award, the Medal of Freedom, in 1984 for meritorious service to his country, the first Mexican American to receive this recognition; and

Whereas Pope John Paul II recognized him with the Pontifical Equestrian Order of Pope Gregory the Great: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) encourages—

(A) teachers of primary schools and secondary schools to launch educational campaigns to inform students about the lifetime of accomplishments by Dr. Hector Garcia; and

(B) all people of the United States to educate themselves about the legacy of Dr. Hector Garcia; and

(2) recognizes the leadership and historical contributions of Dr. Hector Garcia to the Hispanic community and his remarkable efforts to combat racial and ethnic discrimination in the United States of America.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3242. Mr. CRAPO 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.

SA 3243. 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 3244. 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 3245. 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 3246. Mr. CASEY 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 3247. 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 3248. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

SA 3249. Mr. REID proposed an amendment to the bill H.R. 3326, supra.

SA 3250. Mr. REID proposed an amendment to amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3251. Mr. REID proposed an amendment to amendment SA 3250 proposed by Mr. REID to the amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3252. Mr. REID proposed an amendment to amendment SA 3248 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3253. Ms. MURKOWSKI 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.

SA 3254. Ms. MURKOWSKI 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 3255. Ms. MURKOWSKI 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 3256. Mr. BENNET submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3257. Ms. MURKOWSKI 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 3258. Mrs. SHAHEEN 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 3242. Mr. CRAPO 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 1053, between lines 2 and 3, insert the following:

SEC. 3403A. IMPROVEMENTS TO THE INDEPENDENT MEDICARE ADVISORY BOARD.

Section 1899A of the Social Security Act, as added by section 3403, is amended—

(1) in subsection (c)—

(A) in paragraph (1)—

(i) by redesignating subparagraph (B) as subparagraph (C); and

(ii) by inserting after subparagraph (A) the following new subparagraph:

''(B) PROMULGATION OF REGULATIONS TO PROVIDE FOUNDATION FOR BOARD PROPOSALS.—

''(i) IN GENERAL.—Before developing any proposal under this section, the Board, after consultation with the Secretary, shall promulgate regulations through which the Board interprets the provisions of this section that concern the duties of the Board in order to provide a substantive and procedural foundation for carrying out such duties. Such regulations shall be promulgated in accordance with the procedures under section 553 of title 5, United States Code, that relate to substantive rules.

''(ii) RULE OF CONSTRUCTION.—Clause (i) may not be construed as requiring that proposals under this section be promulgated in accordance with the rulemaking procedures referred to in clause (i).'';

(B) in paragraph (2), by adding at the end the following new subparagraphs:

''(G) CONSULTATION WITH INDEPENDENT ADVISORY COMMITTEE.—

''(i) IN GENERAL.—Not later than 60 days after the date of the enactment of the Patient Protection and Affordable Care Act, the Secretary shall establish an advisory committee to review, in accordance with procedures established in the Federal Advisory Committee Act, each proposal to be submitted to Congress under this section.

''(ii) COMPOSITION.—The advisory committee under clause (i) (referred to in this subparagraph as the 'Independent Committee') shall be composed of not more than 15 members who are medical and scientific experts appointed from among individuals who are not officers or employees of the Federal Government.

''(iii) REVIEW AND REPORT.—The Board shall submit a draft copy of each proposal to be submitted to the President under this section to the Independent Committee for its review. The Board shall submit such draft copy by not later than September 1 of the year preceding the year for which the proposal is to be submitted. Not later than November 1 of such year, the Independent Committee shall submit a report to Congress and the Board on the results of such review, including matters reviewed pursuant to the succeeding provisions of this subparagraph.

''(iv) CLINICAL APPROPRIATENESS OF PAYMENT RESTRICTIONS AND COVERAGE RESTRICTIONS.—The review of the Independent Committee of a recommendation in a proposal under this section shall, with respect to any changes in items or services under this title, include evaluating the differences in treatment guidelines and variables of treatment costs for items and services under this title that are subject to a reduction in payment or restriction in coverage pursuant to the recommendation. The purpose of such evaluation shall be to ensure that the recommendation applies only to those items and services for which such comparisons may be made in a clinically appropriate manner.

''(v) SUBSTANTIAL EVIDENCE REGARDING CERTAIN RECOMMENDATIONS.—With respect to a recommendation in a proposal of the Board that reduces payment or restricts coverage for items and services under this title, the Independent Committee shall determine whether the recommendation is supported by substantial evidence.

''(vi) SPECIAL POPULATIONS; HEALTH DISPARITIES.—In reviewing a recommendation in a proposal under this section, the Independent Committee shall evaluate the effect on special populations and whether the recommendation is consistent with Federal policies to reduce health disparities.

''(vii) PUBLIC MEETING TO PRESENT AND DISCUSS FINDINGS.—Before issuing a report under clause (iii), the Independent Committee shall hold a public meeting at which it presents the findings of its review under such clause and seeks comments from individuals attending the meeting.

''(H) PUBLICATION OF INITIAL PROPOSAL IN FEDERAL REGISTER.—

''(i) IN GENERAL.—Not later than October 1 preceding the proposal year involved, the Board shall publish in the Federal Register an initial proposal of the Board under this section and shall seek comments from the public on the proposal. The final proposal shall be published in the Federal Register on the same date as the date on which such proposal is submitted to the President under paragraph (3)(A) (or under paragraph (5), as the case may be).

''(ii) LIMITATION ON JUDICIAL REVIEW.—The publication under clause (i) of a final proposal of the Board does not constitute final agency action for purposes of section 704 of title 5, United States Code.''; and

(C) in paragraph (3)(B), by striking clause (ii) and inserting the following new clause:

''(ii) taking into account comments received from the public under paragraph (2)(H)(i), an explanation of each recommendation contained in the proposal and the reasons for including such recommendation, and a statement of whether and to what extent the Board considered it feasible—

''(I) to protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas; and

''(II) to otherwise comply with the requirements of paragraph (2)(B); and''; and

(2) in subsection (e), by striking paragraph (5) and inserting the following new paragraph:

''(5) LIMITATION ON REVIEW.—

''(A) IN GENERAL.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal, except as provided in subparagraph (B).

''(B) JUDICIAL REVIEW OF SCOPE OF AGENCY AUTHORITY; COMPLIANCE WITH PROCEDURAL SAFEGUARDS.—

''(i) IN GENERAL.—An aggrieved beneficiary or other party may, in accordance with the procedures that apply under section 1869(f)(3), seek review by a court of competent jurisdiction of the implementation by the Secretary of any recommendation in a proposal of the Board if the moving party alleges that the only issue of law is the constitutionality of a recommendation, or one or more issues described in clause (ii). For purposes of this subparagraph, a regulation, determination, or ruling by the Secretary under such a recommendation is final agency action within the meaning of section 704 of title 5, United States Code.

''(ii) RELEVANT ISSUES; PROCEDURAL SAFEGUARDS.—For purposes of clause (i), the court shall hold unlawful and set aside a regulation, determination, or ruling by the Secretary under a recommendation in a proposal of the Board if the court finds that—

''(I) the regulation, determination, or ruling exceeds the scope of the recommendation;

''(II) the Board failed to promulgate regulations in accordance with subsection (c)(1)(B) (relating to a substantive and procedural foundation for carrying out the duties of the Board);

''(III) the Board failed to comply with subsection (c)(2)(A)(ii) (relating to prohibitions against rationing health care; increasing beneficiary cost-sharing, such as deductibles, coinsurance, and copayments; or otherwise restricting benefits or modifying eligibility criteria);

''(IV) the Board failed to comply with subparagraph (D), (E), (G), or (H) of subsection (c)(2) (relating to review by the Medicare Payment Advisory Board, review by the Secretary, review by an independent advisory panel of experts, and publishing initial and final proposals of the Board in the Federal Register, respectively); or

''(V) the Board failed to comply with subsection (c)(3)(B)(ii) (relating to providing explanations of recommendations, providing statements of whether certain duties are feasible, and taking into account public comments).

''(iii) SUBSTANTIAL EVIDENCE REGARDING CERTAIN RECOMMENDATIONS.—With respect to a recommendation in a proposal of the Board under this section that reduces payment or restricts coverage for items and services under this title:

''(I) The review by a court under clause (i) of the implementation by the Secretary of the recommendation shall include a review of the basis of the recommendation.

''(II) The court shall hold unlawful and set aside the recommendation, and any regulation, determination, or ruling by the Secretary under the recommendation, if the court finds that the recommendation is unsupported by substantial evidence within the meaning of section 706 of title 5, United States Code.''.

SA 3243. 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 1790, between lines 9 and 10, insert the following:

SEC. 6508. REQUIREMENT FOR ALL MEDICAID AND CHIP APPLICANTS TO PRESENT AN IDENTIFICATION DOCUMENT.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 211(a)(1)(A)(i) of Public Law 111–3 and section 2303(a)(2) of this Act, is amended—

(1) in subsection (a)(46), —

(A) in subparagraph (A), by striking ''and'' after the semicolon;

(B) in subparagraph (B), by adding ''and'' after the semicolon; and

(C) by adding at the end the following:

''(C) provide that each applicant for medical assistance (or the parent or guardian of an applicant who has not attained age 18), regardless of whether the applicant is described in paragraph (2) of section 1903(x), shall present an identification document described in subsection (jj) when applying for medical assistance (and shall be provided with at least the reasonable opportunity to present such identification as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status;''; and

(2) by adding at the end the following:

''(jj) For purposes of subsection (a)(46)(C), a document described in this subsection is—

''(1) in the case of an individual who is a national of the United States—

''(A) a United States passport, or passport card issued pursuant to the Secretary of State's authority under the first section of the Act of July 3, 1926 (44 Stat. 887, Chapter 772; 22 U.S.C. 211a); or

''(B) a driver's license or identity card issued by a State, the Commonwealth of the Northern Mariana Islands, or an outlying possession of the United States that—

''(i) contains a photograph of the individual and other identifying information, including the individual's name, date of birth, gender, and address; and

''(ii) contains security features to make the license or card resistant to tampering, counterfeiting, and fraudulent use;

''(2) in the case of an alien lawfully admitted for permanent residence in the United States, a permanent resident card, as specified by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B);

''(3) in the case of an alien who is authorized to be employed in the United States, an employment authorization card, as specified by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B); or

''(4) in the case of an individual who is unable to obtain a document described in paragraph (1), (2), or (3), a document designated by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B).''.

(b) APPLICATION TO CHIP.—Section 2105(c)(9)(A) (42 U.S.C. 1397ee(c)(9)(A)) is amended by striking ''section 1902(a)(46)(B)'' and inserting ''subparagraphs (B) and (C) of subsection (a)(46) and subsection (jj) of section 1902''.

SA 3244. 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:

At the appropriate place, insert the following:

Subtitle __—Improved Patient Access and Medical Care

PART I—EPSDT BENEFITS FOR CHILDREN

SEC. __01. EPSDT BENEFITS FOR CHILDREN.

Section 1902(gg) of the Social Security Act, as added by section 2001(b)(2) of this Act, is amended by redesignating paragraph (4) as paragraph (5) and inserting after paragraph (3) the following:

''(4) STATES CERTIFYING ESSENTIAL BENEFITS AND COST-SHARING PROTECTIONS FOR CHILDREN IN FAMILIES WITH INCOME UP TO 300 PERCENT OF THE POVERTY LINE.—The requirements under paragraphs (1) and (2) and section 2105(d)(3)(A) shall not apply to a State with respect to individuals whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved for any fiscal year or portion of a fiscal year that occurs on or after the date on which the State certifies to the Secretary that—

''(A) coverage available through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act for children who reside in the State, are under 19 years of age, and are in families with income that does not exceed 300 percent of the poverty line (as so defined), is at least the same as the level of benefits and cost-sharing under the State child health plan under title XXI (whether implemented under that title, this title, or both); and

''(B) the State Medicaid agency and qualified health plans offered through such an Exchange have established adequate procedures, with respect to such children, to ensure access to, and the coordinated provision of—

''(i) services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

''(ii) cost-sharing protections consistent with section 2103(e) of the Social Security Act.

A State may comply with the requirements of subparagraph (B) by providing the services and cost-sharing protections required under that subparagraph directly under the State plan under title XIX or title XXI of the Social Security, or under arrangements entered into with qualified health plans offered through such an Exchange. Expenditures by the State to provide such services and cost-sharing protections shall be treated as medical assistance for purposes of section 1903(a) and, notwithstanding section 1905(b), the enhanced FMAP under section 2105(b) shall

apply to such expenditures. In no event shall a State receive a payment under section 1903(a) for any such expenditures made prior to the date on which an Exchange is established by the State and operating under section 1311 of the Patient Protection and Affordable Care Act.''.

PART II—MEDICAL CARE ACCESS PROTECTION

SEC. __11. SHORT TITLE OF PART.

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

SEC. __12. 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 part 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. __13. DEFINITIONS.

In this part:

(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 part, 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. _14. 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 part 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. _15. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this part 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. _16. 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. _17. 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. __18. 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. __19. 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 part.

SEC. __20. 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 part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part 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 part or otherwise applicable law (as determined under this part) 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 part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part 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 part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this part 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. __21. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this part 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 part. The provisions governing health care lawsuits set forth in this part 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 part; or

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

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this part shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this part) 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 part, notwithstanding section __15(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 part (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this part 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 part;

(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 part;

(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. __22. APPLICABILITY; EFFECTIVE DATE.

This part 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 part, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this part shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3245. 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:

At the appropriate place, insert the following:

Subtitle __—Improved Patient Access and Medical Care

PART I—INCREASED MEDICAID PAYMENTS FOR PEDIATRIC CARE

SEC. __01. INCREASED PAYMENTS FOR PEDIATRIC CARE UNDER MEDICAID.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b), as amended by section 2001(b)(2), is amended—

(A) in subsection (a)(13)—

(i) by striking ''and'' at the end of subparagraph (A);

(ii) by adding ''and'' at the end of subparagraph (B); and

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

''(C) payment for pediatric care services (as defined in subsection (hh)(1)) furnished by hospitals or physicians (as defined in section 1861(r)) (or for services furnished by other health care professionals that would be pediatric care services under such subsection if furnished by a physician) at a rate not less than—

''(i) in the case of such services furnished by physicians (or professionals), 80 percent of the payment rate that would be applicable if the adjustment described in subsection (hh)(2) were to apply to such services and physicians or professionals (as the case may be) under part B of title XVIII (or, if there is no payment rate for such services under part B of title XVIII, the payment rate for the most comparable services, as determined by the Secretary in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 and adjusted as appropriate for a pediatric population) for services furnished in 2010, 90 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2011, and 100 percent of such adjusted payment rate for services and hospitals or physicians (or professionals) furnished in 2012 and each subsequent year; and

''(ii) in the case of such services furnished by hospitals, 80 percent of the payment rate that would be applicable if such services were furnished under part A of title XVIII (or, if there is no payment rate for such services under part A of title XVIII, the payment rate for the most comparable services, as determined by the Secretary in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 and adjusted as appropriate for a pediatric population) for services furnished in 2010, 90 percent of such payment rate for services furnished in 2011, and 100 percent of such payment rate for services furnished in 2012 and each subsequent year;''; and

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

''(hh) INCREASED PAYMENT FOR PEDIATRIC CARE.—For purposes of subsection (a)(13)(C):

''(1) PEDIATRIC CARE SERVICES DEFINED.—The term 'pediatric care services' means evaluation and management services, without regard to the specialty of the physician or hospital furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary) and that are furnished to an individual who is enrolled in the State plan under this title who has not attained age 19. Such term includes procedure codes established by the Secretary, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, for services furnished under State plans under this title to individuals who have not attained age 19 and for which there is not an a procedure code (or a procedure code that the Secretary, in consultation with such Commission, determines is comparable) established under the Healthcare Common Procedure Coding System.

''(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PEDIATRIC CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of pediatric care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASED FMAP.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2006 and 4107(a)(2), is amended

(1) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods beginning with 2010) with respect to amounts described in subsection (cc)''; and

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

''(cc) For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of the date of enactment of the Patient Protection and Affordable Care Act.

''(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

PART II—MEDICAL CARE ACCESS PROTECTION

SEC. __11. SHORT TITLE OF PART.

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

SEC. __12. 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 part 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. __13. DEFINITIONS.

In this part:

(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 part, 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. __14. 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 part 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. __15. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this part 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. __16. 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. __17. 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. __18. 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. __19. 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 part.

SEC. __20. 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 part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part 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 part or otherwise applicable law (as determined under this part) 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 part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part 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 part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this part 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. __21. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this part 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 part. The provisions governing health care lawsuits set forth in this part 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 part; or

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

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this part shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this part) 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 part, notwithstanding section __15(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 part (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this part 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 part;

(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 part;

(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. __22. APPLICABILITY; EFFECTIVE DATE.

This part 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 part, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this part shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3246. Mr. CASEY 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 974, between lines 9 and 10, insert the following:

SEC. 3315. EXPANSION OF THE DEFINITION OF A COVERED PART D DRUG UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1860D–2(e)(1)(A) of the Social Security Act (42 U.S.C. 1395w–102(e)(1)(A)) is amended by inserting ''and disposable medical devices which reduce the side effects associated with the treatment of cancer'' after ''1927(k)(2)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs dispensed on or after January 1, 2011.

SA 3247. 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 2074, after line 25, insert the following:

TITLE X—TO EXPAND ACCESS TO PRIMARY CARE SERVICES BY IMPROVING MEDICARE REIMBURSEMENT FOR PRIMARY CARE PRACTITIONERS WITH A SPECIALTY DESIGNATION OF NEUROLOGY

Subtitle A—Access to Primary Care Services

SEC. 10001. IMPROVED REIMBURSEMENT FOR PRIMARY CARE PRACTITIONERS WITH A SPECIALTY DESIGNATION OF NEUROLOGY.

Section 1833(x)(2)(A)(i)(I) of the Social Security Act, as added by section 5501, is amended by striking ''or pediatric medicine'' and inserting ''neurology, or pediatric medicine''.

Subtitle B—Medical Care Access Protection

SEC. 10101. SHORT TITLE.

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

SEC. 10102. 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 subtitle 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. 10103. DEFINITIONS.

In this subtitle:

(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 subtitle, 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. 10104. 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 subtitle 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. 10105. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle 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. 10106. 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. 10107. 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. 10108. 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. 10109. 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 subtitle.

SEC. 10110. 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 subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle 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 subtitle or otherwise applicable law (as determined under this subtitle) 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 subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle 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 subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle 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. 10111. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle 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 subtitle. The provisions governing health care lawsuits set forth in this subtitle 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 subtitle; or

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

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this subtitle 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 subtitle, notwithstanding section 10105(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 subtitle (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this subtitle 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 subtitle;

(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 Act;

(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. 10112. APPLICABILITY; EFFECTIVE DATE.

This subtitle 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 Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3248. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end of the House Amendment, insert the following:

The provisions of this Act shall become effective 5 days after enactment.

SA 3249. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, insert the following:

The Appropriations Committee is requested to study the impact of any delay in implementing the provisions of the Act on service members families.

SA 3250. Mr. REID proposed an amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, add the following:

''and the health care provided to those service members.''

SA 3251. Mr. REID proposed an amendment to amendment SA 3250 proposed by Mr. REID to the amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, add the following:

''and the children of service members.''

SA 3252. Mr. REID proposed an amendment to amendment SA 3248 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

Strike ''5 days'' and insert ''1 day''.

SA 3253. Ms. MURKOWSKI 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 816, after line 20, insert the following:

SEC. 3115. INCREASING THE LIMITATION ON CHARGES FOR PHYSICIANS' SERVICES UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1848(g)(2)(C) of the Social Security Act (42 U.S.C. 1395w–4(g)(2)(C)) is amended by striking ''115 percent'' and all that follows through the period at the end and inserting ''the greater of—

''(i) 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons; or

''(ii) the average private insurance reimbursement rate for the item or service (as determined by the Secretary for that geographic practice cost index area).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after the date of the enactment of this Act.

SA 3254. Ms. MURKOWSKI 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 816, after line 20, insert the following:

SEC. 3115. ALLOWING INDIVIDUALS TO CHOOSE TO OPT OUT OF THE MEDICARE PART A BENEFIT.

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to—

(1) opt-out of benefits under title II of such Act as a condition for making such election; and

(2) repay any amount paid under such part A for items and services furnished prior to making such election.

SA 3255. Ms. MURKOWSKI 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:

At the appropriate place in title II, insert the following:

SEC. ___. MEDICAL MALPRACTICE REFORM.

Notwithstanding any other provision of this Act, a State that receives Federal funds under any amendment made by this Act to the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to increase eligibility for participation in such program, shall implement reforms in the State medical malpractice litigation system that are designed to achieve cost savings through the development and implementation of alternatives to tort litigation.

SA 3256. Mr. BENNET submitted an amendment intended to be proposed by him 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:

At the appropriate place, insert the following:

SEC. ___. LONG-TERM FISCAL ACCOUNTABILITY.

(a) PURPOSE.—The purpose of this section is—

(1) to provide a fail-safe mechanism for ensuring that actual budgetary savings from this Act equal or exceed initial estimates of such savings;

(2) to create expedited procedures for Congress to consider legislative changes to increase savings to at least the initial estimate of this Act if actual budgetary savings are less than initial estimates; and

(3) to ensure that additional budget savings will further extend the solvency of the HI Trust Fund, lower premiums and other out-of-pocket costs for Medicare beneficiaries, and reduce the national debt.

(b) DEFINITIONS.—For the purposes of this section:

(1) BUDGETARY EFFECTS.—The term ''budgetary effects'' refers to the sum of the spending reductions and revenue increases for the period 2010 through 2019 from this Act less the sum of the spending increases and revenue reductions resulting from this Act for the same time period. The calculation shall not include an estimate of the change in federal interest payments.

(2) FEDERAL BUDGETARY COMMITMENT TO HEALTH CARE.—The term ''Federal budgetary commitment to health care'' refers to the sum of net Federal outlays for all Federal programs and tax preferences for health care.

(3) OMB PROPOSAL.—The term ''OMB proposal'' refers to the proposed legislative language and such proposal as subsequently modified, if modified by amendment in either House required under subsection (e)(2)(C) to carry out recommendations pursuant to subsection (e)(2)(A).

(4) SAVINGS TARGET.—The term ''savings target'' refers to the net total provided under subsection (d)(1) for the period 2010 through 2019.

(c) CBO ADVISORY REPORTS.—Starting on October 1, 2012, and every 2 years thereafter, through October 1, 2018, not later than 60 days after the start of the fiscal year, the Congressional Budget Office (CBO) shall submit an updated advisory report to Congress and the President. The updated report shall include a detailed estimate of the budgetary effects of this Act based on the information available for the period 2010 through 2019, as well as information on the budgetary effects for the period 2020 through 2029.

(d) OMB COST ESTIMATE REPORTS.—

(1) INITIAL COST ESTIMATE REPORT.—Not later than 60 days after the date of enactment of this Act, the Director of the Office of Management and Budget (OMB) shall submit to Congress a report containing an estimate of the budgetary effects of this Act for 2010 through 2019, as well as information on the budgetary effects for 2020 through 2029. The estimate of net savings produced by this Act for the period 2010 through 2019 period shall serve as the savings target for future cost estimate reports, provided that the OMB estimate is not less than the final CBO estimate of net savings produced by this Act made by CBO prior to its enactment. If the savings estimated by OMB is less than the amount estimated by the CBO, then the estimate of net savings produced by the CBO shall serve as the savings target.

(2) UPDATED COST ESTIMATE REPORTS.—Starting on October 1, 2012, and every 2 years thereafter, through fiscal year 2019, OMB shall reestimate the budgetary effects of this Act based on the information available at that time. The updated cost estimate report shall include a detailed reestimate of the budgetary effects of this Act for the period 2010 through 2019, as well as information on the budgetary effects for the period 2020 through 2029.

(e) BIENNIAL SUBMISSION TO CONGRESS.—

(1) IN GENERAL.—Starting on October 1, 2012, and every 2 years thereafter, through fiscal year 2019, OMB shall submit the following to Congress along with its submission of the upcoming fiscal year budget of the United States Government required pursuant to section 1105 of title 31 of the United States Code:

(A) The updated cost estimate report completed pursuant to subsection (d)(2).

(B) An explanation of any discrepancies between the OMB updated cost estimate report and the updated advisory report prepared by CBO pursuant to subsection (c).

(2) REQUIRED INFORMATION UPON SAVINGS SHORTFALL.—For a fiscal year in which the amount estimated by OMB in its updated cost estimate report for the period 2010 through 2019 is less than the savings target, OMB shall also submit the following:

(A) Recommendations for increasing actual savings to or above the level of the savings target for years where the amount estimated under the updated cost estimate report is less than the savings target.

(B) An explanation of each recommendation.

(C) Proposed legislative language to carry out such recommendations (OMB proposal).

(D) Any other appropriate information.

(3) CONSIDERATIONS.—In developing and submitting the information required under paragraph (2), the OMB shall, to the extent feasible, give priority to recommendations that—

(A) preserve access to affordable health care;

(B) extend the solvency of the Medicare HI Trust Fund; and

(C) strengthen the long-term viability of the programs created under this Act.

(4) CONSULTATION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CHIEF ACTUARY OF THE CENTERS OF MEDICARE AND MEDICAID SERVICES.—In carrying out this subsection, OMB shall consult with, including submitting a draft copy of any recommendations and legislation implementing such recommendations to, the Secretary of the Department of Health and Human Services and the Chief Actuary of the Centers of Medicare and Medicaid Services.

(f) EXPEDITED CONSIDERATION OF OMB PROPOSAL.—

(1) INTRODUCTION OF OMB PROPOSAL.—The OMB proposal shall be introduced in the House of Representatives and in the Senate not later than 5 days of session after receipt by the Congress pursuant to subsection (e), by the majority leader of each House of Congress, for himself, the minority leader of each House of Congress, for himself, or any member of the House designated by the majority leader or minority leader. If the OMB proposal is not introduced in accordance with the preceding sentence in either House of Congress, then any Member of that House may introduce the OMB proposal on any day thereafter. Upon introduction, the OMB proposal shall be referred to the relevant committees of jurisdiction.

(2) COMMITTEE CONSIDERATION.—The committees to which the OMB proposal is referred shall report the OMB proposal without any revision and with a favorable recommendation, an unfavorable recommendation, or without recommendation, not later than 30 calendar days after the date of introduction of the bill in that House, or the first day thereafter on which that House is in session. If any committee fails to report the bill within that period, that committee shall be automatically discharged from consideration of the bill, and the bill shall be placed on the appropriate calendar.

(3) FAST TRACK CONSIDERATION IN HOUSE OF REPRESENTATIVES.—

(A) PROCEEDING TO CONSIDERATION.—It shall be in order, not later than 7 days of session after the date on which an OMB proposal is reported or discharged from all committees to which it was referred, for the majority leader of the House of Representatives or the majority leader's designee, to move to proceed to the consideration of the OMB proposal. It shall also be in order for any Member of the House of Representatives to move to proceed to the consideration of the OMB proposal at any time after the conclusion of such 7-day period. All points of order against the motion are waived. Such a motion shall not be in order after the House has disposed of a motion to proceed on the OMB proposal. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. The motion shall not be debatable. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(B) CONSIDERATION.—The OMB proposal shall be considered as read. The previous question shall be considered as ordered on the OMB proposal to its passage without intervening motion except 50 hours of debate, including the 2 amendments described in subparagraph (E), equally divided and controlled by the proponent and an opponent. A motion to limit debate shall be in order during such debate. A motion to reconsider the vote on passage of the OMB proposal shall not be in order.

(C) APPEALS.—Appeals from decisions of the chair relating to the application of the Rules of the House of Representatives to the procedure relating to the OMB proposal shall be decided without debate.

(D) APPLICATION OF HOUSE RULES.—Except to the extent specifically provided in this paragraph, consideration of an OMB proposal shall be governed by the Rules of the House of Representatives. It shall not be in order in the House of Representatives to consider any

OMB proposal introduced pursuant to the provisions of this subsection under a suspension of the rules pursuant to clause 1 of House Rule XV, or under a special rule reported by the House Committee on Rules.

(E) AMENDMENTS.—

(i) IN GENERAL.—It shall be in order for the majority leader, or his designee, and the minority leader, or his designee, to each offer one amendment in the nature of a substitute to the OMB proposal, provided that any such amendment would not have the effect of decreasing any specific budget outlay reductions below the level of such outlay reductions provided in the OMB proposal, or would have the effect of reducing Federal revenue increases below the level of such revenue increases provided in the OMB proposal, unless such amendment makes a reduction in other specific budget outlays related to Federal health expenditures, an increase in other specific Federal revenues related to Federal health expenditures, or a combination thereof, at least equivalent to the sum of any increase in outlays or decrease in revenues provided by such amendment.

(ii) SCORING.—CBO scores of the OMB proposal and any amendment in the nature of a substitute shall be used for the purpose of determining whether such amendment achieves at least the same amount of savings as the OMB proposal.

(iii) MULTIPLE AMENDMENTS.—If more than 1 amendment is offered under this subparagraph, then each amendment shall be considered separately, and the amendment receiving both an affirmative vote of three-fifths of the Members, duly chosen and sworn, and the highest number of votes shall be the amendment adopted.

(F) VOTE ON PASSAGE.—Immediately following the conclusion of consideration of the OMB proposal, the vote on passage of the OMB proposal shall occur without any intervening action or motion and shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn. If the OMB proposal is passed, the Clerk of the House of Representatives shall cause the bill to be transmitted to the Senate before the close of the next day of session of the House.

(4) FAST TRACK CONSIDERATION IN SENATE.—

(A) IN GENERAL.—Notwithstanding rule XXII of the Standing Rules of the Senate, it is in order, not later than 7 days of session after the date on which an OMB proposal is reported or discharged from all committees to which it was referred, for the majority leader of the Senate or the majority leader's designee to move to proceed to the consideration of the OMB proposal. It shall also be in order for any Member of the Senate to move to proceed to the consideration of the OMB proposal at any time after the conclusion of such 7-day period. A motion to proceed is in order even though a previous motion to the same effect has been disagreed to. All points of order against the motion to proceed to the OMB proposal are waived. The motion to proceed is not debatable. The motion is not subject to a motion to postpone. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the OMB proposal is agreed to, the OMB proposal shall remain the unfinished business until disposed of.

(B) DEBATE.—Consideration of an OMB proposal and of all debatable motions and appeals in connection therewith shall not exceed a total of 50 hours. Debate shall be divided equally between the majority and minority leaders or their designees. A motion further to limit debate on the OMB proposal is in order. Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal. All time used for consideration of the OMB proposal, including time used for quorum calls and voting, shall be counted against the total 50 hours of consideration.

(C) AMENDMENTS.—

(i) IN GENERAL.—It shall be in order for the majority leader, or his designee, and the minority leader, or his designee, to each offer one amendment in the nature of a substitute to the OMB proposal, provided that any such amendment would not have the effect of decreasing any specific budget outlay reductions below the level of such outlay reductions provided in OMB proposal, or would have the effect of reducing Federal revenue increases below the level of such revenue increases provided in the OMB proposal, unless such amendment makes a reduction in other specific budget outlays related to Federal health expenditures, an increase in other specific Federal revenues related to Federal health expenditures, or a combination thereof, at least equivalent to the sum of any increase in outlays or decrease in revenues provided by such amendment.

(ii) SCORING.—CBO scores of the OMB proposal and any amendment in the nature of a substitute shall be used for the purpose of determining whether such amendment achieves at least the same amount of savings as the OMB proposal.

(D) VOTE ON PASSAGE.—The vote on passage shall occur immediately following the conclusion of the debate on the OMB proposal and a single quorum call at the conclusion of the debate if requested. Passage shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn.

(E) RULINGS OF THE CHAIR ON PROCEDURE.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a OMB proposal shall be decided without debate.

(5) RULES TO COORDINATE ACTION WITH OTHER HOUSE.—

(A) REFERRAL.—If, before the passage by 1 House of an OMB proposal of that House, that House receives from the other House an OMB proposal, then such proposal from the other House shall not be referred to a committee and shall immediately be placed on the calendar.

(B) TREATMENT OF OMB PROPOSAL OF OTHER HOUSE.—If 1 House fails to introduce or consider a OMB proposal under this section, the OMB proposal of the other House shall be entitled to expedited floor procedures under this section.

(C) PROCEDURE.—

(i) OMB PROPOSAL IN THE SENATE.—If prior to passage of the OMB proposal in the Senate, the Senate receives an OMB proposal from the House, the procedure in the Senate shall be the same as if no OMB proposal had been received from the House except that—

(I) the vote on final passage shall be on the OMB proposal of the House if it is identical to the OMB proposal then pending for passage in the Senate; or

(II) if the OMB proposal from the House is not identical to the OMB proposal then pending for passage in the Senate and the Senate then passes the Senate OMB proposal, the Senate shall be considered to have passed the House OMB proposal as amended by the text of the Senate OMB proposal.

(ii) DISPOSITION OF THE OMB PROPOSAL.—Upon disposition of the OMB proposal received from the House, it shall no longer be in order to consider the OMB proposal originated in the Senate.

(D) TREATMENT OF COMPANION MEASURES IN THE SENATE.—If following passage of the OMB proposal in the Senate, the Senate then receives an OMB proposal from the House of Representatives that is the same as the OMB proposal passed by the House, the House-passed OMB proposal shall not be debatable. If the House-passed OMB proposal is identical to the Senate-passed OMB proposal, the vote on passage of the OMB proposal in the Senate shall be considered to be the vote on passage of the OMB proposal received from the House of Representatives. If it is not identical to the House-passed OMB proposal, then the Senate shall be considered to have passed the OMB proposal of the House as amended by the text of the Senate OMB proposal.

(E) CONSIDERATION IN CONFERENCE.—Upon passage of the OMB proposal, the Senate shall be deemed to have insisted on its amendment and requested a conference with the House of Representatives on the disagreeing votes of the two Houses, and the Chair be authorized to appoint conferees on the part of the Senate, without any intervening action.

(F) ACTION ON CONFERENCE REPORTS IN SENATE.—

(i) MOTION TO PROCEED.—A motion to proceed to the consideration of the conference report on the OMB proposal may be made even though a previous motion to the same effect has been disagreed to.

(ii) CONSIDERATION.—During the consideration in the Senate of the conference report (or a message between Houses) on the OMB proposal, and all amendments in disagreement, and all amendments thereto, and debatable motions and appeals in connection therewith, debate (or consideration) shall be limited to 10 hours, to be equally divided between, and controlled by, the majority leader and minority leader or their designees. Debate on any debatable motion or appeal related to the conference report (or a message between Houses) shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the conference report (or a message between Houses).

(iii) DEBATE IF DEFEATED.—If the conference report is defeated, debate on any request for a new conference and the appointment of conferees shall be limited to 1 hour, to be equally divided between, and controlled by, the manager of the conference report and the minority leader or his designee, and should any motion be made to instruct the conferees before the conferees are named, debate on such motion shall be limited to one-half hour, to be equally divided between, and controlled by, the mover and the manager of the conference report. Debate on any amendment to any such instructions shall be limited to 20 minutes, to be equally divided between and controlled by the mover and the manager of the conference report. In all cases when the manager of the conference report is in favor of any motion, appeal, or amendment, the time in opposition shall be under the control of the minority leader or his designee.

(iv) AMENDMENTS IN DISAGREEMENT.—If there are amendments in disagreement to a conference report on the OMB proposal, time on each amendment shall be limited to 30 minutes, to be equally divided between, and controlled by, the manager of the conference report and the minority leader or his designee. No amendment that is not germane to the provisions of such amendments shall be received.

(G) VOTE ON CONFERENCE REPORT IN EACH HOUSE.—Passage of the conference in each House shall be by an affirmative vote of three-fifths of the Members of that House, duly chosen and sworn.

(H) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

(6) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SA 3257. Ms. MURKOWSKI 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 352, line 8, strike ''50'' and insert ''500''.

On page 352, line 13, strike ''50'' and insert ''500''.

On page 352, line 16, strike ''50'' and insert ''500''.

On page 352, line 20, strike ''50'' and insert ''500''.

SA 3258. Mrs. SHAHEEN 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 869, between lines 14 and 15, insert the following:

SEC. 3143. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—Notwithstanding any other provision of law, beginning with discharges occurring on or after October 1, 2009, for purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)), the area wage index applicable under such section to hospitals with Medicare provider numbers 300001, 300003, 300005, 300011, 300012, 300014, 300017, 300018, 300019, 300020, 300023, 300029, and 300034 shall not be less than the post-reclassification area wage index applicable to the hospital for purposes of determining payments during the period beginning on or after October 1, 2006, and before October 1, 2007.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall make a proportional adjustment in the standardized amounts determined under section 1886(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) to assure that the provisions of this section do not result in aggregate payments under section 1886 of such Act (42 U.S.C. 1395ww) that are greater or less than those that would otherwise be made. Notwithstanding any other provision of law, for purposes of making adjustments under this subsection, the Secretary shall not further adjust the wage index or standardized amounts for any area, State, or region within the United States.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on December 16, 2009.

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

COMMITTEE ON ARMED SERVICES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on December 16, 2009, at 1:30 p.m.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on December 16, at 11:30 a.m., in room SD–366 of the Dirksen Senate Office Building.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 16, 2009, at 10 a.m.

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

COMMITTEE ON THE JUDICIARY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 16, 2009, at 3 p.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Judicial Nominations.''

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

COMMITTEE ON VETERANS' AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on December 16, 2009.

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

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs' Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security be authorized to meet during the session of the Senate on December 16, 2009, at 2:30 p.m. to conduct a hearing entitled, ''Tools to Combat Deficits and Waste: Enhanced Rescission Authority''.

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

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on the Judiciary, Subcommittee on Human Rights and the Law, be authorized to meet during the session of the Senate on December 16, 2009, at 10:30 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''The Law of the Land: U.S. Implementation of Human Rights Treaties.''

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

HONORING THE ESTABLISHMENT OF DIPLOMATIC RELATIONS BETWEEN THE UNITED STATES AND THE HASHEMITE KINGDOM OF JORDAN

Mr. DURBIN. I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 376, submitted earlier today.

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

The assistant legislative clerk read as follows:

A resolution (S. Res. 376) honoring the 60th anniversary of the establishment of diplomatic relations between the United States and the Hashemite Kingdom of Jordan, the 10th anniversary of the accession to the throne of His Majesty King Abdullah II Ibn Al Hussein, and for other purposes.

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

Mr. INOUYE. Madam President, today, I am supporting this resolution to honor the 60th anniversary of the establishment of diplomatic relations between the U.S. and the Hashemite Kingdom of Jordan, as well as to honor the 10th anniversary of His Majesty King Abdullah II Ibn Al Hussein's accession to the throne. I am pleased to be joined in this endeavor by Senator GREGG.

Since establishing diplomatic relations, Jordan has worked together with the U.S. towards the mutual goal of peace in the Middle East. In 1994, King Hussein and Prime Minister of Israel, Yitzhak Rabin, signed the Jordan-Israel peace treaty, ending nearly 50 years of war between the two countries. The government of Jordan has been an instrumental partner in the fight against al-Qaida and terrorism. As a result, the people of Jordan have also suffered devastating losses at the hands of terrorists.

Mr. DURBIN. I ask unanimous consent to be added as a cosponsor to this legislation.

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

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to,