existing model diabetes projects through 2017. ▪ Exempts health professionals employed by a Tribal Health Program from licensing requirements of the state in which the Tribal Health Program provides service. ▪ Directs the Secretary of Health and Human Services working through the states, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to develop and disseminate best practices to facilitate agreements between states and Indian Tribes, Tribal Organizations, and Urban Indian Organizations concerning enrollment and retention of Indians in SCHIP, Medicare and Medicaid. ▪ Establishes a right of recovery of payment for Indian Tribe and Tribal Organizations for services provided through these organizations to beneficiaries under SCHIP, Medicare and Medicaid. ▪ Provides that Indian Health Programs and health care programs operated by Urban Indian Organizations will be considered the payer of last resort for services provided to persons eligible for services under these programs. ▪ Provides for the confidentiality of medical quality assurance records created by or for any Indian Health Program or a health program of an urban Indian organization as part of a medical quality assurance program.	House Committee on Energy and Commerce. The subcommittee amended the Senate bill. (11/7/07) ▪ Report filed from the Senate Committee on Indian Affairs, S. Rpt. 110-197. (10/16/07)	

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Authorizes the Secretary to enter into agreements with states to reimburse states for medical assistance provided by an Indian Health Program to Indians who are eligible for Medicaid under the state plan o r under waiver authority. ▪ Instructs states to disregard certain property from resources for the purposed of determining the eligibility of an individual who is an Indian for medical assistance including real property and improvements held in trust under federal supervision and located on the reservation. ▪ Provides for a continuation of current law which protects certain Indian property from Medicaid estate recovery. ▪ Requires non-Indian Medicaid managed care entities to permit an Indian to receive service from an Indian health care provider if they have the capacity to provide primary care services.		
The Indian Health Improvement Act of 2007 (S. 1200) *Sponsor: Senator Baucus (D-MT);*	**Description** ▪ Improves access to health services through Indian Health Programs for Indians enrolled in both the Medicaid program and the Indian Health Service (IHS). **State Issues** ▪ Imposes new rules on State Medicaid programs, prohibits states from imposing cost-sharing requirements or charging premiums to Indians who receive services or benefits through an Indian health program. ▪ New requirements on State Medicaid programs which necessitate ongoing consultation and advisement with Indian Health Programs (IHPs) on	▪ Adopted in the Senate as amended by recorded vote, 83 yeas – 10 nays. (2/26/08) ▪ Motion to invoke cloture on the bill. (02/14/08) ▪ Report filed from the Senate Committee on Indian Affairs, S. Rpt. 110-197. (10/16/07) ▪ Ordered to be reported by the Senate Committee on Finance.	**NCSL Policy** ▪ NCSL has no policy

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	matters pertaining to revisions in Medicaid law likely to impact on these entities. **Summary** *Health Professions* ▪ Authorizes the continuation of recruitment and scholarship programs for Indian health professionals. ▪ Exempts from state licensing requirements any health professionals employed by a Tribal Health Program (THP) to perform services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (ISDEAA). *Health Promotion and Disease Prevention* ▪ Expands current cancer screening programs for Native Americans by eliminating the minimum age requirement for a screening mammography. ▪ Improves and expands the current diabetes screening including the treatment and control of the disease. ▪ Expands programs for specified disease prevention, control, elimination of tuberculosis to include other communicable and infectious diseases. ▪ Directs the Secretary of Health and Human Services to fund urban Indian youth residential treatment centers to provide alcohol and substance abuse treatment services to urban Indian youth in a culturally competent residential setting. *Funding for Health Services to Indians* ▪ Extends the authorization of appropriations for Indian health programs through FY2017. ▪ Establishes IHPs and health care programs operated by Urban Indian Organizations (UIOs) as the payer	(9/12/07)	

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	of last resort for services provided to eligible persons. *Medicaid and SCHIP* ▪ Encourages states to make efforts to enroll eligible Indians living on or near the reservation into the Medicaid and SCHIP programs. ▪ Directs the secretary to study and report barriers to interstate coordination of enrollment and coverage under Medicaid and SCHIP of eligible children who frequently change their state residency and an examination of the enrollment and coverage coordination issues faced by relevant Indian children. ▪ Prohibits states from imposing cost-sharing requirements or charging premiums, deductibles or copays to Indians who receive services or benefits through an Indian health program or by a health care provider through referral under the contract health services. ▪ Directs states to disregard for purposes of determining an individual's eligibility for Medicaid effective October 1, 2009; ▪ property held in trust or under the supervision of the Secretary of Interior, ▪ ownership interest in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally protected rights, ▪ ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to tribal law or custom.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Continues protections under current law of certain Indian property from Medicaid estate recovery. ▪ Requires nondiscrimination with regard to qualifications for payment from a federal health program for services provided by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization or UIO to an Indian if the provider meets state or other requirements. ▪ Deems state and local licensure requirements for health care providers operated by the HIS, an Indian Tribe, Tribal Organization, or UIO if the provider meets all the applicable standards for licensure regardless of whether they obtained the license under state law. ▪ Creates a safe harbor for health care items and services transferred among Indian organizations for the treatment of a patient from being treated as remuneration. *Medicaid Managed Care Provisions* ▪ Requires that Indians enrolled in a non-Indian Medicaid managed care organization (MCO) be allowed to select participating IHPs or UIOs as their primary care provider when available and even when the Indian is otherwise eligible to receive services from that provider. ▪ Prohibits states from restricting the choice of Indian enrollees in selection of Medicaid MCOs to only an Indian Medicaid MCO. ▪ State contracts with MCOs must require that: ▪ MCOs demonstrate their network of participating Indian health providers is adequate to ensure timely access to covered Medicaid services for		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	those enrollees eligible to receive services with these providers, and ▪ MCOs must agree to pay non-participating Indian health providers (excluding non-participating Federally Qualified Health Centers (FQHC)) at a rate equal to the rate negotiated between the MCE and the provider, or at a rate reimbursed to a participating non-Indian health care provider. ▪ MCOs would have to accept claims submitted by Indian health programs instead of requiring enrollee submission of claims. ▪ Requires states to offer contracts to Indian health programs seeking to operate their own MCO. ▪ Waives certain rules of participation for Indian Health programs seeking to operate as an MCO. *Miscellaneous Health Provisions* ▪ Creates a demonstration project to test telemental health services in suicide prevention, intervention, and treatment of Indian youth. ▪ Establishes requirements for privacy protections so that the Indian Health Service and tribal health programs are in line with other health agencies and departments. *Moratorium on the Implementation of Changes to Case Management and Targeted Case Management Payment Requirement Under Medicaid* ▪ Delays implementation of the interim final rules published in the December 4, 2007 *Federal Register* until March 31, 2009. The interim final rules governing the use of case management and targeted case management (TCM) services which went into effect March 3, 2008 would implement provisions		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	redefining TCM in the Deficit Reduction Act of 2005 and limiting those services to those which are medically necessary. *Medicaid Fraud and Abuse* ▪ Increases sentences for felonies involving assisting individuals in disposing assets to become eligible for medical assistance under a state plan, receiving or paying illegal remunerations, giving false statements or representations with respect to the condition or operation of institutions, and enabling illegal patient admittance and retention practices.		
Native American Methamphetamine Enforcement and Treatment Act of 2007 (H.R. 545; S. 85; S 267) *Sponsors: Representative Udall(D-NM); Senator McCain (R-AZ); Senator Bingaman (D-NM))*	**Description** ▪ Amends the Omnibus Crime Control and Safe Streets Act of 1968 to clarify that territories and Indian tribes are eligible to receive grants for confronting the use of methamphetamine. **State Issues** ▪ Assists tribal governments to reduce the use of methamphetamines. **Summary** ▪ Amends the Omnibus Crime Control and Safe Streets Act of 1968 to include territories and Indian tribes as eligible grant recipients (or reaffirm that eligibility) under the programs to: (1) address the manufacture, sale, and use of methamphetamine; (2) aid children in homes in which methamphetamine or other drugs are unlawfully manufactured, distributed, dispensed, or used; and (3) address methamphetamine use by pregnant and parenting women offenders.	▪ Adopted in the House by recorded vote, 423 yeas - 0 nays. (3/22/07) ▪ S. 267 (Bingaman) introduced in the Senate. (1/11/07) ▪ S. 85 (McCain) introduced in the Senate. (1/4/07)	**NCSL Policy** ▪ NCSL has no policy.
Indian Youth Telemental Health Demonstration Project (S. 322)	**Description** ▪ Establishes an Indian youth telemental health	▪ Favorably reported by the Committee on Indian Affairs with a	**NCSL Policy** ▪ NCSL has no policy.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
Sponsor: Senator Dorgan (D-ND)	demonstration project. **State Issues** ▪ Assists tribal organizations to provide mental health services to Indian youth. **Summary** ▪ Authorizes the HHS Secretary to carry out a demonstration project to award up to five grants, of up to four years each, for the provision of telemental health services to Indian youth who have expressed suicidal ideas, have attempted suicide, or have mental health conditions that increase or could increase the risk of suicide. ▪ Makes eligible for the grants any Indian tribes and tribal organizations that operate one or more facilities: (1) located in Alaska and part of the Alaska Federal Health Care Access Network; (2) reporting active clinical telehealth capabilities; or (3) offering school-based telemental health services relating to psychiatry to Indian youth.	report (S. Rpt. 110-43) and placed on the Senate calendar. (4/10/07)	
PHARMACEUTICAL ISSUES			
Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (S. 980) *Sponsor: Senator Feinstein (D-CA)*	**Description** ▪ Amends the Controlled Substances Act to impose registration and reporting requirements on pharmacies that seek to deliver, distribute, or dispense by means of the Internet a controlled substance (online pharmacies). **State Issues** ▪ Preempts some state laws that regulate internet prescribing. ▪ Provides a state cause of action option against online pharmacies when a state has reason for concern.	▪ Adopted in the Senate as amended by unanimous consent. (4/01/08)	**NCSL Policy** ▪ Regulation of Internet Pharmacies. NCSL urges Congress to enact legislation that would: (1) establish new disclosure standards for internet pharmacies; (2) prohibit the dispensing of prescription drugs over the internet to individuals who have not be seen by a physician, but have merely filled out an on-line questionnaire; and (3) authorize state attorneys general to shutdown non-complying sites across the country by using the federal court system.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	Summary *Requirements for Dispensing Controlled Substances on the Internet* ▪ Prohibits the delivery, dispensing or distribution of any controlled substance through the internmnet without a valid prescription. ▪ A valid prescription is defined as meaning a prescription issued for a legitimate medical purpose in the usual course of medical practice by a pratitioner who has conducted at least one in-person medical evaluation of the patient, or a covering pratitioner for that individual if unavailable. *Definition of the Term Internet Pharmacy* ▪ The term "internet pharmacy" is defined as meaning a person, entity, or internet site, whether in the United States or abroad, that knowingly or intentionally delivers, distributes, or dispenses, or offers or attempts to deliver, distribute or dispense a controlled substance by mean of the internet. *Internet Pharmacy Disclosure Information* ▪ Requires all internet paharmacies to display on their home page a statement that it complies with the requirements of this act with respect to the delivery or sale of controlled substances. ▪ Requires all online pharmacies to comply with the requirements of state law concerning licensure in each state from which and in which it dispenses or delivers controlled substances. ▪ Requires each internet pharmacy to post the following information on the pharmcies who process orders for delivery of controlled substances; ▪ Name and address of the pharmacy as it appears		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	on their Drug Enforcement Administration (DEA) certificate of registration. ▪ The pharmacies telephone number and email address. ▪ The name, professional degree, and states of licensure of the pharmacist-in-charge and a telephone numbe where they may be contacted. ▪ A list of states in which the pharmacy is licensed. ▪ A certificate that the pharmacy is registered to handle controlled substances through the internet, and ▪ A list of professionals including their states of licensure who have a contractural relationship to provide medical evaluationsor issue prescruiptions for controlled substances through the web site. *Notifications* ▪ Requires each pharmacy to provide notice to the U.S. Attorney General, and the state boards of pharmacy in any state in which the pharmacy offers service 30 days prior to offering a controlled substance for sale and post a declaration of compliance on their web page. *Penalties for Illegal Distribution* ▪ Increases the penalties for illegal distribution of Schedule III, IV and V substances as catagorized by the DEA. *State Cause of Action Pertaining to Online Pharmacies* ▪ Enables a state attorney general to take action on behalf of their state if they have reason to believe the state residents are being threatened or adversely		

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	affected by actions of the internet pharmacy that violate the provisions of this act . ▪ Before taking action the state attonrey general must first serve a copy of the complaint with the U.S. Attorney General and the United States Attorney for the judicial district in which the complaint is to be filed.		
Preserve Access to Affordable Generics Act (S. 316) *Sponsor: Senator Kohl (D-WI)*	**Description** ▪ Prohibits brand name drug companies from compensating generic drug companies to delay the entry of a generic drug into the market. **State Issues** ▪ Would help increase the availability of generic drugs. **Summary** ▪ Amends the Clayton Act to make it unlawful for a person, in connection with the sale of a drug product, to be a party to any agreement resolving or settling a patent infringement claim in which: (1) an abbreviated new drug (generic) application filer receives anything of value; and (2) such filer agrees not to research, develop, manufacture, market, or sell the generic product for any period. Excludes a resolution or settlement that includes no more than the right to market the generic product prior to the expiration of the patent. ▪ Amends the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to set forth additional filing requirements related to agreements between a brand name drug company and a generic drug applicant. Requires the Chief Executive Officer or the company official responsible for negotiating any agreement to file a	▪ Favorably reported by the Senate Judiciary Committee and placed on the Senate calendar. (2/27/07)	**NCSL Policy** ▪ NCSL has no policy.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	certification that materials filed with respect to such agreements are complete, final, and exclusive. ▪ Amends the Federal Food, Drug, and Cosmetic Act to provide that forfeiture of the 180-day exclusivity period for the marketing of a generic drug occurs if there is a final decision of the Federal Trade Commission (FTC) or the court that an agreement has violated this Act. ▪ Requires the FTC to study the prevalence of anticompetitive agreements in the pharmaceutical industry and their impact. Requires the Attorney General or FTC to consider whether any additional enforcement action is necessary.		
PUBLIC HEALTH			
Josh Miller Helping Everyone Access Responsive Treatment in Schools Act of 2008 (H.R. 4926) *Sponsor: Representative Sutton (D-OH)*	**Description** ▪ Amends the Elementary and Secondary Education Act of 1965 by directing the Secretary of Education to provide grants to local educational agencies for the purchase of automated external defibrillators (AED) and or to provide training to adult employees or volunteers. **State Issues** ▪ Provides grants to educational agencies for purchase of AEDs and training for their use in school facilities. **Summary** ▪ Amends the Elementary and Secondary Education Act of 1965 by directing the Secretary of Education to provide grants to local educational agencies for the purchase of AEDs for school buildings and/or training so that at least five adult employees or volunteers at each school with an AED are trained in its use and in cardiopulmonary resuscitation (CPR).	▪ Adopted in the House by 2/3 majority voice vote. (6/9/08) ▪ Introduced. (12/19/07)	**NCSL Policy** **Public Health** ▪ Federal support through grants and cooperative agreements, research and technical assistance is key to the stabilization and effective operation of the nation's public health system and provides critical support for the state and local public health infrastructure. NCSL urges Congress to continue: (1) to support grants and cooperative agreements to states and local governments for a broad range of public health activities; and (2) to support research and technical assistance, which aides states in the development and implementation of effective programs. In addition, NCSL wishes to foster the development of public and private sector partnerships to increase community accessibility to public health information

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	▪ Requires matching funds of $1 from a public or private (non Federal) source for every $3 received in the grant. ▪ Priority for the funds will be given to schools currently without AED devices, have greater numbers of students and employees, and require more time for emergency medical services to reach the school.		and public health programs.

Poison Center Support, Enhancement, and Awareness Act of 2008 (H.R. 5669)
 	
Sponsor: Representative Towns (D-NY)
	Description
	▪ Reauthorizes the funding for the poison control program through 2014.
	State Issues
	▪ Provides grants to poison control centers and other organizations focusing on poison control.
	Summary
	▪ Authorizes $37.5 million for each year from 2010 through 2014 to fund the poison control program as follows:
	  ▪ $35 million per year for the grant program,
	  ▪ $1.5 million per year for the media campaign, and
	  ▪ $1 million per year for maintenance of the toll-free number.
		▪ Report filed from the House Committee on Energy and Commerce, H. Rpt. 110-681. (6/4/08)
		▪ Adopted in the House by a 2/3 majority vote, 405 yeas– 10 nays. (6/4/08)
		▪ Ordered to be reported by the House Committee on Energy and Commerce. (5/7/08)
		▪ Introduced. (4/1/08)
			NCSL Policy
			Public Health
			▪ Federal support through grants and cooperative agreements, research and technical assistance is key to the stabilization and effective operation of the nation's public health system and provides critical support for the state and local public health infrastructure. NCSL urges Congress to continue: (1) to support grants and cooperative agreements to states and local governments for a broad range of public health activities; and (2) to support research and technical assistance, which aides states in the development and implementation of effective programs. In addition, NCSL wishes to foster the development of public and private sector partnerships to increase community accessibility to public health information and public health programs.

Wakefield Act (H.R. 2464) *Sponsor: Representative Matheson (D-UT)*	**Description** ▪ Reauthorizes the Emergency Medical Services for Children program.	▪ Adopted in the House by a two thirds majority voice vote. (4/08/08) ▪ Report filed from the	**NCSL Policy** **Public Health** ▪ Federal support through grants and cooperative agreements, research and

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	State Issues ▪ Provides grants to states. **Summary** ▪ Amends the Public Health Service Act to extend the time in which a grant may be awarded to states under the Emergency Medical Services for Children grant program. Authorizes $137.5 million in funding for Fiscal Years 2009 through 2013. ▪ Directs the Secretary of Health and Human Services (HHS) to support projects through this program that (1) develop and present scientific evidence; (2) promote existing and innovative technologies appropriate for the care of children, or; (3) provide information on health outcomes and effectiveness and cost-effectiveness. ▪ Directs that these programs strive to enhance the pediatric capability of emergency medical service systems which were originally designed primarily for adults, and be coordinated with all research, evaluations and awards supported by the federal government to avoid duplication.	House Committee on Energy and Commerce, H. Rpt. 110-568. (4/08/08) ▪ Ordered to be report by the House Committee on Energy and Commerce. (3/13/08)	technical assistance is key to the stabilization and effective operation of the nation's public health system and provides critical support for the state and local public health infrastructure. NCSL urges Congress to continue: (1) to support grants and cooperative agreements to states and local governments for a broad range of public health activities; and (2) to support research and technical assistance, which aides states in the development and implementation of effective programs. In addition, NCSL wishes to foster the development of public and private sector partnerships to increase community accessibility to public health information and public health programs.
Vision Care for Kids Act of 2007 (H.R. 507; S. 1117) *Sponsors: Representative Green (D-TX); Senator Bond (R-MO)*	**Description** ▪ Establishes a grant program to provide vision care to children. **State Issues** ▪ Provides grants to states. **Summary** ▪ Authorizes the HHS Secretary, acting through the Director of the Centers for Disease Control and Prevention (CDC), to award grants to states to: (1) provide comprehensive eye examinations by a	▪ Adopted in the House by a two thirds majority voice vote. Report filed by the House Committee on Energy and Commerce (H. Rpt. 110-376). (10/15/07) ▪ Introduced in the Senate. (4/16/07)	**NCSL Policy** ▪ NCSL has no policy.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	licensed optometrist or ophthalmologist for children identified by a licensed health care provider or vision screener, with priority to children under age nine; (2) provide treatment or services to correct vision problems of such children; and (3) develop and disseminate educational materials on recognizing signs of visual impairment in children.		
STEM CELL RESEARCH			
Hope Offered through Principled and Ethical Stem Cell Research Act or the HOPE Act (S. 30) *Sponsor: Senator Coleman (R-MN)*	**Description** ▪ A bill to intensify research to derive human pluripotent stem cell lines. **State Issues** ▪ State interest in federal stem cell policy. **Summary** *Human Pluripotent Stem Cell Research* ▪ Directs the HHS Secretary to conduct and support basic and applied research to develop techniques for the isolation, derivation, production, or testing of stem cells, including pluripotent stem cells that have the flexibility of embryonic stem cells (whether or not they have an embryonic source), that may result in improved understanding of or treatments for diseases and other adverse health conditions, provided that the isolation, derivation, production, or testing of such cells will not involve: ▪ the creation of a human embryo or embryos for research purposes; or ▪ the destruction or discarding of, or risk of injury to, a human embryo or embryos other than those that are naturally dead. ▪ Directs the Secretary to, not later than 90 days after the date of the enactment of this section, after consultation with the Director of NIH, issue final	▪ Adopted in the Senate by recorded vote 70 yeas – 28 nays. (4/11/07)	**NCSL Policy** ▪ NCSL has no policy.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	guidelines that: ▪ provide guidance concerning the next steps required for additional research, which shall include a determination of the extent to which specific techniques may require additional animal research to ensure that any research involving human cells using these techniques would clearly be consistent with the standards established under the Act; ▪ prioritize research with the greatest potential for near-term clinical benefit; ▪ consistent with standards established under the Act, take into account techniques outlined by the President's Council on Bioethics and any other appropriate techniques and research; and ▪ in the case of research involving stem cells from a naturally dead embryo, require assurances from grant applicants that no alteration of the timing, methods, or procedures used to create, maintain, or intervene in the development of a human embryo was made solely for the purpose of deriving the stem cells. ▪ Directs the HHS Secretary to, not later than January 1 of each year, prepare and submit to the appropriate committees of the Congress a report describing the activities carried out under the Act during the fiscal year, including a description of the research conducted. ▪ Authorizes such sums as may be necessary. *Definitions* ▪ Naturally dead. The term `naturally dead' means having naturally and irreversibly lost the capacity for integrated cellular division, growth, and differentiation that is characteristic of an organism, even if some cells of the former organism may be alive in a disorganized state.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Human embryo or embryos. The term `human embryo or embryos' includes any organism, not protected as a human subject under part 46 of title 45, Code of Federal Regulations, as of the date of enactment of this section, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells. ▪ Risk of Injury. The term `risk of injury' means subjecting a human embryo or embryos to risk of injury or death greater than that allowed for research on fetuses in utero under existing federal law. *National Amniotic and Placental Stem Cell Bank* ▪ Directs the HHS Secretary of Health and Human Services to enter into a contract with the Institute of Medicine for the conduct of a study to recommend an optimal structure for an amniotic and placental stem cell bank program and to address pertinent issues to maximize the potential of such technology, including collection, storage, standards setting, information sharing, distribution, reimbursement, research, and outcome measures. In conducting the study, the Institute should receive input from relevant experts including the existing operators of federal tissue bank programs and the biomedical research programs within the Department of Defense. ▪ Provides that no later than 180 days after the date of enactment of the Act, the Institute of Medicine must complete the study and submit to the HHS Secretary and the appropriate committees of Congress a report on the results of the study.		
SUPPLEMENTAL SECURITY INCOME (SSI)			
SSI Extensions for Elderly and Disabled Refugees Act (H.R. 2608; S.	**Description**	▪ Adopted in the House	**NCSL Policy**

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
821) *Sponsors: Representative McDermott (D-WA); Senator Smith(R-OR)*	▪ Amends the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform) to provide for an extension of eligibility for supplemental security income through FY 2010 for refugees, asylees, and certain other humanitarian immigrants. ▪ Amends the Internal Revenue Code to collect unemployment compensation debts resulting from fraud. **State Issues** ▪ Individuals eligible for SSI are categorically eligible for Medicaid. **Summary** ▪ Amends the Immigration and Nationality Act to extend for two years (through FY 2010) the eligibility of certain refugees, asylees, and other immigrants with pending applications for naturalization for SSI benefits. ▪ Amends the Internal Revenue Code to require the Treasury Secretary to offset overpayments of federal taxes by any amount owed to a state for a covered unemployment compensation debt, including penalties and interest, for erroneous payment of state unemployment compensation due to fraud which has become final and remains uncollected.	by voice vote. (7/11/07) ▪ Introduced in the Senate. (3/8/07)	▪ NCSL has no policy.
TOBACCO			
A Bill to Make Cigarettes and Certain Other Tobacco Products Nonmailable, and for Other Purposes (H.R. 5912) *Sponsor: Representative McHugh (R-NY)*	**Description** ▪ Prohibits the use of the U.S. Postal Service for the purpose of the delivery of cigarettes, smokeless tobacco, and roll-your-own-tobacco. **State Issues**	▪ Report filed from the House Committee on Oversight and Government Reform (H. Rpt. 110-711). (6/12/08)	**NCSL Policy** **Federal Tobacco Regulation** ▪ **Federal Regulation of Tobacco and Tobacco Products.** If federal legislation authorizing the Food and Drug Administration (FDA) to regulation

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ May improve recovery of lost tax revenue through civil action taken by state attorneys general in U.S. District Court for violations of this act. **Summary** *Regulatory Authority* ▪ Amends the Postal Service Code to prohibit the use of the Postal Service for the purpose of the delivery of cigarettes, smokeless tobacco, and roll-your-own-tobacco. ▪ Imposes civil penalties of up to $100,000 for violations of this act. ▪ Authorizes the Postal Service to determine guilt and penalty for violations through hearing proceedings. ▪ Authorizes a state attorney general or local government to bring an action in U.S. district court against individuals suspected of violations of this act in order to restrain these mailings to state residents and to obtain damages equal to the amount that would be owed to the state and other relief as the court deems appropriate. ▪ Prohibits a state from civil action at the same time as Postal Service proceedings are being conducted.	▪ Ordered to be reported with an amendment in the nature of a substitute by the House Committee on Oversight and Government Reform. (5/10/08) ▪ Introduced. (4/29/08)	tobacco products is enacted, NCSL urges the Congress to: (1) Preserve State and Local Authority to enact, adopt, promulgate and enforce any law, rule or regulation with respect to tobacco products that is in addition to or more stringent than the provisions in federal law relating to the sale, distribution, possession, exposure to, access to, advertising and promotion of, or use of tobacco products by individuals of any age, information reporting to the state, or measures relating to fire safety standards for cigarette; (2) Improve access to drug products used to treat tobacco dependence; and (3) Prevent illegal sales of tobacco products by improving recordkeeping and labeling requirements.
Family Smoking Prevention and Tobacco Control Act (S. 625; H.R. 1108) *Sponsors: Senator Kennedy (D-MA)*	**Description** ▪ Authorizes the Food and Drug Administration (FDA) to regulate tobacco products. **State Issues** ▪ Preemption of some state laws. ▪ May improve the regulation of tobacco products. **Summary**	▪ Report filed from the House Committee on Energy and Commerce, H. Rpt. 110-762. (7/17/08) ▪ Ordered to be reported with an amendment in the nature of a substitute by the House Committee on Energy	**NCSL Policy** **Federal Tobacco Regulation** ▪ **FDA Regulation of Tobacco and Tobacco Products**. If federal legislation authorizing the Food and Drug Administration (FDA) to regulation tobacco products is enacted, NCSL urges the Congress to: (1) Preserve State and Local Authority to enact, adopt,

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	Regulatory Authority ▪ Amends the Federal Food, Drug, and Cosmetic Act to provide for the regulation of tobacco products by the Secretary of Health and Human Services through the Food and Drug Administration (FDA), including through disclosure, annual registration, inspection, recordkeeping, and user fee requirements. ▪ Authorizes the secretary to restrict the sale or distribution of tobacco products, including advertising and promotion. Prohibits the regulations from: (1) limiting product sales or distribution to authorization of a practitioner licensed to prescribe medical products; (2) prohibiting product sales in face-to-face transactions by a specific category of retail outlets; or (3) establishing a minimum age greater than 18 years of age for product purchases. ▪ Requires the secretary to establish tobacco product standards to protect the public health, but reserves to congress the power to ban any tobacco products or reduce the nicotine level to zero. ▪ Requires pre-market approval of all new tobacco products. ▪ Prohibits cigarettes from containing any artificial or natural flavor (other than tobacco or menthol) or an herb or spice, including strawberry, cinnamon, or coffee. ▪ Establishes standards for the sale of modified risk tobacco products. ▪ Preempts state laws relating to tobacco product standards, pre market approval, adulteration, misbranding, labeling, registration, good manufacturing standards, or modified risk tobacco products.	and Commerce. (4/02/08) ▪ Ordered to be favorably reported by the Senate Health, Education, Labor and Pensions Committee. (8/1/07)	promulgate and enforce any law, rule or regulation with respect to tobacco products that is in addition to or more stringent than the provisions in federal law relating to the sale, distribution, possession, exposure to, access to, advertising and promotion of, or use of tobacco products by individuals of any age, information reporting to the state, or measures relating to fire safety standards for cigarette; (2) Improve access to drug products used to treat tobacco dependence; and (3) Prevent illegal sales of tobacco products by improving recordkeeping and labeling requirements.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Clarifies that states may enact statutes or promulgate rules which impose specific bans or restrictions on the time, place or manner of cigarette smoking but not the content of the advertising or promotion of cigarettes. *Labeling* ▪ Authorizes the Secretary to require prior approval of all label statements. ▪ Amends the Federal Cigarette Labeling and Advertising Act to change cigarette warning label and advertising requirements. ▪ Amends the Comprehensive Smokeless Tobacco Health Education Act of 1986 to change smokeless tobacco warning label and advertising requirements. *Tobacco Sales to Minors* ▪ Directs the secretary to issue regulations regarding the sale and distribution of tobacco products that occur through other means than direct sales to prevent the sale and distribution of tobacco products to minors. ▪ Requires the secretary to coordinate with the states in enforcing this act and to consider penalties paid by retailers to a state when determining the amount of federal penalty for violations. ▪ Prohibits the distribution of smokeless tobacco products to any person younger than the minimum age established by applicable law for the purchase of smokeless tobacco products. ▪ Requires the secretary to convene an expert panel to conduct a study on the public health implications of raising the minimum age to purchase tobacco products.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Requires the Government Accounting Office to conduct a study on youth tobacco use and the feasibility of structuring the user fee based on a manufacturer's share of the youth market.		
Prevent All Cigarette Trafficking Act or PACT Act (S. 1027; H.R. 4081) *Sponsor: Senator Kohl (D-WI); Representative Weiner (D-NY)*	**Description** ▪ Amends the Jenkins Act to revise provisions governing the collection of taxes on, and trafficking in, cigarettes. **State Issues** ▪ Enhances the ability of states to collect tobacco taxes. **Summary** *Collection of state Cigarette and Smokeless Tobacco Taxes* ▪ Requires reports to state tobacco tax administrators to: (1) cover smokeless tobacco; (2) include telephone numbers for each place of business, a principal electronic mail address, any website addresses, and the name, address, and telephone number of an agent in the state authorized to accept service and the person delivering the shipment; and (3) require all invoice or memoranda information relating to specified customers to be organized by city or town and by zip code, with copies of each memorandum or invoice filed with a state also to be filed with the tobacco tax administrators and chief law enforcement officers of the local governments and Indian tribes operating within the borders of the state that apply their own local or tribal taxes on cigarettes or smokeless tobacco. ▪ Requires each delivery seller, with respect to delivery sales into a specific state and place, to: (1) comply with specified shipping and record-keeping requirements, all state, local, tribal, and other laws	▪ H.R. 4801 ordered to be reported as amended by the House Committee on the Judiciary. (7/16/08) ▪ Introduced in the House. (11/5/07) ▪ Report filed by the Senate Judiciary Committee (S. Rpt. 110-153). (9/11/07) ▪ Ordered to be favorably reported by the Senate Judiciary Committee. (5/17/07)	**NCSL Policy** **Federal Tobacco Regulation** ▪ **Regulation of Interstate and Internet Sales of Tobacco Products.** Illegal interstate, tribal and internet sale of tobacco products affects the health and safety of the nation's citizens and has a particularly negative effect on state revenues. Tobacco sellers that evade state tobacco taxes: ▪ Use the profits of these sales to finance other illicit activities; ▪ Undermine state efforts to reduce youth access to tobacco products by making lower cost products available to them through the mail; and ▪ Reduce state revenue. ▪ In addition, many of these sellers are failing to comply with the provisions of the Master Settlement Agreement, endangering state compliance with the Agreement and reducing state payments under the agreement by illegally gaining market share in cigarette sales by offering lower prices made possible by their failure to pay the appropriate state taxes. A recent Government Accounting Office (GAO) report advised that states would lose approximately $1.5 billion in tax revenues by the year 2005 if the current state of Internet tobacco sales

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	generally applicable to sales of cigarettes or smokeless tobacco as if such delivery sales occurred entirely within the specific state and place (including laws imposing excise taxes and licensing and tax-stamping requirements), and specified tax collection requirements; (2) include on the bill of lading for the shipping package containing cigarettes or smokeless tobacco a clear and conspicuous statement that Federal law requires the payment of all applicable excise and sales taxes and compliance with applicable licensing and tax-stamping obligations; and (3) keep a record of all delivery sales, organized by state. Defines a "delivery sale" as a sale of cigarettes or smokeless tobacco in interstate commerce to a consumer if the consumer orders by telephone, mail, or the Internet and the product is delivered by a common carrier, a private delivery service, or the mail. ▪ Requires: (1) any shipping package that is not labeled in accordance with this Act to be treated as non-deliverable matter by a common carrier or the U.S. Postal Service; (2) records of delivery sales to be kept in the year of such sales and for the next four years; and (3) such records to be made available, to ensure compliance with this Act, to tobacco tax administrators of the states, local governments and Indian tribes that apply their own local or tribal taxes on cigarettes or smokeless tobacco, state attorneys general, the chief law enforcement officers of such local governments and Indian tribes, and the Attorney General of the United states. ▪ Prohibits cigarettes or smokeless tobacco from being delivered to the buyer pursuant to a delivery sale in interstate commerce unless, in advance of the delivery, the excise tax has been paid and any required stamps or other indicia of payment are properly affixed to the product. Sets forth exceptions		continues. NCSL urges the federal government to enact legislation that will: ▪ Reduce the illegal sale of tobacco products in violation of state and federal law; ▪ Improve the ability of states to enforce state laws regulating the sale of tobacco products and to collect state taxes associated with those sales; and ▪ Increase penalties to individuals and entities that fail to comply with state and federal laws regulating interstate and internet sale of tobacco products; ▪ NCSL urges Congress to adopt legislation that would specifically: ▪ Impose improved recordkeeping requirements; ▪ Prohibit the commercial importation of tobacco products, including smokeless tobacco products, into any state in violation of state or federal law; ▪ Lower the threshold for cigarettes to be treated as contraband from 60,000 to 10,000 and impose a threshold of up to 500 single-units of consumer-sized cans or packages of smokeless tobacco or their equivalent within any single month; ▪ Increase the penalties for noncompliance with the federal laws regulating interstate and internet sale of tobacco products; ▪ Authorize states to enforce tobacco tax collections through the Jenkins Act;

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	where: (1) the law of the state or local government of the place where the smokeless tobacco is to be delivered requires or otherwise provides that delivery sellers collect the excise tax from the consumer and remit that tax to the state or local government; and (2) the delivery seller complies with the requirement. ▪ Authorizes each state and each local government or Indian tribal government that levies a tax subject to this Act to compile a list of delivery sellers who are in compliance with this Act. Prohibits knowingly delivering cigarettes or smokeless tobacco to consumers unless the delivery seller is on the compliance list. Authorizes each state to compile a confidential list of delivery sellers who are not in compliance. Prohibits a common carrier, the Postal Service, or other person from knowingly delivering any item to a consumer for a delivery seller on the noncompliance list without determining that the item does not include cigarettes or smokeless tobacco. Deems: (1) a delivery sale to have occurred in the state and place where the buyer obtains personal possession of the cigarettes or smokeless tobacco; and (2) a delivery pursuant to a delivery sale to have been initiated or ordered by the delivery seller. ▪ Makes a violation of such Act a felony (currently, a misdemeanor). Increases civil penalties for violations to the greater of $5,000 for a first violation or $10,000 for any other violation, or two percent of the gross sales of cigarettes or smokeless tobacco of such person for the year before the violation. ▪ Directs the Attorney General to administer and enforce this Act. Authorizes a state attorney general, a local government or Indian tribe that levies a tax subject to this Act, or a holder of a permit as a manufacturer or importer of tobacco products or as		▪ Permit states to collect triple damages in any suit against entities selling tobacco in states in violation of the laws of the state and make debts incurred in the purchase of these products uncollectible through actions in courts; and ▪ Prohibit interstate tobacco sellers from doing business in a state that is party to the Master Settlement Agreement if the seller is not in full compliance with the Model Statute or the Qualifying Statute enacted by the state.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	an export warehouse proprietor (permit holder) to bring an action in U.S. district court to prevent and restrain violations of this Act. Authorizes a state attorney general or such a local government or Indian tribe to provide evidence of a violation of this Act by any person not subject to state, local, or tribal government enforcement actions for violations of this Act to the Attorney General or a U.S. Attorney, who shall take appropriate actions. ▪ Directs that 50 percent of any criminal and civil penalties collected by the Federal Government in enforcing this Act be available to the Department of Justice to enforce the provisions of this Act and other laws relating to contraband tobacco products, with not less than 50 percent made available only to the Department's agencies and offices that were responsible for the enforcement actions in which the penalties concerned were imposed. ▪ Directs the U.S. Attorney General to make available to the public (including on the Internet) and report to Congress annually on information about actions and their resolution (in particular, information on how the Attorney General and the U.S. Attorney have responded to referrals of evidence of violations). *Treatment of Cigarettes and Smokeless Tobacco as Nonmailable Matter* ▪ Amends the federal criminal code to prohibit the transmission in the mails of any tobacco product, including cigarettes and smokeless tobacco, but makes this prohibition applicable only to states that are contiguous with at least one other state. *Penal Provisions Regarding Trafficking in Contraband Cigarettes or Smokeless Tobacco* ▪ Modifies the definition of "contraband cigarettes" to mean a quantity in excess of 10,000 (currently,		

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	60,000) cigarettes. Defines "contraband smokeless tobacco" to mean a quantity in excess of 500 single-unit consumer-sized cans or packages. Prohibits: (1) the sale or purchase of, and other specified activities regarding**,** contraband smokeless tobacco; and (2) knowingly making false statements regarding information required to be kept in the records of persons who sell, distribute, or purchase any quantity of smokeless tobacco in excess of the contraband quantity in a single transaction. ▪ Requires any person who engages in a delivery sale and who ships, sells, or distributes any quantity in excess of the contraband quantity of cigarettes or smokeless tobacco within a single month to submit to the Attorney General a report setting forth: (1) the person's beginning and ending inventory of cigarettes and smokeless tobacco for such month; (2) the total quantity of cigarettes and smokeless tobacco the person received within such month from each other person (itemized by name and address); and (3) the total quantity of cigarettes and smokeless tobacco that the person distributed with such month to each person other than a retail purchaser. Requires that any such report also be submitted to the Secretary of the Treasury and to the attorneys general and the tax administrators of the states from where the shipments, deliveries, or distributions originated and concluded, and to the chief law enforcement officer and tax administrator of the tribe for shipments, deliveries, or distributions that originated or concluded on Indian country. ▪ Directs that any contraband cigarettes or smokeless tobacco so seized and forfeited be either: (1) destroyed and not resold; or (2) used for undercover investigative operations for the detection and prosecution of crimes and then destroyed and not resold.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Authorizes a state attorney general, a local government or Indian tribe, or a permit holder to bring an action in U.S. district court to prevent and restrain violations regarding contraband cigarettes and smokeless tobacco and to obtain other appropriate relief, except that a permit holder may not bring such an action against a state, local, or tribal government. *Compliance with Model Statute or Qualifying Statute* ▪ Prohibits a tobacco product manufacturer or importer from selling in, delivering to, or placing for delivery sale in a state that is a party to the Master Settlement Agreement (executed November 23, 1998, by state attorneys general and certain tobacco manufacturers) any cigarette of such a manufacturer that is not in full compliance with the terms of the Model Statute or Qualifying Statute enacted by such state requiring funds to be placed into a qualified escrow account. Grants the U.S. district courts jurisdiction to prevent and restrain violations. Authorizes a state attorney general or any permit holder to bring an action in U.S. district court to prevent and restrain violations. Entitles such state to reasonable attorney fees for willful and knowing violations. *Undercover Criminal Investigations of the Bureau of Alcohol, Tobacco, Firearms and Explosives* ▪ Grants specified authorities under the Department of Justice and Related Agencies Appropriations Act, 1993, to the Bureau of Alcohol, Tobacco, Firearms, and Explosives (BATF) for undercover investigative operations that are necessary for the detection and prosecution of crimes against the United States. ▪ Authorizes any BATF officer, during normal business hours, to enter the premises of any person		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	who engages in a delivery sale and who ships, sells, distributes, or receives any quantity in excess of the contraband quantity of cigarettes or smokeless tobacco within a single month for purposes of inspecting: (1) any information required to be maintained by such person under the Jenkins Act, provisions regarding contraband cigarettes and smokeless tobacco, or this Act; or (2) any cigarettes or smokeless tobacco kept or stored by such person at such premises. Grants U.S. district courts authority in a civil action to compel inspections authorized. Sets civil penalties of up to $10,000 per violation. *Compliance with the Tariff Act of 1930* ▪ Amends the Tariff Act of 1930 to: (1) make an exemption for the import of personal use cigarettes inapplicable to any cigarettes sold in connection with a delivery sale; and (2) entitle a state and an Indian tribe to obtain copies of a certification required directly upon request from the U.S. agency responsible for collecting it or from the importer, manufacturer, or authorized official of such importer or manufacturer. ▪ Authorizes: (1) a permit holder to bring an action in the U.S. district courts to prevent and restrain violations by any person other than by a state, local, or tribal government; and (2) a state or local government or tribe to commence a civil action to prevent and restrain violations by any person or to obtain any other appropriate relief for violations by any person, including civil penalties, money damages, and injunctive or equitable relief. ▪ Includes smokeless tobacco under civil penalty and forfeiture provisions relating to violations for entry of cigarettes.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	Exclusions Regarding Indian Tribes and Tribal Matters ▪ Provides that nothing in this Act shall be construed to modify specified agreements or limitations regarding the collection of taxes on, and related matters regarding, cigarettes or smokeless tobacco sold in Indian country, or to inhibit the coordination of law enforcement by states or other jurisdictions, including Indian tribes, with respect to interstate sales or seizures of tobacco products.		
TRADE			
The Trade and Globalization Adjustment Assistance Act of 2007 (S. 1848; H.R. 3920) *Sponsor: Senator Baucus (D-MT); Representative Rangel (D-NY)*	**Description** ▪ Reauthorizes all Trade Adjustment Assistance (TAA) programs through September 20, 2012. The TAA programs are scheduled to expire September 20, 2007. ▪ Extends Trade Adjustment Assistance to services sector workers and workers affected by "off-shoring" to other countries. ▪ Creates a new program for rural and distressed communities. ▪ Makes training, health care and wage insurance benefits more accessible and flexible. **State Issues** ▪ Improves access to health care to workers adversely affected by trade-related decisions by their employers. **Summary of Health Provisions (Senate)** *Increases the Health Care Tax Credit (HCTC)*[7]	▪ Adopted in the House by recorded vote 264 yeas – 157nays. (10/31/07) ▪ Introduced in the Senate. (7/23/07) *Note: The Trade Adjustment Assistance for Workers was temporarily extended, through 12/31/07 in P.L. 110-89. Congress failed to extend the program beyond 12/31/07 before adjourning.*	**NCSL Policy** **Free Trade and Federalism** ▪ Adjusting to Free Trade. NCSL encourages Congress and the implementing federal agencies to: (1) ensure that the funding for TAA programs is sufficient to meet current and future needs; (2) expand benefits eligibility to service-sector and agricultural workers impacted by trade; (3) work with NCSL and state legislatures to ensure that TAA programs are flexible to suit different states' needs; (4) engage in aggressive outreach to ensure that workers, employers, and communities are informed of the benefits of the TAA program and are able to effectively utilize the program; (5) ensure that adversely affected workers are provided the full income support, training, reemployment services and other services and benefits to which they are entitled, and that claims for such benefits are reviewed expeditiously and

[7] The Health Care Tax Credit (HCTC) program provides health insurance assistance to TAA eligible workers or retirees covered by pension plans taken over by PBGC who have lost their employer-sponsored coverage.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	▪ Increases the premium subsidy level from 65 percent to 85 percent. *Addresses Administrative and Market Barriers* ▪ Improves coverage of spouses and dependents; and ▪ Improves insurance options in markets that lack affordable choices. **Summary of Health Provisions (House)** *Makes Changes to the Health Care Tax Credit* ▪ Increases the premium subsidy level from 65 to 85 percent. ▪ Allows the end-of-year credit to be applied to premiums paid prior to TAA eligibility determination provided the person is ultimately determined eligible for assistance. *Changes to Eligibility for Coverage* ▪ Eliminates the training requirement for TAA eligible individuals who are receiving unemployment insurance. ▪ Makes certain allowances for continued coverage of spouses and dependents. *Government Accountability Office (GAO) Study* ▪ Calls for a GAO study on the HCTC concerning the development of an alternative health benefit for trade displaced workers.		objectively; (6) simplify procedures for determining TAA eligibility; and (7) refrain from modifying TAA in any way that would jeopardize the program's mandate to help trade-affected workers who have lost their jobs as a result of increased imports or shifts in production out of the United States. In general, the federal government should work with the states and the private sector to develop lifetime educational and workforce training opportunities that prepare Americans to compete successfully in a changing global economy.
Early Warning and Health Care for Workers Affected by Globalization Act (H.R. 3796) *Sponsor: Representative Miller (D-CA)*	**Description** ▪ Amends the Worker Adjustment and Retraining Notification Act (the Act) to redefine the terms "employer," "plant closing," and "mass layoff" for purposes of the Act.	▪ Report filed (H. Rpt. 110–410) by the House Committee on Education and Labor. (10/25/07)	**NCSL Policy** **Free Trade and Federalism** ▪ Adjusting to Free Trade. NCSL encourages Congress and the implementing federal agencies to: (1)

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	State Issues ▪ Improves access to health care to workers adversely affected by trade-related decisions by their employers. **Description** ▪ Requires an employer to: (1) give 90-day written notice (under current law, 60-day) to employees and appropriate state and local governments before ordering a plant closing or mass layoff; (2) notify the Secretary of Labor of such closing or layoff; and (3) provide affected employees with information regarding benefits and services available to them, including unemployment compensation, trade adjustment assistance, COBRA benefits, and certain other services. ▪ Amends the Employee Retirement Income Security Act of 1974 (ERISA) to extend COBRA continuation coverage for certain qualified Trade Adjustment Assistance (TAA) eligible employees. ▪ Requires the Secretary to notify the appropriate U.S. Senators and Members of the House of Representatives who represent the area where such closing or mass layoff is to occur. ▪ Makes an employer who violates such notice requirements liable to the employee for, among other things, interest on back pay due the affected employee and an additional amount as liquidated damages for each day of the violation for up to 90 days (under current law, 60 days). ▪ Authorizes an affected employee to file a complaint with the Secretary alleging a violation of the notice requirements. Requires the Secretary to investigate and attempt to resolve complaints of violations committed by an employer. Authorizes the Secretary	▪ Ordered to be favorably reported by the House Committee on Education and Labor. (10/18/07)	ensure that the funding for TAA programs is sufficient to meet current and future needs; (2) expand benefits eligibility to service-sector and agricultural workers impacted by trade; (3) work with NCSL and state legislatures to ensure that TAA programs are flexible to suit different states' needs; (4) engage in aggressive outreach to ensure that workers, employers, and communities are informed of the benefits of the TAA program and are able to effectively utilize the program; (5) ensure that adversely affected workers are provided the full income support, training, reemployment services and other services and benefits to which they are entitled, and that claims for such benefits are reviewed expeditiously and objectively; (6) simplify procedures for determining TAA eligibility; and (7) refrain from modifying TAA in any way that would jeopardize the program's mandate to help trade-affected workers who have lost their jobs as a result of increased imports or shifts in production out of the United States. In general, the federal government should work with the states and the private sector to develop lifetime educational and workforce training opportunities that prepare Americans to compete successfully in a changing global economy.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	to bring an action in court to recover on behalf of an affected employee any backpay (including interest), benefits, and liquidated damages due to the employee. ▪ Requires an employer to post conspicuously upon its premises pertinent provisions of this Act and information on the filing of a complaint. Requires the Secretary to maintain a guide on the benefits and services available to affected employees.		
VETERANS HEALTH			
To Amend Title 38, U.S.C., to Establish an Ombudsman Within the Department of Veterans Affairs (H.R. 2192) *Sponsor: Representative Hodes (D-NH)*	**Description** ▪ Requires the Veterans Health Administration to establish an Office of the Ombudsman. ▪ The newly established office is directed to appoint three regional directors to support VA facilities and Veterans Integrated Services Netwirks. ▪ Also requires the establishment of a board of appeals to be directed by the regional administrators	▪ Ordered to be reported as amended by the House Committee on Veterans Affairs. (7/16/08)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS

Veterans Health Care Policy Enhancement Act of 2008 (H.R. 6445)
 	
Sponsor: Representative Cazayoux (D-LA)
	Description
	▪ Prohibits the Department of Veterans Affairs from collecting certain copayments from veterans who are catastrophically disabled.
	▪ Applies to copayments for services provided in hospitals or nursing homes.
	▪ Expands the authority of the Secretary of Veterans Affairs to provide counseling for family members of veterans receiving non-service connected treatment.
	▪ Directs the VA to develop and implement a comprehensive policy on management of pain experienced by veterans enrolled for health care services provided by the VA system to include the following:
	  ▪ management of acute and chronic pain,
	  ▪ standards of care for pain management within the VA system,
	  ▪ a consistent evaluation of pain assessment to be used throughout the VA system,
	  ▪ research related to acute and chronic pain, including pain attributable to central and peripheral nervous system damage,
	  ▪ a program for pain care education and training for health care personnel, and
	  ▪ a program of patient education for veterans suffering from acute or chronic pain and their families.
	▪ Directs the Secretary of Veterans Affairs to establish patient accounting centers for conducting
		▪ Ordered to be reported as amended by the House Committee on Veterans Affairs. (7/16/08)	**NCSL Policy**
			Veteran's Health
			▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.

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	regionalized billing and collection activities. ▪ Amends the Veterans' Benefits and Services Act of 1988 to simplify the national standard to encourage testing of the Human Immunodeficiency Virus (HIV) by removing the requirement for written informed consent for HIV testing among veterans reducing barriers to the early diagnosis of HIV infection.		
Rural Veterans Access to Care Act (H.R. 1527) *Sponsor: Representative Moran(R-KS)*	**Description** ▪ Creates a pilot program to permit certain highly rural veterans enrolled in the health system of the Department of Veterans Affairs to receive covered health services through a non-VA health care provider. ▪ Define a "highly rural veteran" as one who: ▪ resides more than 60 miles from the nearest VA facility providing primary care, ▪ more that 120 miles from a VA facility providing acute care, ▪ more than 240 miles from a VA facility providing tertiary care, or ▪ one who experiences hardships or other difficulty in travel to the nearest appropriate VA facility that travel is not in the best interest of the veteran.	▪ Ordered to be reported as amended by the House Committee on Veterans Affairs. (7/16/08)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
Veterans' Mental Health and Other Care Improvements Act of 2008 (S 2162) *Sponsor: Senator Akaka (D-HI)*	**Description** ▪ Requires the Department of Veterans Affairs (VA) to expand the treatments and services available to veterans suffering from disorders related to post-traumatic stress disorder (PTSD), substance abuse, and other mental health problems. ▪ Requires the VA to reimburse non-department facilities for emergency services furnished to veterans. ▪ Requires the VA to ensure that veterans being treated for both substance abuse disorder and another mental health disorder receive treatment by a health professional trained in both disorders, a team of clinicians with the approximate expertise, or coordinated but separate services for each disorder. ▪ Requires the VA to provide certain services and treatments to veterans suffering from substance abuse disorders, either at VA medical facilities or through contracts at community-based organizations. ▪ Requires the VA to establish at least six centers of excellence on PTSD and substance abuse disorders at it health care facilities. ▪ Authorizes the appropriation of two million dollars a year from 2008 through 2011 for research into co morbid substance use disorders and PTSD in veterans. ▪ Creates a pilot program to provide counseling, outreach and other services to certain veterans. ▪ Requires the VA to conduct a study of the feasibility of providing counseling, peer outreach,	▪ Adopted in the Senate as amended by unanimous consent. (6/3/08) ▪ Report filed (S. Rpt. 110-281) by the Senate Committee on Veterans Affairs. (4/8/08) ▪ Ordered to be reported by the Senate Committee on Veterans Affairs'. (11/14/07) ▪ Introduced. (10/15/07)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.

[8] Community-based centers that provide counseling and outreach services to combat veterans and their families.

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
	peer support and other mental health services to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, including the use of community health centers and the Indian Health Service to reach rural veterans. ▪ Requires the VA to develop and implement a comprehensive policy on the management of acute and chronic pain experienced by veterans inclusive of the standard of care, programs of research, pain care education for are personnel and patient education. ▪ Requires the VA to assess the feasibility of providing readjustment and transition assistance through private organizations, in collaboration with the Vet Centers[8] and would authorize the appropriation of one million dollars a year from 2008 through 2010.		
Veterans Health Care Improvement Act of 2007 (H.R. 2874) *Sponsor: Representative Michaud (D-ME)*	**Description** ▪ Provides grants for support of therapeutic readjustment programs for veteran. ▪ Provides transportation grants for rural veterans service organizations. ▪ Establishes permanent treatment authority for participants in Department of Defense chemical and biological testing conducted by Deseret Test Center. ▪ Provides for readjustment and mental health services for Operation Enduring Freedom and Operation Iraqi Freedom veterans. ▪ Establishes a number of grants, programs and services for homeless veterans, including an expansion of eligibility for dental care.	▪ Adopted in the House by voice vote. (7/30/07) ▪ Ordered to be favorably reported by the Health Subcommittee of the House Veterans Affairs Committee. (7/11/07)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
			Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.
Traumatic Brain Injury Health Enhancement and Long-Term Support Act of 2007 (H.R. 2199) *Sponsor: Representative Michaud (D-ME)*	**Description** ▪ Directs the Secretary of Veterans Affairs to establish a program to screen veterans eligible for Department of Veterans Affairs (VA) hospital, medical, and nursing home care for symptoms of traumatic brain injury (TBI). ▪ Requires the Secretary to develop and carry out a program of long-term care for post-acute TBI rehabilitation in four geographically dispersed polytrauma network sites designated by the Secretary. ▪ Includes veterans who: (1) served on active duty in a theater of combat operations during a period of war after the Persian Gulf War or during a period of hostilities after November 11, 1998; (2) are diagnosed with moderate to severe TBI; and (3) are unable to manage routine daily living activities without supervision or assistance. Requires a program report from the Secretary to the congressional veterans' committees. ▪ Directs the Secretary to: (1) establish a TBI transition office at each polytrauma network site to coordinate the provision of health care and services to veterans who suffer from moderate to severe TBI and are in need of health care and services not immediately offered by the VA; and (2) establish and maintain the Traumatic Brain Injury Veterans'	▪ Adopted by the House by recorded vote 421 yeas – 0 nays. (5/23/07)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.

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	Health Registry. ▪ Requires: (1) the Secretary to establish and operate up to five centers for TBI research, education, and clinical activities; (2) the establishment of a peer review panel to assess the scientific and clinical merit of proposals submitted for the designation of such centers; (3) the VA Under Secretary of Health to ensure that information produced at such centers is disseminated throughout the Veterans Health Administration (VHA); and (4) annual reports from the Secretary to the veterans' committees on the status and activities of the centers. Authorizes appropriations. ▪ Directs the Secretary to establish within the VHA the Committee on Care of Veterans with Traumatic Brain Injury. Requires annual reports from the Secretary to the veterans' committees on Committee activities. ▪ Directs the Secretary to carry out a pilot program to provide veterans' readjustment counseling, related mental health services, benefits outreach, and claims assistance through the use of mobile Vet Centers. Requires: (1) the establishment of two mobile Vet Centers in each of five specified Veterans Integrated Service Network areas; and (2) a pilot program report from the Secretary to the veterans' committees. ▪ Directs the Secretary to establish the Advisory Committee on Rural Veterans to advise the Secretary with respect to the administration of VA benefits for rural veterans. Requires: (1) the Committee to report to the Secretary on each odd-numbered year through 2013 on VA programs and activities that pertain to rural veterans; and (2) the Secretary to forward each report to Congress.		

ISSUE/TITLE	DESCRIPTION/STATE ISSUES/SUMMARY	LEGISLATIVE ACTION	NCSL POLICY, CORRESPONDENCE & PUBLICATIONS
Veterans Traumatic Brain Injury Rehabilitation Act of 2007 (S. 1233) *Sponsor: Senator Akaka (D-HI)*	**Description** ▪ Expresses the sense of Congress that the Department of Veterans Affairs (VA) should have the capacity and expertise to provide veterans who have a traumatic brain injury (TBI) with health care, rehabilitation, and community integration. ▪ Requires the Secretary of Veterans Affairs to develop individualized plans for the rehabilitation and reintegration of veterans with TBI, and to provide each plan to the individual before their discharge from inpatient care. Requires: (1) the involvement of family members in plan development; and (2) the Secretary to periodically evaluate plan effectiveness. ▪ Directs the Secretary to enter into agreements with non-VA facilities to provide veterans' TBI intervention, rehabilitative treatment, and reintegration services when the Secretary is unable to provide such services or for veterans who reside at such a distance from a VA facility as to make plan implementation impracticable. ▪ Requires the Secretary to establish a program on research, education, and clinical care to provide intensive neuro-rehabilitation to veterans with severe TBI, including veterans in a minimally conscious state who would otherwise receive nursing home care. ▪ Directs the Secretary to conduct a five-year pilot program to assess the effectiveness of providing assisted living services to veterans with TBI to enhance their rehabilitation, quality of life, and community integration. ▪ Requires the Secretary to include research on TBI under ongoing VA research programs.	▪ Adopted in the Senate by unanimous consent. (9/27/07) ▪ Report filed (S. Rpt. 110-147) by the Senate Committee on Veterans Affairs. (8/29/07) ▪ Ordered to be favorably reported by the Senate Veterans' Affairs Committee by voice vote. (6/27/07)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.

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To prohibit the collection of copayments for all hospice care furnished by the Department of Veterans Affairs (H.R. 2623) *Sponsor: Representative Miller (R-FL)*	**Description** ▪ Prohibits the collection of copayments for all hospice care provided by the Department of Veterans Affairs.	▪ Adopted in the House by voice vote. (7/30/07) ▪ Ordered to be favorably reported by the House Committee on Veterans' Affairs. (7/17/07)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.
Chiropractic Care Available to All Veterans Act (H.R. 1470) *Sponsor: Representative Filner (X-CA)*	**Description** ▪ Amends the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 to require a program under which the Secretary of Veterans Affairs provides chiropractic care and services to veterans through Department of Veterans Affairs medical centers and clinics to be carried out at: (1) no fewer than 75 medical centers by December 31, 2009; and (2) all medical centers by December 31,	▪ Adopted by the House by recorded vote 421 yeas – 1 nay. (5/23/07)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3)

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	2011.		provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.
Returning Servicemember VA Healthcare Insurance Act of 2007 (H.R. 612; S. 383) *Sponsors: Representative Filner (x-CA); Senator Akaka (D-HI)*	**Description** ▪ Extends from two years to five years the period of time during which certain combat veterans may seek health care from the Department of Veterans Affairs (VA) without establishing that any injury or illness is connected to military service.	▪ Adopted by the House by recorded vote 419 yeas – 0 nays. (5/23/07) ▪ Introduced in the Senate. (1/24/07)	**NCSL Policy** **Veteran's Health** ▪ NCSL supports federal initiatives to improve the accessibility and quality of health care services to U.S. veterans and their families. NCSL is particularly supportive of efforts to: (1) increase access to health care services to veterans and their families; (2) improve and expand mental health services; (3) provide assistance to veterans and their families regarding the range of health care services available to them and the appropriate means of accessing the services; (4) expand and improve services to veterans who are amputees, who have traumatic brain injuries or other conditions or injuries sustained during active duty. NCSL urges the Department of Defense and the Department of Veteran's Affairs to work

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			closely with state and local governments to when they can assist in the implementation of these initiatives, including sharing information with state Veteran's Departments regarding the status of veterans residing in the state.