SA 3204. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3205. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3206. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3207. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3208. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3209. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3210. Mrs. HUTCHISON submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3211. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3212. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3213. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3214. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3215. Mr. LIEBERMAN (for himself, Ms. COLLINS, Mr. SPECTER, and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3216. Mr. NELSON, of Florida submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3217. Mrs. FEINSTEIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3218. Mr. DORGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3201. Mr. BROWNBACK submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 377, between lines 14 and 15, insert the following:

SEC. 1562. CONSCIENCE PROTECTION.

(a) PERMISSIBLE ACCOMMODATIONS.—Nothing in this Act (or an amendment made by this Act) shall be construed to—

(1) require a health plan or health insurance issuer to provide coverage of any item or service to which the health insurance issuer, purchaser, or plan sponsor has a moral or religious objection, or require such coverage for the purpose of—

(A) qualifying as a qualified health plan or participating in an Exchange; or

(B) being eligible for a premium tax credit or cost-sharing reduction or avoiding an assessable payment under section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) or any other tax, assessment, or penalty; or

(2) require an individual or institutional health care provider to provide, participate in, or refer for an item or service to which such provider has a moral or religious objection, or require such conduct as a condition of contracting with a qualified health plan.

(b) NONDISCRIMINATION.—No person implementing this Act (or an amendment made by this Act) shall discriminate against a health plan, health insurance issuer, purchaser, plan sponsor, or individual or institutional health care provider based in whole or in part on an accommodation permitted under subsection (a).

(c) EXCEPTION.—Nothing in this section authorizes a health plan, health insurance issuer, or individual or institutional health care provider to deny all medical care or to deny life-preserving care to an individual based on the view that, because of a disability or other characteristic of such individual, extending the life or preserving the health of such individual is less valuable than extending the life or preserving the health of another individual who does not have such disability or other characteristic.

SA 3202. Mr. BEGICH submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

SEC. 9_____. DISALLOWANCE OF DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.

(a) IN GENERAL.—Part IX of subchapter B of chapter 1 of subtitle A of the Internal Revenue Code of 1986 (relating to items not deductible) is amended by adding at the end the following new section:

''SEC. 280I. DISALLOWANCE OF DEDUCTION FOR DIRECT TO CONSUMER ADVERTISING EXPENSES FOR PRESCRIPTION PHARMACEUTICALS.

''No deduction shall be allowed under this chapter for expenses relating to direct to consumer advertising in any media for the sale and use of prescription pharmaceuticals for any taxable year.''.

(b) CONFORMING AMENDMENT.—The table of sections for such part IX of the Internal Revenue Code of 1986 is amended by adding after the item relating to section 280H the following new item:

''Sec. 280I. Disallowance of deduction for direct to consumer advertising expenses for prescription pharmaceuticals.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred after the date of the enactment of this Act, in taxable years ending after such date.

SEC. 9_____. PHYSICAL LIFESTYLES FOR AMERICA'S YOUTH (PLAY) DEDUCTION.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by redesignating section 224 as section 225 and inserting after section 223 the following new section:

''SEC. 224. FEES FOR ORGANIZATIONS PROMOTING CHILDREN'S PHYSICAL ACTIVITY.

''(a) GENERAL RULE.—There shall be allowed as a deduction under this chapter an amount equal to the lesser of—

''(1) the amount paid or incurred by the taxpayer during the taxable year for the participation of a qualifying child (as defined in section 152(c)) of the taxpayer in a qualified organization, or

''(2) $500.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—No deduction shall be allowed under subsection (a) with respect to any taxpayer whose adjusted gross income for the taxable year exceeds $250,000.

''(2) ADJUSTED GROSS INCOME.—For purposes of this subsection, adjusted gross income shall be determined—

''(A) without regard to this section and sections 199, 911, 931, and 933, and

''(B) after the application of sections 86, 135, 137, 219, 221, 222, and 469.

''(c) QUALIFIED ORGANIZATION.—For purposes of this section, the term 'qualified organization' means any other organization the principal activities of which are designed to promote or provide for the physical activity of children, as determined under guidelines published by the Secretary in consultation with the Secretary of Health and Human Services.''.

(b) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by redesignating the item relating to section 224 as relating to section 225 and inserting after the item relating to section 223 the following new item:

''Sec. 224. Fees for organizations promoting children's physical activity.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SA 3203. Mr. BAYH (for himself, Ms. KLOBUCHAR, Mr. FRANKEN, Mr. KOHL, Mr. KERRY, Ms. STABENOW, and Mrs. GILLIBRAND) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr.

HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2046, after line 24, add the following:

SEC. 9_____. MODIFICATION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) DELAY IN IMPOSITION OF FEE.—

(1) IN GENERAL.—Section 9009(i) of this Act is amended by striking ''2008'' and inserting ''2011''.

(2) CONFORMING AMENDMENT.—Section 9009(a)(1) of this Act is amended by striking ''2009'' and inserting ''2012''.

(b) INCREASE IN AGGREGATE FEE AMOUNT.—Section 9009(b)(1) of this Act is amended by striking ''$2,000,000,000'' and inserting ''$3,800,000,000 ($2,660,000 for calendar years after 2019)''.

(c) INCREASE IN GROSS RECEIPTS FROM SALES TAKEN INTO ACCOUNT.—The table in paragraph (2) of section 9009(b) of this Act is amended to read as follows:

''With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:	The percentage of gross receipts takes into account is:
Not more than $100,000,000.	0 percent
More than $100,000,000 but not more than $150,000,000.	50 percent
More than $150,000,000	100 percent.''.

(d) TAX TREATMENT OF FEES.—Subsection (e) of section 9009 of this Act is amended to read as follows:

''(e) TAX TREATMENT OF FEES.—For purposes of subtitle F of the Internal Revenue Code of 1986, the fees imposed by this section shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply.''.

SA 3204. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1783, between lines 2 and 3, insert the following:

SEC. 6412. MANDATORY REPORTING OF FRAUD BY MEDICARE ADVANTAGE PLANS, PRESCRIPTION DRUG PLANS, AND PROVIDERS OF SERVICES AND SUPPLIERS.

(a) MANDATORY REPORTING BY MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

''(7) REPORTING OF PROBABLE FRAUD.—

''(A) IN GENERAL.—Each Medicare Advantage organization and, in accordance with section 1860D–12(b)(3)(C), each PDP sponsor of a prescription drug plan shall, in accordance with regulations established by the Secretary under subparagraph (B), report to the Secretary and to the appropriate law enforcement or oversight agencies any matter for which the organization or sponsor has identified, from any source (including the organization or sponsor itself), credible evidence of fraud by subcontractors or others related to the program under this part or part D, whether self-identified or reported by another party.

''(B) REGULATIONS.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish regulations to carry out this paragraph.''.

(b) MANDATORY REPORTING BY PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1866(j)(7)(B) of the Social Security Act, as inserted by section 6401, is amended by adding at the end the following sentence: ''Such core elements shall include, to the extent determined appropriate by the Secretary, internal monitoring and auditing of, and responding to, identified deficiencies. Such response shall include reporting to the Secretary and to the appropriate law enforcement or oversight agency credible evidence of fraud related to the program under this title, title XIX, or title XXI.''.

(c) PROMPT AND APPROPRIATE ACTION BY THE SECRETARY.—The Secretary shall take prompt and appropriate action to forward information on fraud reported under sections 1857(d)(7) and 1866(j)(7)(B) of the Social Security Act, as added by subsection (a) and amended by subsection (b), respectively, to the appropriate agencies.

(d) ANNUAL REPORT TO CONGRESS.—Not later than October 1 of each year, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to Congress a report on general trends and conditions that give rise to waste, fraud, and abuse, including identified patterns of incidents, and general actions taken to address such trends and conditions, together with recommendations for such legislation and administrative action as the Secretary determines as appropriate.

SA 3205. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1542, between lines 10 and 11, insert the following:

(c) EXCEPTION FOR CERTAIN HOSPITALS.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn), as amended by subsection (a), is further amended—

(1) in subsection (d)(2)(C), by striking ''in the case'' and inserting ''except as provided in subsection (j), in the case''; and

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

''(j) EXCEPTION FOR CERTAIN HOSPITALS.—The requirements of paragraph (3)(D) shall not apply to any hospital which is in development as of the date of enactment of the Patient Protection and Affordable Care Act.''.

SA 3206. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1542, between lines 10 and 11, insert the following:

(c) ADDITIONAL TIME FOR HOSPITALS TO MEET REQUIREMENTS.—

(1) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn), as amended by subsection (a), is further amended—

(A) in subsection (d)(3)(D), by striking ''not later than 18 months after the date of the enactment of this subparagraph'' and inserting ''not later than January 1, 2014''; and

(B) in subsection (i)—

(i) in paragraph (1)—

(I) in subparagraph (A), by striking ''February 1, 2010'' and inserting ''January 1, 2014'';

(II) in subparagraph (D), by striking ''the date of enactment of this subsection'' and inserting ''January 1, 2014''; and

(III) in subparagraph (F), by striking ''the date of enactment of this subsection'' and inserting ''January 1, 2014''; and

(ii) in paragraph (3)—

(I) in subparagraph (A)—

(aa) in clause (iii), by striking ''August 1, 2011'' and inserting ''January 1, 2014''; and

(bb) in clause (iv), by striking ''July 1, 2011'' and inserting ''December 1, 2013''; and

(II) in subparagraph (C)(iii), by striking ''the date of enactment of this subsection'' and inserting ''January 1, 2014''.

(2) CONFORMING AMENDMENT REGARDING CONDUCT OF AUDITS.—Subsection (b)(2) is amended by striking ''November 1, 2011'' and inserting ''February 1, 2014''.

SA 3207. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 268, after line 19, insert the following:

SEC. 1403. FAIL-SAFE MECHANISM TO PREVENT INCREASE IN FEDERAL BUDGET DEFICIT.

(a) ESTIMATE AND CERTIFICATION OF EFFECT OF ACT ON BUDGET DEFICIT.—

(1) IN GENERAL.—The President shall include in the submission under section 1105 of title 31, United States Code, of the budget of the United States Government for fiscal year 2013 and each fiscal year thereafter an estimate of the budgetary effects for the fiscal year of the provisions of (and the amendments made by) this Act, based on the information available as of the date of such submission.

(2) CERTIFICATION.—The President shall include with the estimate under paragraph (1) for any fiscal year a certification as to whether the sum of the decreases in revenues and increases in outlays for the fiscal year by reason of the provisions of (and the amendments made by) this Act exceed (or do not exceed) the sum of the increases in revenues and decreases in outlays for the fiscal year by reason of the provisions and amendments.

(b) EFFECT OF DEFICIT.—If the President certifies an excess under subsection (a)(2) for any fiscal year—

(1) the President shall include with the certification the percentage by which the credits allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing subsidies under section 1402 must be reduced for plan years beginning during such

fiscal year such that there is an aggregate decrease in the amount of such credits and subsidies equal to the amount of such excess; and

(2) the President shall instruct the Secretary of Health and Human Services and the Secretary of the Treasury to reduce such credits and subsidies for such plan years by such percentage.

SA 3208. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1783, between lines 2 and 3, insert the following:

SEC. 6412. EXTENSION OF NUMBER OF DAYS IN WHICH MEDICARE CLAIMS ARE REQUIRED TO BE PAID IN ORDER TO PREVENT OR COMBAT FRAUD, WASTE, OR ABUSE.

(a) PART A CLAIMS.—Section 1816(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2)) is amended—

(1) in subparagraph (B)(ii)(V), by striking ''with respect'' and inserting ''subject to subparagraph (D), with respect''; and

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

''(D)(i) Upon a determination by the Secretary that there is a likelihood of fraud, waste, or abuse involving a particular category of providers of services or suppliers, categories of providers of services or suppliers in a certain geographic area, or individual providers of services or suppliers, the Secretary shall extend the number of calendar days described in subparagraph (B)(ii)(V) to—

''(I) up to 365 calendar days with respect to claims submitted by—

''(aa) categories of providers of services or suppliers; or

''(bb) categories of providers of services or suppliers in a certain geographic area; or

''(II) such time that the Secretary determines is necessary to ensure that the claims with respect to individual providers of services or suppliers are clean claims.

''(ii) During the extended period of time under subclauses (I) and (II) of clause (ii), the Secretary shall engage in heightened scrutiny of claims, such as prepayment review and other methods the Secretary determines to be appropriate.

''(iii) Not later than 90 days after the date of enactment of this subparagraph and not less than annually thereafter, the Inspector General of the Department of Health and Human Services shall submit to the Secretary a report containing recommendations with respect to the application of this subparagraph and section 1842(c)(2)(D). Not later than 60 days after receiving such a report, the Secretary shall submit to the Inspector General a written response to the recommendations contained in the report.

''(iv) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation of this subparagraph by the Secretary.''.

(b) PART B CLAIMS.—Section 1842(c)(2) of the Social Security Act (42 U.S.C. 1395u(c)(2)) is amended—

(1) in subparagraph (B)(ii)(V), by striking ''with respect'' and inserting ''subject to subparagraph (D), with respect''; and

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

''(D)(i) Upon a determination by the Secretary that there is a likelihood of fraud, waste, or abuse involving a particular category of providers of services or suppliers, categories of providers of services or suppliers in a certain geographic area, or individual providers of services or suppliers, the Secretary shall extend the number of calendar days described in subparagraph (B)(ii)(V) to—

''(I) up to 365 calendar days with respect to claims submitted by—

''(aa) categories of providers of services or suppliers; or

''(bb) categories of providers of services or suppliers in a certain geographic area; or

''(II) such time that the Secretary determines is necessary to ensure that the claims with respect to individual providers of services or suppliers are clean claims.

''(ii) During the extended period of time under subclauses (I) and (II) of clause (ii), the Secretary shall engage in heightened scrutiny of claims, such as prepayment review and other methods the Secretary determines to be appropriate.

''(iii) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation of this subparagraph by the Secretary.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the day that is 6 months after the date of the enactment of this Act.

(2) EXPEDITING IMPLEMENTATION.—The Secretary shall promulgate regulations to carry out the amendments made by this section which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comment on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.

SA 3209. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 823, after line 22, insert the following:

SEC. 3125A. ADJUSTMENT TO LOW-VOLUME HOSPITAL PROVISION; QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.

(a) ADJUSTMENT TO LOW-VOLUME HOSPITAL PROVISION.—Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12), as amended by section 3125, is amended—

(1) in subparagraph (C)(i), by striking ''1,500 discharges'' and inserting ''1,600 discharges''; and

(2) in subparagraph (D), by striking ''1,500 discharges'' and inserting ''1,600 discharges''.

(b) QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.—Section 1886(s) of the Social Security Act, as added by section 3401(f), is amended by adding at the end the following new paragraph:

''(4) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than such payment rates for the preceding rate year.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

''(C) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by the entity with a contract under section 1890(a).

''(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital and a psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Internet website of the Centers for Medicare & Medicaid Services.''.

SA 3210. Mrs. HUTCHISON submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 309, strike lines 1 through 5, and insert the following:

(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is an

amount equal to 1.5 times such dollar amount.

On page 309, line 14, strike ''twice'' and insert ''2.5 times''.

On page 314, line 3, strike ''2-consecutive-taxable year'' and insert ''4-consecutive-taxable year''.

On page 318, line 6, strike ''2-year'' and insert ''4-year''.

At the end of the amendment, insert:

TITLE X—MEDICAL CARE ACCESS PROTECTION

SECTION 10001. SHORT TITLE.

This title may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. 10002. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 10003. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this Act, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and

not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 10004. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this Act applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 10005. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this title shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 10006. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 10007. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits

has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 10008. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 10009. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. 10010. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this title shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 10011. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this title shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 10005(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this title (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this title;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this title;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 10012. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this title, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3211. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 136, between lines 3 and 4, insert the following:

(6) RESTRICTIONS ON ENROLLMENT.—The following restrictions on enrollment in a qualified health plan offered through an Exchange, during any enrollment period described in paragraph (5), shall apply:

(A) During any enrollment period or upon any qualifying event (described in section 603 of the Employee Retirement Income Security Act of 1974), an individual who, in the previous year was enrolled in a qualified health plan through an Exchange, may not enroll in a qualified health plan offering a level of coverage (as defined in section 1302(d)(1)) that is more than one level greater than the level at which the individual received coverage in the previous year.

(B) If an individual misses the first enrollment period for which such individual is eligible to enroll in a qualified health plan offered through an Exchange, if such individual enrolls in a health plan through an Exchange during the next enrollment period, for a period of not more than 90 days after first enrolling in such plan, such individual shall not receive coverage for elective services that are not of urgent medical necessity, except where the denial of services could pose significant risk to the life of such individual, or could be reasonably assumed to exacerbate an underlying condition. At no time after an individual described in the preceding sentence enrolls in a qualified health plan offered through an Exchange may such individual be denied coverage for preventive health services (as described in section 2713 of the Public Health Service Act, as added by section 1001) or the treatment of chronic conditions that otherwise are available under the health plan.

SA 3212. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 113, line 18, strike ''may'' and insert ''shall''.

SA 3213. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 2008. APPLICATION OF MEDICAID PROMPT PAY REQUIREMENTS TO NURSING FACILITIES AND HOSPITALS.

Section 1902(a)(37) of the Social Security Act (42 U.S.C. 1396a(a)(37)) is amended by striking ''and (B)'' and inserting ''(B) insofar as nursing facilities or hospitals are paid under the State plan on the basis of submission of claims, ensure that 90 percent of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by all such facilities or hospitals that are paid on that basis are paid within 30 days of the date of receipt of such claims and that 99 percent of such claims are paid within 90 days of the date of receipt of such claims, and (C)''.

SA 3214. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 34, line 16, insert before the semicolon the following: ''operated by a non-profit consumer-based community group or groups''.

On page 35, strike lines 3 through 6, and insert the following:

''(2) CRITERIA.—The Secretary in collaboration with the Administrator of the Center for Medicaid & Medicare Services shall develop standards that must be met by all entities that provide consumer assistance, including standards relating to—

''(A) adequate capacity and training to respond to consumer concerns;

''(B) a review process for monitoring accuracy of responses;

''(C) cultural and linguistic competency to meet the needs of the community; and

''(D) documented experience working with the target population.''.

On page 36, line 6, insert before the period the following: '', including regular and timely accounting of types of problems and inquiries; income, zip code, gender, race or ethnicity and language spoken by persons served; enrollment and outreach activities provided; and implementation issues encountered or identified, if any''.

On page 36, line 15, strike ''$30,000,000'' and insert ''$100,000,000''.

SA 3215. Mr. LIEBERMAN (for himself, Ms. COLLINS, Mr. SPECTER, and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1134, between lines 3 and 4, insert the following:

Subtitle G—Additional Health Care Quality and Efficiency Improvements

SEC. 3601. REPORT ON DEMONSTRATION AND PILOT PROGRAMS.

(a) REPORT.—Not later than 12 months after the date of enactment of this Act, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a report that describes all pilot programs and demonstration projects that the Secretary has authority to carry out (regardless of whether such programs or projects are actually implemented), as authorized by law, during the period for which the report is submitted.

(b) REQUIREMENTS.—A report under subsection (a) shall—

(1) list all pilot programs or demonstration projects involved and indicate whether each program or project is—

(A) not yet being implemented;

(B) currently being implemented; or

(C) complete and awaiting further determinations; and

(2) with respect to programs or projects described in subparagraphs (A) or (B) of paragraph (1), include the recommendations of the Secretary as to whether such programs or projects are necessary.

(c) ACTIONS BASED ON RECOMMENDATIONS.—Based on the recommendations of the Secretary under subsection (b)(2)—

(1) if the Secretary determines that a program or project is necessary, the Secretary shall submit to Congress a strategic plan for the implementation of the program or project and may transfer such program or project into the jurisdiction of the Innovation Center of the Centers for Medicare & Medicaid Services; or

(2) if the Secretary determines that a program or project is unnecessary, the Secretary may terminate the program.

(d) ACTION BY CONGRESS.—Congress may continue in effect any program or project terminated by the Secretary under subsection (c)(2) through the enactment of a Concurrent Resolution expressing the sense of Congress to continue the program or project involved.

SEC. 3602. AVAILABILITY OF DATA ON DENIAL OF CLAIMS.

Section 2715(b)(3) of the Public Health Service Act, as added by section 1001, is amended—

(1) in subparagraph (H), by striking ''and'' at the end;

(2) by redesignating subparagraph (I) as subparagraph (J): and

(3) by inserting after subparagraph (H) the following new subparagraph:

''(I) a statement relating to claims procedures including the percentage of claims that are annually denied by the plan or coverage and the percentage of such denials that are overturned on appeal; and''.

SEC. 3603. ACCELERATION AND INCREASE OF THE PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

Section 1886(p) of the Social Security Act (42 U.S.C. 1395(p)), as added by section 3008(a), is amended—

(1) in paragraph (1)—

(A) by striking ''2015'' and inserting ''2013''; and

(B) by striking ''99 percent'' and inserting ''98 percent''; and

(2) in paragraph (5), by striking ''2015'' and inserting ''2013''.

SEC. 3604. IMPROVEMENTS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in subsection (a)(3), by striking ''January 1, 2013'' and inserting ''January 1, 2012''; and

(2) by amending subsection (g) to read as follows:

''(g) AUTHORITY TO EXPAND IMPLEMENTATION.—

''(1) IN GENERAL.—Taking into account the evaluation under subparagraph (e), the Secretary may, through rulemaking, expand (including implementation nationwide on a voluntary basis) the duration and the scope of the pilot program, to the extent determined appropriate by the Secretary, if—

''(A) the Secretary determines that such expansion is expected to—

''(i) reduce spending under this title without reducing the quality of care; or

''(ii) improve the quality of care and reduce spending; and

''(B) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under this title.

''(2) IMPLEMENTATION PLAN.—In the case where the Secretary does not exercise the authority under paragraph (1) by January 1, 2015, not later than such date, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the

Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.''.

SEC. 3605. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

(a) IN GENERAL.—

(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w–4).

(2) PLAN.—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall also implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician performance that provides comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program under such section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) OTHER REQUIRED CONSIDERATIONS.—In developing and implementing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the implementation of the plan and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians concerning the data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) ENSURING PATIENT PRIVACY.—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(d) FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.—The Secretary shall take into consideration input provided by multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act, as added by section 3014 of this Act, in selecting quality measures for use under this section.

(e) CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.—In developing the plan under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275).

(f) REPORT TO CONGRESS.—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the efforts of and plans made by the Secretary to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(g) EXPANSION.—At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other providers of services and suppliers under title XVIII of the Social Security Act) the information made available on such website.

(h) FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.—The Secretary may establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the Secretary based on factors in subparagraphs (A) through (G) of subsection (a)(2). In no case may Medicare beneficiaries be required to pay increased premiums or cost sharing or be subject to a reduction in benefits under title XVIII of the Social Security Act as a result of such demonstration program. The Secretary shall ensure that any such demonstration program does not disadvantage those beneficiaries without reasonable access to high performing physicians or create financial inequities under such title.

(i) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL.—The term ''eligible professional'' has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4)

(2) PHYSICIAN.—The term ''physician'' has the meaning given that term in section 1861(r) of such Act (42 U.S.C. 1395x(r)).

(3) PHYSICIAN COMPARE.—The term ''Physician Compare'' means the Internet website developed under subsection (a)(1).

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

SA 3216. Mr. NELSON of Florida submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2046, after line 24, add the following:

SEC. _____. INCREASE IN MEDICAL DEVICE RECEIPTS EXEMPT FROM ANNUAL FEE.

The table contained in paragraph (2) of section 9009(b) is amended—

(1) by striking ''$5,000,000'' both places it appears and inserting ''$100,000,000'', and

(2) by striking ''$25,000,000'' both places it appears and inserting ''$150,000,000''.

SA 3217. Mrs. FEINSTEIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 131, between lines 2 and 3, insert the following:

(3) PRESUMPTION FOR EXISTING SMALL EMPLOYER EXCHANGES.—

(A) IN GENERAL.—Notwithstanding the requirements of subsection (d)(1), or other provisions of this Act, in the case of an entity that—

(i) was approved by the appropriate agency of a State to operate as the functional equivalent of a small employer health benefit exchange under State law;

(ii) was fully operational as of January 1, 2010; and

(iii) had enrolled a minimum of 50,000 covered lives through small business employers as of January 1, 2010, and offers and administers coverage on behalf of a minimum of 3 unaffiliated health plans;

the Secretary shall deem such exchange to be a SHOP Exchange for purposes of this title, unless the Secretary determines, after completion of the process established under subparagraph (B), that the exchange does not comply with the standards for SHOP Exchanges under this section.

(B) PROCESS.—The Secretary shall establish a process to work with an entity described in subparagraph (A) to assist the entity in achieving compliance with the requirements and standards applicable to SHOP Exchanges under this title as soon as practicable, but not later than January 1, 2014, including the requirements of a SHOP Exchange to offer all applicable private and public sector health care coverage products and programs described in this title, including, without limitation, the enrollment of small employers in all such products and programs, and to service the premium assistance and cost-sharing programs available under this title to eligible small employers and their employees.

SA 3218. Mr. DORGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time

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

On page 99, between lines 4 and 5, insert the following:

(e) APPLICATION OF LIFETIME AGGREGATE LIMITS.—

(1) IN GENERAL.—Notwithstanding any other provision of this section, the provisions of section 2711 of the Public Health Service Act (as added by section 1001) that relate to lifetime limits shall apply to grandfathered health plans (including group health plans and individual health insurance coverage), except as provided for in paragraph (2).

(2) PHASE-OUT.—A grandfathered health plan—

(A) may not apply a lifetime limit that is less than $5,000,000 during the first two plan years beginning after the date of enactment of this Act;

(B) may not apply a lifetime limit that is less than $10,000,000 during the third and fourth plan years beginning after the date of enactment of this Act; and

(C) shall not apply any lifetime limit for plans years beginning on or after January 1, 2014.

PRIVILEGES OF THE FLOOR

Mr. DODD. Mr. President, I ask unanimous consent that Lia Lopez, an intern in my office, be granted floor privileges for the remainder of consideration of H.R. 3590.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNANIMOUS-CONSENT AGREEMENT—H.R. 3590

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the vote order with respect to the Lautenberg and Dorgan amendments to H.R. 3590 be reversed to Dorgan and then Lautenberg.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMATEUR RADIO EMERGENCY COMMUNICATIONS ENHANCEMENT ACT OF 2009

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 224, S. 1755.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1755) to direct the Department of Homeland Security to undertake a study on emergency communications.

There being no objection, the Senate proceeded to consider the bill.

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table with no intervening action or debate, and any statements related to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 1755) was ordered to be engrossed for a third reading, was read the third time, and passed, as follows:

S. 1755

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Amateur Radio Emergency Communications Enhancement Act of 2009''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Nearly 700,000 amateurs radio operators in the United States are licensed by the Federal Communications Commission in the Amateur Radio Service.

(2) Amateur Radio Service operators provide, on a volunteer basis, a valuable public sector service to their communities, their States, and to the Nation, especially in the area of national and international disaster communications.

(3) Emergency and disaster relief communications services by volunteer Amateur Radio Service operators have consistently and reliably been provided before, during, and after floods, hurricanes, tornadoes, forest fires, earthquakes, blizzards, train accidents, chemical spills and other disasters. These communications services include services in connection with significant examples, such as—

(A) hurricanes Katrina, Rita, Hugo, and Andrew;

(B) the relief effort at the World Trade Center and the Pentagon following the 2001 terrorist attacks; and

(C) the Oklahoma City bombing in April 1995.

(4) Amateur Radio Service has formal agreements for the provision of volunteer emergency communications activities with the Department of Homeland Security, the Federal Emergency Management Agency, the National Weather Service, the National Communications System, and the Association of Public Safety Communications Officials, as well as with disaster relief agencies, including the American National Red Cross and the Salvation Army.

(5) Section 1 of the joint resolution entitled ''Joint Resolution to recognize the achievements of radio amateurs, and to establish support for such amateurs as national policy'', approved October 22, 1994 (Public Law 103–408), included a finding that stated: ''Reasonable accommodation should be made for the effective operation of amateur radio from residences, private vehicles and public areas, and the regulation at all levels of government should facilitate and encourage amateur radio operations as a public benefit.''.

(6) Section 1805(c) of the Homeland Security Act of 2002 (6 U.S.C. 757(c)) directs the Regional Emergency Communications Coordinating Working Group of the Department of Homeland Security to coordinate their activities with ham and amateur radio operators among the 11 other emergency organizations such as ambulance services, law enforcement, and others.

(7) Amateur Radio Service, at no cost to taxpayers, provides a fertile ground for technical self-training in modern telecommunications, electronic technology, and emergency communications techniques and protocols.

(8) There is a strong Federal interest in the effective performance of Amateur Radio Service stations, and that performance must be given—

(A) support at all levels of government; and

(B) protection against unreasonable regulation and impediments to the provision of the valuable communications provided by such stations.

SEC. 3. STUDY OF ENHANCED USES OF AMATEUR RADIO IN EMERGENCY AND DISASTER RELIEF COMMUNICATION AND FOR RELIEF OF RESTRICTIONS.

(a) AUTHORITY.—Not later than 180 days after the date of enactment of this Act, the Secretary of Homeland Security shall—

(1) undertake a study on the uses and capabilities of Amateur Radio Service communications in emergencies and disaster relief; and

(2) submit a report on the findings of the Secretary to Congress.

(b) SCOPE OF THE STUDY.—The study required by this section shall—

(1) include a review of the importance of amateur radio emergency communications in furtherance of homeland security missions relating to disasters, severe weather, and other threats to lives and property in the United States, as well as recommendations for—

(A) enhancements in the voluntary deployment of amateur radio licensees in disaster and emergency communications and disaster relief efforts; and

(B) improved integration of amateur radio operators in planning and furtherance of the Department of Homeland Security initiatives; and

(2)(A) identify impediments to enhanced Amateur Radio Service communications, such as the effects of unreasonable or unnecessary private land use regulations on residential antenna installations; and

(B) make recommendations regarding such impediments for consideration by other Federal departments, agencies, and Congress.

(c) USE OF EXPERTISE AND INFORMATION.—In conducting the study required by this section, the Secretary of Homeland Security shall utilize the expertise of stakeholder entities and organizations, including the amateur radio, emergency response, and disaster communications communities.

CONVENING OF 2ND SESSION OF 111TH CONGRESS

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.J. Res. 62, which was received from the House.

The PRESIDING OFFICER. The clerk will report the joint resolution by title.

The legislative clerk read as follows:

A joint resolution (H.J. Res. 62) appointing the day for the convening of the second session of the One Hundred Eleventh Congress.

There being no objection, the Senate proceeded to consider the joint resolution.

Ms. KLOBUCHAR. Mr. President, I ask unanimous consent that the joint resolution be read three times and passed, the motion to reconsider be laid upon the table, with no intervening action or debate, and any statements related to the joint resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The joint resolution (H.J. Res 62) was ordered to a third reading, was read the third time, and passed, as follows:

H.J. RES. 62

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the second regular session of the One Hundred Eleventh Congress shall begin at noon on Tuesday, January 5, 2010.