FRED UPTON, MICHIGAN
CHAIRMAN

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RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

April 27, 2012

The Honorable Paul Ryan
Chairman
Committee on the Budget
U.S. House of Representatives
207 Cannon House Office Building
Washington, DC 20515

Dear Chairman Ryan,

Pursuant to section 201(a) of the Concurrent Resolution on the Budget for Fiscal Year 2013, I hereby transmit these recommendations which have been approved by vote of the Committee on Energy and Commerce, and the appropriate accompanying material including additional, supplemental or dissenting views, to the House Committee on the Budget. This submission is in order to comply with reconciliation directives included in H. Con. Res. 112, the fiscal year 2013 budget resolution and is consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974.

Sincerely,

Fred Upton
Chairman

RECOMMENDATIONS APPROVED BY THE COMMITTEE ON ENERGY AND COMMERCE FOR TRANSMITTAL TO THE COMMITTEE ON BUDGET PURSUANT TO SECTION 201(A) OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2013

TITLE II—COMMITTEE ON ENERGY AND COMMERCE

Subtitle A—Repeal of Certain ACA Funding Provisions

SEC. 201. REPEALING MANDATORY FUNDING TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.

(a) IN GENERAL.—Section 1311(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(a)) is repealed.

(b) RESCISSION OF UNOBLIGATED FUNDS.—Of the funds made available under such section 1311(a), the unobligated balance is rescinded.

SEC. 202. REPEALING PREVENTION AND PUBLIC HEALTH FUND.

(a) IN GENERAL.—Section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is repealed.

(b) RESCISSION OF UNOBLIGATED FUNDS.—Of the funds made available by such section 4002, the unobligated balance is rescinded.

SEC. 203. RESCINDING UNOBLIGATED BALANCES FOR CO-OP PROGRAM.

Of the funds made available under section 1322(g) of the Patient Protection and Affordable Care Act (42 U.S.C. 18042(g)), the unobligated balance is rescinded.

Subtitle B—Medicaid

SEC. 211. REVISION OF PROVIDER TAX INDIRECT GUARANTEE THRESHOLD.

Section 1903(w)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1396b(w)(4)(C)(ii)) is amended by inserting ''and for portions of fiscal years beginning on or after October 1, 2012,'' after ''October 1, 2011,''.

SEC. 212. REBASING OF STATE DSH ALLOTMENTS FOR FISCAL YEAR 2022.

Section 1923(f) of the Social Security Act (42 U.S.C. 1396r-4(f)) is amended—

(1) by redesignating paragraph (9) as paragraph (10);

(2) in paragraph (3)(A) by striking ''paragraphs (6), (7), and (8)'' and inserting ''paragraphs (6), (7), (8), and (9)''; and

(3) by inserting after paragraph (8) the following new paragraph:

''(9) REBASING OF STATE DSH ALLOTMENTS FOR FISCAL YEAR 2022.—With respect to fiscal 2022, for purposes of applying paragraph (3)(A) to determine the DSH allotment for a State, the amount of the DSH allotment for the State under paragraph (3) for fiscal year 2021 shall be treated as if it were such amount as reduced under paragraph (7).''.

SEC. 213. REPEAL OF MEDICAID AND CHIP MAINTENANCE OF EFFORT REQUIREMENTS UNDER PPACA.

(a) REPEAL OF PPACA MEDICAID MOE.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by striking subsection (gg).

(b) REPEAL OF PPACA CHIP MOE.—Section 2105(d)(3) of the Social Security Act (42 U.S.C. 1397ee(d)(3)) is amended—

(1) by striking subparagraph (A);

(2) by redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively; and

(3) in the paragraph heading, by striking ''CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019'' and inserting ''CONTINUITY OF COVERAGE''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by striking paragraph (74).

(2) Effective January 1, 2014, paragraph (14) of section 1902(e) (as added by section 2002(a) of Public Law 111–148) is amended by striking the third sentence of subparagraph (A).

(d) EFFECTIVE DATE.—Except as provided in subsection (c)(2), the amendments made by this section shall take effect on the date of the enactment of this section.

SEC. 214. MEDICAID PAYMENTS TO TERRITORIES.

(a) LIMIT ON PAYMENTS.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2)—

(A) by striking ''paragraphs (3) and (5)''; and

(B) by inserting ''paragraph (3)'' after ''and subject to'';

(2) in paragraph (4), by striking ''(3), and'' and all that follows through ''of this subsection'' and inserting ''and (3) of this subsection''; and

(3) by striking paragraph (5).

(b) FMAP.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking ''shall be 55 percent'' and inserting ''shall be 50 percent''.

SEC. 215. REPEALING BONUS PAYMENTS FOR ENROLLMENT UNDER MEDICAID AND CHIP.

(a) IN GENERAL.—Paragraphs (3) and (4) of section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a)) are repealed.

(b) RESCISSION OF UNOBLIGATED FUNDS.—Of the funds made available by section 2105(a)(3) of the Social Security Act, the unobligated balance is rescinded.

(c) CONFORMING CHANGES.—

(1) AVAILABILITY OF EXCESS FUNDS FOR PERFORMANCE BONUSES.—Section 2104(n)(2) of the Social Security Act (42 U.S.C. 1397dd(n)(2)) is amended by striking subparagraph (D).

(2) OUTREACH OR COVERAGE BENCHMARKS.—Section 2111(b)(3) of the Social Security Act (42 U.S.C. 1397kk(b)(3)) is amended—

(A) in subparagraph (A)—

(i) in clause (i), by inserting ''or'' after the semicolon at the end; and

(ii) by striking clause (ii); and

(B) by striking subparagraph (C).

Subtitle C—Liability Reform

SEC. 221. 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. 222. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

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. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of 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.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, 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 organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 223. 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 a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, 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 injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 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. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, 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. Whenever a judgment of liability is rendered as to any party, 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. 224. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—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. In particular, 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. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) Forty percent of the first $50,000 recovered by the claimant(s).

(2) Thirty-three and one-third percent of the next $50,000 recovered by the claimant(s).

(3) Twenty-five percent of the next $500,000 recovered by the claimant(s).

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

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. 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. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 225. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health

care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

SEC. 226. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by 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. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such 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. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

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

(2) 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.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, 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, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

(c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT COMPLY WITH FDA STANDARDS.—

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product,

based on a claim that such product caused the claimant's harm where—

(i)(I) such medical product was subject to premarket approval, clearance, or licensure by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and

(II) such medical product was so approved, cleared, or licensed; or

(ii) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with appli-

cable Food and Drug Administration statutes and regulations.

(B) RULE OF CONSTRUCTION.—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

(3) PACKAGING.—In a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required

to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.

(4) EXCEPTION.—Paragraph (1) shall not apply in any health care lawsuit in which—

(A) a person, before or after premarket approval, clearance, or licensure of such medical product, knowingly misrepresented to or withheld from the Food and Drug Administration information that is required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and is causally related to the harm which the claimant allegedly suffered;

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or main-

taining approval, clearance, or licensure of such medical product; or

(C) the defendant caused the medical product which caused the claimant's harm to be misbranded or adulterated (as such terms are used in chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.)).

SEC. 227. 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. 228. 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. The term ''compensatory damages'' includes economic damages and non-economic 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 LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or

pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, 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. Such term does not include a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) 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, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, 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.

(9) 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, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, 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 or medical products, 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.

(10) HEALTH CARE ORGANIZATION.—The term ''health care organization'' means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person or entity required by State or Federal laws or regulations 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.

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

(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) MEDICAL PRODUCT.—The term ''medical product'' means a drug, device, or biological product intended for humans, and the terms ''drug'', ''device'', and ''biological product'' 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(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), re-

spectively, including any component or raw material used therein, but excluding health care services.

(15) 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.

(16) 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, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) 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.

(18) 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. 229. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) 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 does 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) 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) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 230. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle 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, or mandates or permits subrogation or a lien on collateral source benefits.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—(1) Any issue that is not governed by any provision of law established by or under this subtitle (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This subtitle shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this subtitle or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this subtitle shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this subtitle) 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 223(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 231. 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 subtitle, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

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TITLE II—REPEAL OF CERTAIN ACA FUNDING PROVISIONS; MEDICAID; LIABILITY REFORM

PURPOSE AND SUMMARY

The purpose of these Committee Prints is to reign in mandatory spending to avoid a debt crisis. The Committee Prints also comply with the reconciliation directive included in section 201 of H. Con. Res. 112, establishing the budget for the United States Government for fiscal year 2013 and setting forth appropriate budgetary levels for fiscal years 2014 through 2022, and is consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974.

BACKGROUND AND NEED FOR LEGISLATION

Reigning in Irresponsible Spending

Section 1311(a) of the Patient Protection and Affordable Care Act (PPACA) provides the Secretary of Health and Human Services (HHS) a direct appropriation of such sums as necessary for grants to States to establish exchanges and facilitate the purchase of qualified health plans. The size of the direct appropriation is solely determined by the Secretary. The Secretary can determine the amount of spending and spend the funds without further Congressional action. The proposed legislation would strike the unlimited direct appropriation and rescind any unobligated funds.

The Congressional Research Service's (CRS) American Law Division confirmed these facts in a February 7, 2011 memo, stating that "the total amount of money the Secretary may expend

for grants to the states under this section is indefinite." CRS further stated that "[t]his section thus comprises both an authorization and an appropriation of federal funds and as such, it does not require any further congressional action to constitute an effective appropriation."

Section 1311(a) funds could be used by States for activities related to developing State insurance exchanges, which could include hiring and retaining hundreds of employees to establish their State exchanges, such as brokers, advertisers, and customer service agents. Grants under this language can be used to "facilitate enrollment" into exchange plans. However, this term is undefined in the statute and could allow the funds to go towards any activity the Secretary determines could "facilitate" enrollment. The vague definition of "facilitate" is especially troubling in light of the unlimited appropriation provided to the Secretary.

Section 1322 of PPACA created the Consumer Operated and Oriented Plan (CO-OP) program to provide government-subsidized loans to qualified non-profit health insurance plans. The law also appropriated $6 billion for startup and solvency loans under the program.

Analysis of the CO-OP program has raised serious concerns about the liability that taxpayers face from this PPACA loan program. The Office of Management and Budget (OMB) estimates of potential taxpayer losses are troubling. In the proposed rule for CO-OPs issued on July 20, 2011 (76 FR 43237), OMB estimated that up to "50 percent of all loans" will not be repaid – jeopardizing hundreds of millions of taxpayer dollars.

Some awardees also include unions who appear to fail to meet basic eligibility criteria, such as the statutory requirement that award recipients not include health insurers or related entities in existence before July 16, 2009.

Partially in response to such concerns, Congress reduced the appropriation available for the program to $3.8 billion in H.R. 1473, the continuing resolution for fiscal year 2011. Given these facts, it is appropriate for Congress to rescind the entire unobligated balance available for the program to help address runaway federal spending and limit taxpayer losses under the program.

Section 4002 of PPACA created the Prevention and Public Health Fund, a $17.75 billion account (fiscal year 2012 to fiscal year 2021) administered by the Secretary of HHS to provide for "expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs."

Section 4002 appropriates $1 billion for fiscal year 2012; $1.25 billion for fiscal year 2013; $1.5 billion for fiscal year 2014; $2 billion for fiscal year 2015; and each fiscal year thereafter in perpetuity. Although the amount of the fund was reduced in the Middle Class Tax Relief and Job Creation Act passed in February 2012, the fund remains nothing more than a slush fund controlled entirely by the Secretary of HHS that can be spent without further Congressional oversight and severely hampers robust oversight of the program.

Providing an advanced appropriation limits Congressional oversight of spending under the Public Health Service Act and results in the Federal funding of signs, bike paths, and dog

neutering. Rather than provide the Secretary a large appropriation with broad discretion, the Committee believes Congress should identify worthy public health service programs and authorize them at appropriate levels. Congress can then set fiscal priorities by subsequently providing funding through the appropriations process after weighing the relative value of different programs.

Medicaid

For both the Federal and State governments, Medicaid is the largest health care spender of general-revenue funds. The CBO's recent estimates show that the Federal government will spend over $5 trillion on Medicaid over the next 5 years. As the CMS Chief Actuary notes in his 2011 Medicaid Actuarial Report, State spending on the program will surpass $2 trillion over the same time period.

Medicaid is also the largest Federal health care program in terms of lives covered. In fiscal year 2010, 67.7 million people were enrolled in the program at some point during the year and at least 26 million more people will be added to the program because of the program's expansion in PPACA. While Medicaid was originally designed as a safety net, serving just 4 million people in 1966, by 2020 there could be more than 90 million Americans. That means at least 1 in 4 Americans will be dependent on the government program Medicaid. These statistics are alarming and unsustainable given Washington's record debt and deficit levels and the increasing burden on States to sustain their Medicaid programs.

Rather than ensuring the Medicaid program remains fiscally sustainable, PPACA enacted the largest expansion of the entitlement program since its inception in 1965. In fact, half of the individuals gaining health care coverage under the new health law will obtain it through the government's Medicaid program.

While the dramatic expansion of the Medicaid program in PPACA will contribute to a sharp increase in Federal Medicaid expenditures over the next 10 years, program integrity remains a serious concern. The Committee is committed to ensuring greater transparency and accountability in how Federal funds are spent in all 50 States and the U.S territories.

Program integrity can be improved significantly by ensuring eligibility review is done properly and consistently. According to CMS, Medicaid made nearly $22 billion in improper payments in 2011, of which, more than $15 billion was associated with eligibility review errors. Policies such as the implementation of the burdensome Maintenance of Effort (MOE) on States prohibit any changes to eligibility, methods, and procedures until after 2014 for adults in Medicaid. For children under 19 years of age in Medicaid or the Children's Health Insurance Program (CHIP), eligibility, methods, and procedures for determining eligibility cannot be changed until September 2019.

Such policies limit a State's ability to ensure greater program integrity by limiting new eligibility review standards that would ensure the program is used for the truly eligible and most vulnerable. In contrast, the creation of the Performance Bonus Payments in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which was signed into law by President Obama, rewards States for loosening their Medicaid eligibility review procedures.

Such financial incentives only further weaken the program's integrity and exacerbate the existing improper payment rates.

A Broken Medical Liability System

The Nation's medical liability system imperils patient access and imposes tremendous costs on our Nation. It has forced doctors out of practicing in certain specialties; it has caused trauma centers to close; it has forced pregnant women to drive hours to find an obstetrician. This badly broken system also imposes tremendous financial burdens: Americans spend over $200 billion every year in unnecessary "health care" costs;[1] the CBO has reported to the Committee that comprehensive medical liability reform will save American taxpayers $63.9 billion over 10 years.[2]

In sharp contrast, States like California and Texas, as well as others, have already enacted comprehensive medical liability reforms. As discussed below, enacting these reforms nationally will decrease the costs of defensive medicine, reduce medical liability fears that inhibit quality of care improvement, end years of Washington inaction on this recurring crisis, and, as shown by the States, increase patient access to quality care while reducing costs, including liability premiums.

President Obama has repeatedly cited the importance of medical tort reform, but nothing meaningful in this area was included in PPACA.

The Costs of Defensive Medicine

Doctors are sued at an alarming rate (by the age of 55, 61 percent of doctors have been sued)[3] and forced to practice defensive medicine. In fact, a 2005 survey published in the Journal of the American Medical Association (AMA) revealed that 93 percent of doctors said they have practiced defensive medicine and 92 percent said they made referrals to specialists and/or ordered tests or procedures in part to insulate themselves from medical liability.[4]

Part of defensive medicine is called assurance behavior where a monetary value is assigned. This occurs when a doctor orders a test or procedure where at least some of the motivation is to avoid being second-guessed in retrospect and possibly named in a medical liability suit. This is not fraud. Medicine is not an exact science. No doctor can tell whether the patient in front of them is the one who may have the rare clinical condition that may have been detected with an additional test. Faced with the possibility of a professionally devastating malpractice suit, many physicians will order the extra test. Sixty percent of malpractice cases are dropped or dismissed and never go to court, but it costs a doctor an average of $18,000 to defend against a lawsuit. Doctors are found *not* negligent in 90 percent of the cases that *do* go to trial, but each of these cases costs an average of $100,000 to defend.[5]

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[1] PwC's "The Price of Excess" (2010): http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.jhtml

[2] CBO Preliminary Estimates of E&C Reconciliation Proposals.

[3] AMA's "Medical Liability: By late career, 61% of doctors have been sued": http://www.ama-assn.org/amednews/2010/08/ 16/prl20816.htm.

[4] David M. Studdert, Michelle M. Mello, William M. Sage, Catherine M. DesRoches, Jordan Peugh, Kinga Zapert, Troyen A. Brennan, *Defensive Medicine: Among High-Risk Specialist Physicians in a Volatile Malpractice Environment,* 293 J. AM. MED. ASS'N 2609 (2005).

[5] See note 4.

Defensive medicine is not done to increase income. If an internist orders a CAT scan, the radiologist gets paid, not the internist.

Medical malpractice premiums written in 2009 totaled approximately $10.8 billion.[6] Indirect costs, particularly increased use of tests and procedures by providers to protect against future lawsuits ("defensive medicine"), have been estimated to be much higher than direct premiums.

The Pacific Institute puts the cost of defensive medicine at some $200 billion and estimates that these additional liability-based medical care costs add at least 3.4 million Americans to the rolls of the uninsured.[7] Nearly half of all medical malpractice claims do not involve injury or medical error. Likewise, the Manhattan Institute concluded that about ten cents of every dollar paid for health care services goes to cover malpractice premiums, defensive medicine, and other costs associated with excessive litigation.

Medical Liability Fears Inhibit Quality of Care Improvements

Fear of medical liability makes it more difficult to improve systems by making doctors reluctant to discuss and study errors and "near misses" or participate in morbidity and mortality conferences if the findings are "discoverable" in a malpractice claim.

Another common myth is that a small group of bad doctors are responsible for most malpractice cases, and the current medical tort system is needed or they will be free to repeatedly harm patients through their negligence. According to a 2007 analysis of National Practitioner Data Bank (NPDB) files by Public Citizen "[t]he vast majority of doctors – 82 percent – have never had a medical malpractice *payment* since the NPDB was created in 1990. Just 5.9 percent of doctors were responsible for 57.8 percent of all malpractice *payments* since 1991, according to data from September 1990 through 2005. Just 2.3 percent of doctors, having three or more malpractice payments, were responsible for 32.8 percent of all payments. Only 1.1 percent of doctors, having four or more malpractice payments, were responsible for 20.2 percent of all payments."[8]

However, Public Citizen's own report highlights the problem. According to the AMA Physician Practice Information Survey, 75.4 percent of cardiothoracic surgeons, 68.3 percent of general surgeons, 79.1 percent of neurosurgeons, 70.3 percent of orthopedic surgeons, and 69.6 percent of OB/GYNs have been sued.[9] The numbers do not add up. Either there are a lot of frivolous lawsuits or almost all doctors are really bad doctors. The truth is that most claims are meritless and do not result in a payment, yet most doctors have to defend themselves from these unnecessary claims at a substantial cost to themselves and the Nation's health care system.

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[6] NAIC, "Countrywide Summary of Medical Malpractice Insurance, Calendar Years 1991-2009," provided to CRS on December 16, 2010.

[7] Lawrence 1. McQuillan, Hovannes Ahramyan and Anthony P. Archie, *Jackpot Justice: The True Cost of America's Tort System,* Pacific Research Institute (Mar. 2007).

[8] Public Citizen, Congress Watch, *The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes,* (January 2007): http://www.citizen.org/publications/publicationredirect.cfm?ID=7497.

[9] AMA 2007-2008 Physician Practice Information survey.

The medical liability tort system does not improve quality. A number of studies have failed to show that the current system of medical liability deters medical errors or promotes patient safety.[10] This has been most extensively studied in the specialty of obstetrics where the fear of medical liability has not been shown to result in fewer complications or cesarean sections.[11] There is evidence, however, that fears of medical liability deter doctors from treating high risk patients, performing high risk procedures, entering high risk specialties, and practicing in states without liability reform.

This proposal will make it easier to promote efforts at improving patient safety and quality of care by allowing doctors and hospitals to examine the causes of medical errors and make systemic improvements without the fear of litigation that exists in States without liability reform.

A Recurring Crisis, Yet Washington Has Failed to Act

Medical malpractice reform has surfaced as a national issue repeatedly over recent decades during periods of "crisis." A 2004 survey found that three out of four emergency rooms had to divert ambulances because of a shortage of specialists due to medical liability issues.[12] The evidence from States like California that medical liability reform works has been available for over three decades. Unnecessary costs and defensive medicine have a negative effect on the Federal health care programs of Medicare and Medicaid.[13]

President Obama has repeatedly expressed his support for meaningful medical liability reform. In a 2009 speech before the AMA, the President acknowledged that defensive medicine leads to more tests and needless costs because doctors must protect themselves from frivolous lawsuits.[14] Again, during a speech to a Joint Session of Congress in September 2009, President Obama said "I don't believe malpractice reform is a silver bullet, but I've talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs."[15] In his 2011 State of the Union address, President Obama again included medical liability reform as part of his agenda.[16]

A common question from the American people is why there were no meaningful medical liability reform provisions in the health reform law. An October 2009 survey conducted by the

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[10] *Mello MM, Brennan TA. Deterrence of medical errors: theory and evidence for malpractice reform. Texas Law Review. 2002; 80:1595-638.*

[11] A. Russell Localio, JD, MPH, MS; Ann G. Lawthers, ScD; Joan M. Bengtson, MD; Liesi E. Hebert, ScD; Susan L. Weaver; Troyen A. Brennan, MD, JD; J. Richard Landis, PhD, Relationship Between Malpractice Claims and Cesarean Delivery, JAMA. 1993;269(3):366-373.

[12] Hospital Emergency Department Administration Survey, "Federal Medical Liability Reform," 2004, the Schumacher Group, *Alliance of Specialty Medicine*, July 2005.

[13] Under Medicare, the federal government pays a percentage of doctors' liability premiums through the practice expense component of the physician fee schedule. The federal government also incurs costs because of defensive medicine.

[14] The text of the June 2009 speech can be found here: http://www.whitehouse.gov/the-press-office/remarks-president-annual-conference-american-medical-association.

[15] The text of this address can be found here: http://www.whitehouse.gov/the-press-office/remarks-president-a-joint-session-congress-health-care.

[16] In his January 25, 2011, State of the Union address, President Obama specifically called for "medical malpractice reform to rein in frivolous lawsuits." On January 27, Republicans on the Committee wrote directly to the President seeking his leadership in crafting such legislation. There has been no response from the Administration.

Health Coalition on Liability and Access found that 69 percent of Americans wanted medical liability reform included in health care reform legislation.[17] One of the most truthful answers came from Governor Howard Dean when he commented as follows on the House bill (H.R. 3200):

> Here's why tort reform is not in the bill. When you go to pass a really enormous bill like that, the more stuff you put in it, the more enemies you make, right? And the reason that tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers in addition to everyone else they were taking on. And that is the plain and simple truth.[18]

As Shown by the States, Comprehensive Reform Will Increase Patient Access to Quality Care While Reducing Costs

States that have adopted caps have seen tremendous benefits. Patients who are harmed are still compensated 100 percent for economic losses (anything to which a receipt can be attached), suffered as the result of a health care injury. California's landmark legislation, the Medical Injury Compensation Reform Act of 1975 (MICRA) signed into law by Governor Jerry Brown (D), helped to stabilize the California medical liability insurance market. From 1976 through 2009, California's medical liability insurance premiums increased by 261 percent compared to a total increase of 945 percent for the other 49 States.[19]

Additionally, Texas adopted comprehensive medical malpractice reform, including caps on non-economic damages, in 2003, and these reforms have yielded remarkable outcomes, including an increase in new physicians, additional obstetricians, and reduced medical liability premiums. From 2003 through 2009, the Texas Medical Board saw an increase of roughly 60 percent in their new physician licensure applications.[20] While other states were losing obstetricians, Texas actually gained obstetricians. The number of obstetricians in Texas increased by 218 between 2002 and 2009 to a total of 2,444.[21] Finally, all major physician liability carriers in Texas have reduced their rates resulting in nearly all Texas physicians having their premiums lowered by at least 30 percent and some by well over 40 percent since 2004.[22]

Caps on non-economic damages do not deny injured patients the ability to have their cases heard. States that have enacted caps have not seen a significant reduction in the *number* of claims, only in the number of unpredictable and unreasonably large awards for pain and

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[17] 112th Congress Committee on the Judiciary Report on the "Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2011."

[18] http://washingtonexaminer.com/blogs/beltway-confidential/2009/08/dean-says-obamacare-authors-dont-want-challenge-trial-lawyers.

[19] The American Medical Association's written testimony for January 20, 2011, House Judiciary Committee hearing: http://www.ama-assn.org/ama1/pub/upload/mm/399/ama-statement-medical-liability-reform-2011.pdf

[20] Texas Medical Association's "Proposition 12 Produces Healthy Benefits": http://www.texmed.org/Template.aspx?id=5238.

[21] The chart detailing obstetricians in Texas can be found here: http://www.tapa.info/Downloads/Improving_Access/2010_Charts/06_TAPA_Obstetricians.pdf.

[22] Texas Medical Association "Professional Liability Insurance Reform": http://www.texmed.org/Template.aspx?id=780.

suffering.[23] States that have not enacted reform continue to allow a few patients and their attorneys unlimited awards while everyone else is burdened with limited health care and rising costs.

Twenty-eight States have enacted meaningful medical liability reform that includes, among other provisions, a cap on non-economic damages, while twenty-two States continue to operate within the national health care system without meaningful liability reform.[24] In States with caps on non-economic damages, liability premiums are 17 percent lower than they are in States without such caps.[25]

In those States that have enacted meaningful reform, malpractice premiums are affordable, defensive medicine costs are lower and patients have greater access to care when and where they need it. For example, two thorough studies that used national data on Medicare populations concluded that States with medical liability reforms saw an average reduction of 4.3 percent in hospital costs for patients in managed care programs.[26] This is not the case in States that have refused to enact meaningful reform.

In States without liability reform, the system does not serve anyone except trial lawyers. Injured patients are not compensated in a timely or equitable way. They are forced to wade through several years of litigation and receive, on average, only 46 cents of every dollar awarded while the remaining 54 cents goes to their lawyers and other administrative fees.[27]

State reforms show that comprehensive medical liability reform, that includes caps on non-economic damage awards, will improve patients' access to quality care while reducing the overall cost of health care in America.

HEARINGS

ACA Funding Provisions

The Subcommittee on Health held hearings on Prevention and Public Health Funds during the first session of the 112th Congress. On March 9, 2011, the Subcommittee held a hearing entitled "Setting fiscal Priorities in Health Care Funding." The Subcommittee received testimony from the Honorable Earnest Istook, Distinguished Fellow, the Heritage Foundation; Dr. John C. Goodman, President and CEO, National Center for Policy Analysis; and the Honorable Joseph F. Vitale, New Jersey State Senate.

Medicaid

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[23] In July 2007, a Los Angeles County Court awarded a plaintiff over $96 million in damages while abiding by MICRA's $250,000 cap on non-economic damages. www.micra.org.

[24] AANS/CNS PowerPoint Presentation "The State of Medical Liability Reform: Successes and Challenges for the Future", February 19, 2010.

[25] "The Medical Malpractice 'Crisis': Trends and the Impact of State Tort Reforms," Kenneth E. Thorpe, (January 21, 2004) at 20-30.

[26] Daniel P. Kessler and Mark B. McClellan, "Medical Liability, Managed Care, and Defensive Medicine," National Bureau of Economic Research (NBER) Working Paper 7537 (February 2000) at 16.

[27] NEJM "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation.": http://www.nejm.org/doi/full/10.1056/ NEJMsa054479.

The full Committee and the Subcommittee on Health held hearings on Medicaid reform during the first session of the 112th Congress. On Tuesday, March 1, 2011, the full Committee held a hearing entitled "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform." The Committee received testimony from Utah Governor Gary R. Hubert, Mississippi Governor Haley Barbour, and Massachusetts Governor Deval Patrick.

Medical Liability

The Subcommittee on Health held hearings on Medical Liability during the first session of the 112th Congress. On April 6, 2011, the Subcommittee held a hearing entitled "The Cost of the Medical Liability System Proposals for Reform, including H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011." The Subcommittee received testimony from Dr. Lisa M. Hollier, MPH, American College of Obstetricians and Gynecologists Fellow, Professor and Director of the Lyndon B Jonson Residency Program at the University of Texas Medical School at Houston; Dr. Allen B. Kachalia, Esq., Medical Director of Quality and Safety, Brigham and Women's Hospital, Harvard Medical School; and Dr. Troy M. Tippetts, Past President, American Association of Neurological Surgeons and Past President, Florida Medical Association.

COMMITTEE CONSIDERATION

On April 24 and 25, 2012, the Committee met in open markup session to consider the Committee Prints entitled "Title I—Repeal of Certain ACA Funding Provisions," "Title II—Medicaid," and "Title III—Liability Reform." A motion by Mr. Upton to transmit the Committee Prints as the recommendations of the Committee, and all appropriate accompanying material, including additional, supplemental, or dissenting views, to the House Committee on the Budget, in order to comply with the reconciliation directive included in section 201 of H. Con. Res. 112, establishing the budget for the United States Government for fiscal year 2013 and setting forth appropriate budgetary levels for fiscal years 2014 through 2022, and consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974, was agreed to by a voice vote.

COMMITTEE VOTES

Clause 3(b) of Rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the recorded votes taken on amendments offered to the Committee Prints.

[INSERT VOTES]

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of Rule XIII of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portions of this report, including the finding that reigning in mandatory spending is necessary to avoid a debt crisis.

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 89

BILL: Committee Print, Title I—Repeal of Certain ACA Funding Provisions

AMENDMENT: An amendment offered by Mr. Pallone, No. 1, to provide that section 101 shall not apply to a State award unless the Governor certified that the State prefers not to have a Federal exchange and wants to establish and operate such an exchange.

DISPOSITION: NOT AGREED TO, by a roll call vote of 16 yeas and 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton				Mr. Dingell			
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns			
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green			
Mr. Rogers				Ms. DeGette			
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy				Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin			
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen			
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

04/25/2012

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 90

BILL: Committee Print, Title I—Repeal of Certain ACA Funding Provisions

AMENDMENT: An amendment offered by Mr. Gonzalez, No. 2, to provide that section 101 shall not apply to awards for the Small Business Health Options Program.

DISPOSITION: NOT AGREED TO, by roll call vote of 20 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell			
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

04/25/2012

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 91

BILL: Committee Print, Title I—Repeal of Certain ACA Funding Provisions

AMENDMENT: An amendment offered by Ms. Eshoo, No. 3, section 101 shall not apply for a State award for the use of certifying health plans as qualified health plans that satisfy applicable requirements for not having lifetime or annual limits.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

04/25/2012

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 92

BILL: Committee Print, Title I—Repeal of Certain ACA Funding Provisions

AMENDMENT: An amendment offered by Ms. Schakowsky, No. 4, to provide that section 101 shall not apply to awards for corrective actions related to rate review.

DISPOSITION: NOT AGREED TO, by roll call vote of 18 yeas and 33 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross		X	
Mr. Bass		X		Mr. Matheson		X	
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow		X	
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 93

BILL: Committee Print, Title I—Repeal of Certain ACA Funding Provisions

AMENDMENT: An amendment offered by Mrs. Capps, No. 5, to provide that section 102 shall not take effect until Healthy People 2020 goals have been met.

DISPOSITION: NOT AGREED TO, by a roll call vote of 22 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle	X		
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 94

BILL: Committee Print, Title I—Repeal of Certain ACA Funding Provisions

AMENDMENT: An amendment offered by Ms. Matsui, No. 6, to provide that section 102 shall not take effect until the date that the health objectives in Healthy People 2020 relating to older adults have been met.

DISPOSITION: NOT AGREED TO, by roll call vote of 22 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle	X		
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 95

BILL: Committee Print, Title I—Repeal of Certain ACA Funding Provisions

AMENDMENT: An amendment offered by Ms. Schakowsky, No. 7, to provide that section 102 shall not apply to programs to provide breast cancer, cervical screenings, and other preventive health services for women.

DISPOSITION: NOT AGREED TO, by a roll call vote of 22 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle	X		
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 96

BILL: Committee Print, Title I—Repeal of Certain ACA Funding Provisions

AMENDMENT: A motion by Mr. Upton to agree to the Committee Print. (Final Passage)

DISPOSITION: AGREED TO, as amended, by a roll call vote of 30 yeas and 22 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Dingell		X	
Mr. Stearns	X			Mr. Markey		X	
Mr. Whitfield	X			Mr. Towns		X	
Mr. Shimkus	X			Mr. Pallone		X	
Mr. Pitts	X			Mr. Rush		X	
Mrs. Bono Mack	X			Ms. Eshoo		X	
Mr. Walden	X			Mr. Engel		X	
Mr. Terry	X			Mr. Green		X	
Mr. Rogers				Ms. DeGette		X	
Mrs. Myrick	X			Mrs. Capps		X	
Mr. Sullivan	X			Mr. Doyle		X	
Mr. Murphy	X			Ms. Schakowsky		X	
Mr. Burgess	X			Mr. Gonzalez		X	
Mrs. Blackburn	X			Ms. Baldwin		X	
Mr. Bilbray	X			Mr. Ross		X	
Mr. Bass	X			Mr. Matheson		X	
Mr. Gingrey	X			Mr. Butterfield		X	
Mr. Scalise	X			Mr. Barrow		X	
Mr. Latta	X			Ms. Matsui		X	
Mrs. McMorris Rodgers	X			Mrs. Christensen		X	
Mr. Harper	X			Ms. Castor		X	
Mr. Lance	X			Mr. Sarbanes			
Mr. Cassidy	X						
Mr. Guthrie	X						
Mr. Olson	X						
Mr. McKinley	X						
Mr. Gardner	X						
Mr. Pompeo	X						
Mr. Kinzinger	X						
Mr. Griffith	X						

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 97

BILL: Committee Print, Title II—Medicaid

AMENDMENT: A motion offered by Mr. Sarbanes, No. 1a, second degree amendment to the Barton amendment that would continue the performance bonus payments program beyond its Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) statutory expiration by allowing for the redirection of CHIP funds from the allocations and contingency fund to the performance bonus payments after fiscal year 2013.

DISPOSITION: NOT AGREED TO, by a roll call vote of 18 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey			
Mr. Whitfield		X		Mr. Towns			
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush			
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette			
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 98

BILL: Committee Print, Title II—Medicaid

AMENDMENT: An amendment by Mr. Barton, No. 1, to rescind the performance bonus payments to States that were created in CHIPRA.

DISPOSITION: AGREED TO, by a roll call vote of 30 yeas and 21 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Dingell		X	
Mr. Stearns	X			Mr. Markey		X	
Mr. Whitfield	X			Mr. Towns		X	
Mr. Shimkus	X			Mr. Pallone		X	
Mr. Pitts	X			Mr. Rush		X	
Mrs. Bono Mack	X			Ms. Eshoo		X	
Mr. Walden	X			Mr. Engel		X	
Mr. Terry	X			Mr. Green		X	
Mr. Rogers				Ms. DeGette		X	
Mrs. Myrick	X			Mrs. Capps		X	
Mr. Sullivan	X			Mr. Doyle			
Mr. Murphy	X			Ms. Schakowsky		X	
Mr. Burgess	X			Mr. Gonzalez		X	
Mrs. Blackburn	X			Ms. Baldwin		X	
Mr. Bilbray	X			Mr. Ross		X	
Mr. Bass	X			Mr. Matheson		X	
Mr. Gingrey	X			Mr. Butterfield		X	
Mr. Scalise	X			Mr. Barrow		X	
Mr. Latta	X			Ms. Matsui		X	
Mrs. McMorris Rodgers	X			Mrs. Christensen		X	
Mr. Harper	X			Ms. Castor		X	
Mr. Lance	X			Mr. Sarbanes			
Mr. Cassidy	X						
Mr. Guthrie	X						
Mr. Olson	X						
Mr. McKinley	X						
Mr. Gardner	X						
Mr. Pompeo	X						
Mr. Kinzinger	X						
Mr. Griffith	X						

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 99

BILL: Committee Print, Title II—Medicaid

AMENDMENT: An amendment offered by Mrs. Christensen, No. 2, to strike section 204, which returns Medicaid funding levels for the U.S. territories to pre-PPACA and pre-ARRA levels.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 100

BILL: Committee Print, Title II—Medicaid

AMENDMENT: An amendment offered by Mr. Pallone, No. 3, to amend Section 201 by carving out nursing facilities from the new 5.5% tax threshold.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas and 29 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan				Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 101

BILL: Committee Print, Title II—Medicaid

AMENDMENT: An amendment offered by Mr. Engel, No. 4, to strike section 202, which rebases the State DSH allotments for fiscal year 2022.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 102

BILL: Committee Print, Title II—Medicaid

AMENDMENT: An amendment offered by Ms. Baldwin, No. 5, to amend section 203 of to prevent the repeal of the Maintenance of Effort (MOE) until the Secretary of HHS can certify that disabled children or dual-eligibles are not affected by its repeal.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 103

BILL: Committee Print, Title II—Medicaid

AMENDMENT: An amendment offered by Mr. Markey, No. 6, to require government negation of Part-D prescription drug prices.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas and 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson	X		
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 104

BILL: Committee Print, Title II—Medicaid

AMENDMENT: A motion by Mr. Upton to agree to the Committee Print, as amended. (Final Passage)

DISPOSITION: AGREED TO, as amended, by a roll call vote of 30 yeas and 20 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Dingell		X	
Mr. Stearns	X			Mr. Markey		X	
Mr. Whitfield	X			Mr. Towns		X	
Mr. Shimkus	X			Mr. Pallone		X	
Mr. Pitts	X			Mr. Rush			
Mrs. Bono Mack	X			Ms. Eshoo		X	
Mr. Walden	X			Mr. Engel		X	
Mr. Terry	X			Mr. Green		X	
Mr. Rogers				Ms. DeGette		X	
Mrs. Myrick	X			Mrs. Capps		X	
Mr. Sullivan	X			Mr. Doyle			
Mr. Murphy	X			Ms. Schakowsky		X	
Mr. Burgess	X			Mr. Gonzalez		X	
Mrs. Blackburn	X			Ms. Baldwin		X	
Mr. Bilbray	X			Mr. Ross		X	
Mr. Bass	X			Mr. Matheson		X	
Mr. Gingrey	X			Mr. Butterfield		X	
Mr. Scalise	X			Mr. Barrow		X	
Mr. Latta	X			Ms. Matsui		X	
Mrs. McMorris Rodgers	X			Mrs. Christensen		X	
Mr. Harper	X			Ms. Castor		X	
Mr. Lance	X			Mr. Sarbanes			
Mr. Cassidy	X						
Mr. Guthrie	X						
Mr. Olson	X						
Mr. McKinley	X						
Mr. Gardner	X						
Mr. Pompeo	X						
Mr. Kinzinger	X						
Mr. Griffith	X						

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COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 105

BILL: Committee Print, Title III—Liability Reform

AMENDMENT: An amendment offered by Ms. Baldwin, No. 1, to provide that the Committee Print does not preempt any State law pertaining to medical malpractice or medical product liability case.

DISPOSITION: NOT AGREED TO, by a roll call vote of 22 yeas and 29 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry	X			Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson		X	
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith	X						

04/25/2012

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 106

BILL: Committee Print, Title III—Liability Reform

AMENDMENT: An amendment offered by Mr. Barrow, No. 2, to provide that the Committee Print does not preempt or supersede any State constitution, including provisions construed by State case law.

DISPOSITION: NOT AGREED TO, by a roll call vote of 22 yeas and 29 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry	X			Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson		X	
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith	X						

04/25/2012

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 107

BILL: Committee Print, Title III—Liability Reform

AMENDMENT: An amendment offered by Ms. Castor, No. 3, to provide that the Committee Print does not apply to causes of action arising out of PPACA for services related to women's preventative health services.

DISPOSITION: NOT AGREED TO, by a roll call vote of 20 yeas and 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle			
Mr. Murphy		X		Ms. Schakowsky	X		
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Ms. Baldwin	X		
Mr. Bilbray		X		Mr. Ross	X		
Mr. Bass		X		Mr. Matheson		X	
Mr. Gingrey		X		Mr. Butterfield	X		
Mr. Scalise		X		Mr. Barrow	X		
Mr. Latta		X		Ms. Matsui	X		
Mrs. McMorris Rodgers		X		Mrs. Christensen	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes			
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

04/25/2012

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 108

BILL: Committee Print, Title III—Liability Reform

AMENDMENT: A motion by Mr. Upton to agree to the Committee Print. (Final Passage)

DISPOSITION: AGREED TO, by a roll call vote of 29 yeas and 22 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Dingell		X	
Mr. Stearns	X			Mr. Markey		X	
Mr. Whitfield	X			Mr. Towns		X	
Mr. Shimkus	X			Mr. Pallone		X	
Mr. Pitts	X			Mr. Rush		X	
Mrs. Bono Mack	X			Ms. Eshoo		X	
Mr. Walden	X			Mr. Engel		X	
Mr. Terry		X		Mr. Green		X	
Mr. Rogers				Ms. DeGette		X	
Mrs. Myrick	X			Mrs. Capps		X	
Mr. Sullivan	X			Mr. Doyle			
Mr. Murphy	X			Ms. Schakowsky		X	
Mr. Burgess	X			Mr. Gonzalez		X	
Mrs. Blackburn	X			Ms. Baldwin		X	
Mr. Bilbray	X			Mr. Ross		X	
Mr. Bass	X			Mr. Matheson	X		
Mr. Gingrey	X			Mr. Butterfield		X	
Mr. Scalise	X			Mr. Barrow		X	
Mr. Latta	X			Ms. Matsui		X	
Mrs. McMorris Rodgers	X			Mrs. Christensen		X	
Mr. Harper	X			Ms. Castor		X	
Mr. Lance	X			Mr. Sarbanes			
Mr. Cassidy	X						
Mr. Guthrie	X						
Mr. Olson	X						
Mr. McKinley	X						
Mr. Gardner	X						
Mr. Pompeo	X						
Mr. Kinzinger	X						
Mr. Griffith		X					

04/25/2012

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of Rule XIII of the Rules of the House of Representatives, the performance goals and objectives of the Committee are reflected in the descriptive portions of this report, including the goal of avoiding a debt crisis by reigning in mandatory spending.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of Rule XIII of the Rules of the House of Representatives, the Committee finds that the Committee Prints would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK

In compliance with clause 9(e), 9(f), and 9(g) of Rule XXI, the Committee finds that the Committee Prints contain no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of Rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

[INSERT]

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 7 of Rule XII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Title I – Repeal of Certain ACA Funding Provisions

Section 101. Repealing Mandatory Funding to States to Establish American Health Benefit Exchanges

Section 101 repeals section 1311(a) of the Patient Protection and Affordable Care Act (PPACA), which provided the Secretary of Health and Human Services (HHS) the authority to provide grants to states for activities related to the establishment of American Health Benefit Exchanges. The subsection also provided to the Secretary an appropriation with no monetary cap. Section 101 also rescinds the unobligated balance of funds made available under section 1311(a).

Section 102. Repealing Prevention and Public Health Fund.

Section 102 repeals section 4002 of the PPACA, which created the Prevention and Public Health Fund. The fund provided the Secretary of HHS with a permanent annual appropriation to supplement the spending on any program within the Public Health Services Act (PHSA). Section 102 also rescinds the unobligated balance of funds made available under section 4002.

Section 103. Rescinding Unobligated Balances for CO-OP Program.

Section 103 rescinds the unobligated balance of funds made available under section 1322(g) of the PPACA related to the Consumer Operated and Oriented Plan (CO-OP) program. The CO-OP program provides government subsidized loans to qualified nonprofit health insurance issuers.

Title II – Medicaid

Section 201. Revision of Provider Tax Indirect Guaranteed Threshold

Section 201 amends section 1903(w)(4)(C)(ii) of the Social Security Act to adjust the provider tax hold harmless threshold from 6 to 5.5 percent for portions of fiscal years beginning on or after October 1, 2012.

Section 202. Rebasing of State DSH Allotments for Fiscal Year 2022.

Section 202 amends section 1923(f) of the Social Security Act to extend the reductions in disproportionate share hospital allotments as first proposed in the PPACA into fiscal year 2022.

Section 203.Repeal of Medicaid and CHIP Maintenance of Effort Requirements Under PPACA.

Section 204 amends section 1902 of the Social Security Act to repeal certain state Medicaid maintenance of effort requirements as enacted by PPACA. Section 204 also amends section

2105(d)(3) of the Social Security Act to repeal certain State CHIP maintenance of effort requirements as enacted by PPACA. Both amendments are effective upon date of enactment.

Section 204. Medicaid Payment to Territories.

Section 205 amends Section 1108(g) of the Social Security Act to repeal the $6.3 billion in additional payments to the United States Territories levels as provided in PPACA. Section 205 also amends Section 1905(b) of the Social Security Act to reduce the Federal Medicaid Assistance Payment (FMAP) to the territories from 55 percent to 50 percent.

Section 205. Repealing Bonus Payments for Enrollment Under Medicaid and CHIP.

Mr. Barton offered an amendment adding section 205 (Mr. Barton's amendment was adopted by a roll call vote of 30 yeas and 21 nays). Section 205 rescinds the performance bonus payments to states that were created in the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). These bonus payments are awarded to states that increase their Medicaid enrollment above a defined baseline from the prior year and loosen eligibility review procedures.

Title III – Liability Reform

Section 301. Findings and Purpose

Section 301 states the findings and purpose of the bill.

Section 302. Encouraging Speedy Resolution of Claims

Section 302 states that a health care lawsuit shall be commenced three years after the date of manifestation of injury or one year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. There is an exception for alleged injuries sustained by a minor before the age of 6, in which case a health care lawsuit may be commenced by or on behalf of the minor until the later of three years from the date of manifestation of injury, or the date on which the minor attains the age of 8.

Section 303. Compensating Patient Injury

Section 303 sets forth guidelines regarding patients' ability to recover for certain types of damages. This section provides that in any health care lawsuit, nothing in this Act shall limit a claimant's recovery for the full amount of available economic damages, notwithstanding the limitation on non-economic damages. Under this section, there can be no more than $250,000 in non-economic damages 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 injury. Future noneconomic damages shall not be discounted to present value.

This section also provides that each party shall be liable for the amount of damages allocated to such party. This allocation shall be determined in direct proportion to such party's percentage of responsibility for the damages.

Section 304. Maximizing Patient Recovery

Section 304 requires that courts supervise the arrangements for payment of damages to protect against conflicts of interests that may have the effect of reducing the actual amount of the award paid to the claimant.

This section also establishes a sliding fee schedule for the payment of attorneys' contingency fees. Payments are allocated as follows: 40 percent of the first $50,000 recovered by the claimant; 33 1/3 percent of the next $50,000 recovered by the claimant; 25 percent of the next $500,000 recovered by the claimant; and 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

Section 305. Additional Health Benefits

Section 305 ensures that, in any health care lawsuit involving injury or wrongful death, a party may introduce evidence of collateral source benefits received, or reasonably likely to be received, from other parties. This section also restricts a provider of collateral source benefits from subrogating a claimant's recovery or obtaining any lien or credit against the claimant's damage award.

Section 306. Punitive Damages

Section 306 specifies guidelines for awarding punitive damages. Under this section, punitive damages may be awarded, if otherwise permitted by applicable State or Federal law, against any person in a health care lawsuit if it is proven by clear and convincing evidence that the person acted with malicious intent to injure the claimant, or that the person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

This section also sets guidelines for determining the amount of punitive damages. The amount of punitive damages awarded may be as high as two times the amount of economic damages awarded or $250,000, whichever amount is greater.

In addition, this section shields from punitive damages those companies that are fully compliant with all Federal Food, Drug, and Cosmetic Act (FFDCA) laws and regulations (in the case of biological medical products, full compliance with the FFDCA and section 351 of the PHSA.

Section 307. Authorization of Payment of Future Damages to Claimants in Health Care Lawsuits

Section 307 requires the court, at the request of any party, to order that the award of future damages equaling or exceeding $50,000 be paid by periodic payments.

Section 308. Definitions

Section 308 defines many of the terms included in the legislation.

Section 309. Effect on Other Laws

Section 309 states that this legislation does not apply to civil actions brought for a vaccine-related injury or death, which is covered under provisions of the PHSA. It also states that nothing in the Act should affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

Section 310. State Flexibility and Protection of State's Rights

Section 310 specifies many of the rules governing the relationship between the HEALTH Act and State and Federal laws. Specifically, this section provides that provisions governing health care lawsuits outlined in the legislation preempt State law to the extent that State law prevents the application of these provisions.

The legislation also supersedes the Federal Tort Claims Act (FTCA) to the extent that the FTCA 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 application of periodic payments of future damages. The FTCA also is superseded if it prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

Section 310. Applicability; Eeffective Date

Section 310 states that the provisions of the legislation apply to any health care lawsuit brought in Federal or State court, or subject to alternative dispute resolutions system, that is initiated on or after the date of the enactment of the Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of the Act is governed by the applicable statute of limitations provision in effect at the time the injury occurred.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

[Insert text here]

CHANGES IN EXISTING LAW MADE BY TITLE II, AS TRANSMITTED BY THE COMMITTEE ON ENERGY AND COMMERCE

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by title II, as transmitted by the Committee on Energy and Commerce, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * * * *

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

* * * * * * *

Subtitle D—Available Coverage Choices for All Americans

* * * * * * *

PART 2—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

[(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.—

[(1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

[(2) AMOUNT SPECIFIED.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

[(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

[(4) RENEWABILITY OF GRANT.—

[(A) IN GENERAL.—Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

[(i) is making progress, as determined by the Secretary, toward—

[(I) establishing an Exchange; and

[(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

[(ii) is meeting such other benchmarks as the Secretary may establish.

[(B) LIMITATION.—No grant shall be awarded under this subsection after January 1, 2015.

[(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.—The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.]

* * * * * * *

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

* * * * * * *

[SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.

[(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the "Fund"), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

[(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

[(1) for fiscal year 2010, $500,000,000;

[(2) for each of fiscal years 2012 through 2017, $1,000,000,000;

[(3) for each of fiscal years 2018 and 2019, $1,250,000,000;

[(4) for each of fiscal years 2020 and 2021, $1,500,000,000; and

[(5) for fiscal year 2022, and each fiscal year thereafter, $2,000,000,000.

[(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs.

[(d) TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).]

* * * * * * *

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

PART A—GENERAL PROVISIONS

* * * * * * *

SEC. 1108. ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS.

(a) * * *

* * * * * * *

(g) MEDICAID PAYMENTS TO TERRITORIES FOR FISCAL YEAR 1998 AND THEREAFTER.—

(1) * * *

(2) FISCAL YEAR 1999 AND THEREAFTER.—Notwithstanding subsection (f) and subject to *paragraph (3)* and section 1323(a)(2) of the Patient Protection and Affordable Care Act [paragraphs (3) and (5)], with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under title XIX for payment to—

(A) * * *

* * * * * * *

(4) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal years beginning with fiscal year 2009, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1903(a)(3) for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), [(3), and (4) of this subsection] *and (3) of this subsection*) to such commonwealth or territory for such fiscal year.

[(5) ADDITIONAL INCREASE.—The Secretary shall increase the amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa (after the application of subsection (f) and the preceding paragraphs of this subsection) for the period beginning July 1, 2011, and ending on September 30, 2019, by such amounts that the total additional payments under title XIX to such territories equals $6,300,000,000 for such period. The Secretary shall increase such amounts in pro-

portion to the amounts applicable to such territories under this subsection and subsection (f) on the date of enactment of this paragraph.]

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

[(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg); and]

* * * * * * *

(e)(1) * * *

* * * * * * *

(14) INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—

(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. [For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan.] The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that

States establish income and eligibility determination systems that protect beneficiaries.

* * * * * * *

[(gg) MAINTENANCE OF EFFORT.—

[(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

[(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

[(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

[(4) DETERMINATION OF COMPLIANCE.—

[(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.—A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protec-

tion and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

[(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).]

* * * * * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(w)(1) * * *

* * * * * * *

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) * * *

* * * * * * *

(C)(i) * * *

(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, *and for portions of fiscal years beginning on or after October 1, 2012,* "5.5 percent" shall be substituted for "6 percent" each place it appears.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures

under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) * * *

(b) Subject to subsections (y), (z), and (aa) and section 1933(d), the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa [shall be 55 percent] *shall be 50 percent*, (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII). The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1923) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 2104, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).

* * * * * * *

ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

SEC. 1923. (a) * * *

* * * * * * *

(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

(1) * * *

* * * * * * *

(3) STATE DSH ALLOTMENTS FOR FISCAL YEAR 2003 AND THEREAFTER.—

(A) IN GENERAL.—Except as provided in [paragraphs (6), (7), and (8)] *paragraphs (6), (7), (8), and (9)* and subparagraph (E), the DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraphs (B) and (C) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

* * * * * * *

(9) REBASING OF STATE DSH ALLOTMENTS FOR FISCAL YEAR 2022.—With respect to fiscal 2022, for purposes of applying paragraph (3)(A) to determine the DSH allotment for a State, the amount of the DSH allotment for the State under paragraph (3) for fiscal year 2021 shall be treated as if it were such amount as reduced under paragraph (7).

[(9)] *(10)* DEFINITION OF STATE.—In this subsection, the term "State" means the 50 States and the District of Columbia.

* * * * * * *

TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

* * * * * * *

SEC. 2104. ALLOTMENTS.

(a) * * *

* * * * * * *

(n) CHILD ENROLLMENT CONTINGENCY FUND.—

(1) * * *

(2) DEPOSITS INTO FUND.—

(A) * * *

* * * * * * *

[(D) AVAILABILITY OF EXCESS FUNDS FOR PERFORMANCE BONUSES.—Any amounts in excess of the aggregate cap described in subparagraph (B) for a fiscal year or period shall be made available for purposes of carrying out section 2105(a)(3) for any succeeding fiscal year and the Secretary of the Treasury shall reduce the amount in the Fund by the amount so made available.]

* * * * * * *

SEC. 2105. PAYMENTS TO STATES.

(a) PAYMENTS.—

(1) * * *

* * * * * * *

[(3) PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL MEDICAID AND CHIP CHILD ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.—

[(A) IN GENERAL.—In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2013), the Secretary shall pay from amounts made available under subparagraph (E), to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

[(B) AMOUNT FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—Subject to subparagraph (E), the amount described in this subparagraph for a State for a fiscal year is equal to the sum of the following amounts:

[(i) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year, multiplied by 15 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)) for the State and fiscal year under title XIX.

[(ii) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under title XIX for the State and fiscal year, multiplied by 62.5 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)) for the State and fiscal year under title XIX.

[(C) NUMBER OF FIRST AND SECOND TIER ABOVE BASELINE CHILD ENROLLEES; BASELINE NUMBER OF CHILD ENROLLEES.—For purposes of this paragraph:

[(i) FIRST TIER ABOVE BASELINE CHILD ENROLLEES.—The number of first tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

[(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under the State plan under title XIX; exceeds

[(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under title XIX;

but not to exceed 10 percent of the baseline number of enrollees described in subclause (II).

[(ii) SECOND TIER ABOVE BASELINE CHILD ENROLLEES.—The number of second tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

[(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under title XIX as described in clause (i)(I); exceeds

[(II) the sum of the baseline number of child enrollees described in clause (iii) for the State and fiscal year under title XIX, as described in clause (i)(II), and the maximum number of first tier above baseline child enrollees for the State and fiscal year under title XIX, as determined under clause (i).

[(iii) BASELINE NUMBER OF CHILD ENROLLEES.—Subject to subparagraph (H), the baseline number of child enrollees for a State under title XIX—

[(I) for fiscal year 2009 is equal to the monthly average unduplicated number of qualifying children enrolled in the State plan under title XIX during fiscal year 2007 increased by the population growth for children in that State from 2007 to 2008 (as estimated by the Bureau of the Census) plus 4 percentage points, and further increased by the population growth for children in that State from 2008 to 2009 (as estimated by the Bureau of the Census) plus 4 percentage points;

[(II) for each of fiscal years 2010, 2011, and 2012, is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the respective fiscal year begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 3.5 percentage points;

[(III) for each of fiscal years 2013, 2014, and 2015, is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the respective fiscal year begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 3 percentage points; and

[(IV) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the fiscal year involved begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 2 percentage points.

[(D) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—For purposes of subparagraph (B), the projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita

expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

[(E) AMOUNTS AVAILABLE FOR PAYMENTS.—

[(i) INITIAL APPROPRIATION.—Out of any money in the Treasury not otherwise appropriated, there are appropriated $3,225,000,000 for fiscal year 2009 for making payments under this paragraph, to be available until expended.

[(ii) TRANSFERS.—Notwithstanding any other provision of this title, the following amounts shall also be available, without fiscal year limitation, for making payments under this paragraph:

[(I) UNOBLIGATED NATIONAL ALLOTMENT.—

[(aa) FISCAL YEARS 2009 THROUGH 2012.—As of December 31 of fiscal year 2009, and as of December 31 of each succeeding fiscal year through fiscal year 2012, the portion, if any, of the amount appropriated under subsection (a) for such fiscal year that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 2111 for such fiscal year.

[(bb) FIRST HALF OF FISCAL YEAR 2013.—As of December 31 of fiscal year 2013, the portion, if any, of the sum of the amounts appropriated under subsection (a)(16)(A) and under section 108 of the Children's Health Insurance Reauthorization Act of 2009 for the period beginning on October 1, 2012, and ending on March 31, 2013, that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

[(cc) SECOND HALF OF FISCAL YEAR 2013.—As of June 30 of fiscal year 2013, the portion, if any, of the amount appropriated under subsection (a)(16)(B) for the period beginning on April 1, 2013, and ending on September 30, 2013, that is unobligated for allotment to a State under subsection (m) for such fiscal year

or set aside under subsection (b)(2) of section 2111 for such fiscal year.

[(II) UNEXPENDED ALLOTMENTS NOT USED FOR REDISTRIBUTION.—As of November 15 of each of fiscal years 2010 through 2013, the total amount of allotments made to States under section 2104 for the second preceding fiscal year (third preceding fiscal year in the case of the fiscal year 2006, 2007, and 2008 allotments) that is not expended or redistributed under section 2104(f) during the period in which such allotments are available for obligation.

[(III) EXCESS CHILD ENROLLMENT CONTINGENCY FUNDS.—As of October 1 of each of fiscal years 2010 through 2013, any amount in excess of the aggregate cap applicable to the Child Enrollment Contingency Fund for the fiscal year under section 2104(n).

[(iii) PROPORTIONAL REDUCTION.—If the sum of the amounts otherwise payable under this paragraph for a fiscal year exceeds the amount available for the fiscal year under this subparagraph, the amount to be paid under this paragraph to each State shall be reduced proportionally.

[(F) QUALIFYING CHILDREN DEFINED.—

[(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iii), the term "qualifying children" means children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2008, for enrollment under title XIX, taking into account criteria applied as of such date under title XIX pursuant to a waiver under section 1115.

[(ii) LIMITATION.—A child described in clause (i) who is provided medical assistance during a presumptive eligibility period under section 1920A shall be considered to be a "qualifying child" only if the child is determined to be eligible for medical assistance under title XIX.

[(iii) EXCLUSION.—Such term does not include any children for whom the State has made an election to provide medical assistance under paragraph (4) of section 1903(v) or any children enrolled on or after October 1, 2013.

[(G) APPLICATION TO COMMONWEALTHS AND TERRITORIES.—The provisions of subparagraph (G) of section 2104(n)(3) shall apply with respect to payment under this paragraph in the same manner as such provisions apply to payment under such section.

[(H) APPLICATION TO STATES THAT IMPLEMENT A MEDICAID EXPANSION FOR CHILDREN AFTER FISCAL YEAR 2008.—In the case of a State that provides coverage under section 115 of the Children's Health Insurance Program Reauthor-

ization Act of 2009 for any fiscal year after fiscal year 2008—

[(i) any child enrolled in the State plan under title XIX through the application of such an election shall be disregarded from the determination for the State of the monthly average unduplicated number of qualifying children enrolled in such plan during the first 3 fiscal years in which such an election is in effect; and

[(ii) in determining the baseline number of child enrollees for the State for any fiscal year subsequent to such first 3 fiscal years, the baseline number of child enrollees for the State under title XIX for the third of such fiscal years shall be the monthly average unduplicated number of qualifying children enrolled in the State plan under title XIX for such third fiscal year.

[(4) ENROLLMENT AND RETENTION PROVISIONS FOR CHILDREN.—For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year if it is implementing at least 5 of the following enrollment and retention provisions (treating each subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year:

[(A) CONTINUOUS ELIGIBILITY.—The State has elected the option of continuous eligibility for a full 12 months for all children described in section 1902(e)(12) under title XIX under 19 years of age, as well as applying such policy under its State child health plan under this title.

[(B) LIBERALIZATION OF ASSET REQUIREMENTS.—The State meets the requirement specified in either of the following clauses:

[(i) ELIMINATION OF ASSET TEST.—The State does not apply any asset or resource test for eligibility for children under title XIX or this title.

[(ii) ADMINISTRATIVE VERIFICATION OF ASSETS.—The State—

[(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under title XIX or child health assistance under this title to declare and certify by signature under penalty of perjury information relating to family assets for purposes of determining and redetermining financial eligibility; and

[(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

[(C) ELIMINATION OF IN-PERSON INTERVIEW REQUIREMENT.—The State does not require an application of a child for medical assistance under title XIX (or for child health assistance under this title), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless

there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

[(D) USE OF JOINT APPLICATION FOR MEDICAID AND CHIP.—The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under title XIX and child health assistance under this title.

[(E) AUTOMATIC RENEWAL (USE OF ADMINISTRATIVE RENEWAL).—

[(i) IN GENERAL.—The State provides, in the case of renewal of a child's eligibility for medical assistance under title XIX or child health assistance under this title, a pre-printed form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through electronic and other means, the information so provided.

[(ii) SATISFACTION THROUGH DEMONSTRATED USE OF EX PARTE PROCESS.—A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under title XIX or this title is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

[(F) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State is implementing section 1920A under title XIX as well as, pursuant to section 2107(e)(1), under this title.

[(G) EXPRESS LANE.—The State is implementing the option described in section 1902(e)(13) under title XIX as well as, pursuant to section 2107(e)(1), under this title.

[(H) PREMIUM ASSISTANCE SUBSIDIES.—The State is implementing the option of providing premium assistance subsidies under section 2105(c)(10) or section 1906A.]

* * * * * * *

(d) MAINTENANCE OF EFFORT.—

(1) * * *

* * * * * * *

(3) [CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019] *CONTINUITY OF COVERAGE*.—

[(A) IN GENERAL.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, as a condition of receiving payments under section 1903(a), a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (includ-

ing children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on the date of enactment of that Act. The preceding sentence shall not be construed as preventing a State during such period from—

[(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act;

[(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or

[(iii) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.]

[(B)] *(A)* ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act. For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.

[(C)] *(B)* CERTIFICATION OF COMPARABILITY OF PEDIATRIC COVERAGE OFFERED BY QUALIFIED HEALTH PLANS.—With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children

and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and shall certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan.

* * * * * * *

SEC. 2111. PHASE-OUT OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS; CONDITIONS FOR COVERAGE OF PARENTS.

(a) * * *

(b) RULES AND CONDITIONS FOR COVERAGE OF PARENTS OF TARGETED LOW-INCOME CHILDREN.—

(1) * * *

* * * * * * *

(3) OUTREACH OR COVERAGE BENCHMARKS.—For purposes of paragraph (2), the outreach or coverage benchmarks described in this paragraph are as follows:

(A) SIGNIFICANT CHILD OUTREACH CAMPAIGN.—The State—

(i) was awarded a grant under section 2113 for fiscal year 2011; *or*

[(ii) implemented 1 or more of the enrollment and retention provisions described in section 2105(a)(4) for such fiscal year; or**]**

* * * * * * *

[(C) STATE INCREASING ENROLLMENT OF LOW-INCOME CHILDREN.—The State qualified for a performance bonus payment under section 2105(a)(3)(B) for the most recent fiscal year applicable under such section.**]**

* * * * * * *

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

April 27, 2012

Reconciliation Recommendations of the House Committee on Energy and Commerce

As approved by the House Committee on Energy and Commerce on April 25, 2012

SUMMARY

H. Con. Res. 112, the Concurrent Budget Resolution for fiscal year 2013, as passed by the House of Representatives on March 29, 2012, instructed several committees of the House to recommend legislative changes that would reduce deficits over the 2012-2022 period. As part of this process, the House Committee on Energy and Commerce approved legislation on April 25, 2012, with a number of provisions that would reduce deficits.

In total, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would reduce deficits by about $2.9 billion over the 2012-2013 period, by $45.9 billion between 2012 and 2017, and by $113.4 billion over the 2012-2022 period, assuming enactment on or near October 1, 2012. These figures represent the net effect of changes in direct spending and revenues as a result of the legislation. About $1.4 billion of the reduction for 2012 through 2022 would be off-budget, from net increases in Social Security tax receipts.

In addition, the Chairman of the House Committee on the Budget has directed CBO to prepare estimates assuming a July 1, 2012, enactment date for this year's reconciliation proposals. If the legislation were enacted by that earlier date, some of the provisions would result in greater reductions in direct spending than those estimated assuming enactment on or near October 1, 2012. Under the alternative assumption of a July 1 enactment date, CBO and JCT estimate that the legislation would reduce deficits by $3.9 billion over the 2012-2013 period, by $48.0 billion between 2012 and 2017, and by $115.5 billion over the 2012-2022 period.

The Committee's recommendations would make the following changes:

- Title I would eliminate funding for certain provisions of the Affordable Care Act (ACA), by repealing the authority for the Secretary of Health and Human Services (HHS) to provide grants to states for establishing health insurance exchanges, repealing the Prevention and Public Health Fund, and rescinding funding for loans for the Consumer Operated and Oriented Plan (CO-OP) program.

- Title II would make changes to Medicaid and the Children's Health Insurance Program (CHIP) by limiting states' ability to tax health care providers, reducing Medicaid payments to states for hospitals that serve a disproportionate share of poor and uninsured patients, repealing certain requirements that states maintain Medicaid and CHIP eligibility rules and procedures, limiting Medicaid payments to U.S. territories, and repealing performance bonuses under CHIP.

- Title III would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, modifying the statute of limitations and the "collateral source" rule, and eliminating joint and several liability.

The legislation contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would preempt state laws that provide health care providers and organizations less protection from liability, loss, or damages. CBO estimates the cost of complying with the mandate would be small and would fall well below the threshold established in UMRA for intergovernmental mandates ($73 million in 2012, adjusted annually for inflation).

The legislation contains several mandates on the private sector, including caps on damages and on attorney fees, the statute of limitations, and the fair share rule. The cost of those mandates would exceed the threshold established in UMRA for private-sector mandates ($146 million in 2012, adjusted annually for inflation) in four of the first five years in which the mandates were effective.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the legislation is shown in the following tables. The spending effects of this legislation fall mostly within budget functions 550 (health) and 570 (Medicare).

For purposes of this estimate, CBO assumes that the legislation will be enacted on or near October 1, 2012, as shown in Table 1. As directed by the Chairman of the House Budget Committee, CBO has also prepared a set of estimates based on the assumption that the legislation is enacted by July 1, 2012. Those alternative estimates are presented in Table 2.

Table 1. Effects on Direct Spending and Revenues for Reconciliation Recommendations of the House Committee on Energy and Commerce, as approved by the Committee on April 25, 2012, assuming enactment around October 1, 2012

	By Fiscal Year, in Millions of Dollars												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012-2017	2012-2022
CHANGES IN DIRECT SPENDING ASSUMING ENACTMENT AROUND OCTOBER 1, 2012													
Title I – Repeal of Certain ACA Funding Provisions													
Estimated Budget Authority	0	-4,000	-3,860	-5,500	-5,460	-2,280	-1,250	-1,250	-1,500	-1,500	-2,000	-21,100	-28,600
Estimated Outlays	0	-630	-3,840	-5,960	-5,730	-2,380	-1,090	-1,200	-1,320	-1,450	-1,670	-18,540	-25,270
Title II – Medicaid													
Estimated Budget Authority	0	-9,990	-1,730	110	-1,900	-2,260	-2,050	-2,200	-1,330	-1,400	-5,710	-15,770	-28,460
Estimated Outlays	0	-2,140	-1,800	-3,190	-2,000	-1,690	-2,050	-2,090	-1,280	-1,400	-5,710	-10,820	-23,350
Title III – Liability Reform													
Estimated Budget Authority	0	-100	-880	-3,070	-5,240	-6,510	-6,980	-7,450	-8,000	-8,570	-9,160	-15,800	-55,960
Estimated Outlays	0	-100	-880	-3,070	-5,240	-6,510	-6,980	-7,450	-8,000	-8,570	-9,160	-15,800	-55,960
Total Changes in Direct Spending													
Estimated Budget Authority	0	-14,090	-6,470	-8,460	-12,600	-11,050	-10,280	-10,900	-10,830	-11,470	-16,870	-52,670	-113,020
Estimated Outlays	0	-2,870	-6,520	-12,220	-12,970	-10,580	-10,120	-10,740	-10,600	-11,420	-16,540	-45,160	-104,580
CHANGES IN REVENUES ASSUMING ENACTMENT AROUND OCTOBER 1, 2012													
Estimated Revenues [a]													
On-Budget	0	-10	0	-430	750	1,000	1,010	1,180	1,240	1,300	1,380	1,310	7,420
Off-Budget [b]	0	0	-190	-530	-100	210	330	390	400	420	440	-610	1,370
Total Changes	0	-10	-190	-960	650	1,210	1,340	1,570	1,640	1,720	1,820	700	8,790
INCREASE OR DECREASE (-) IN THE DEFICIT ASSUMING ENACTMENT AROUND OCTOBER 1, 2012													
Net Effect on Deficits													
On-Budget	0	-2,860	-6,520	-11,790	-13,720	-11,580	-11,130	-11,920	-11,840	-12,720	-17,920	-46,470	-112,000
Off-Budget [b]	0	0	190	530	100	-210	-330	-390	-400	-420	-440	610	-1,370
Total Changes	0	-2,860	-6,330	-11,260	-13,620	-11,790	-11,460	-12,310	-12,240	-13,140	-18,360	-45,860	-113,370

Source: CBO and the staff of the Joint Committee on Taxation.

Note: Components may not sum to totals because of rounding; ACA = the Affordable Care Act.

a. Negative numbers denote a reduction in revenues and positive numbers denote an increase in revenues.

b. All off-budget effects would come from changes in revenues. (Payroll taxes for Social Security are classified as off-budget.)

Table 2. Effects on Direct Spending and Revenues from Reconciliation Recommendations of the House Committee on Energy and Commerce, as approved by the Committee on April 25, 2012, assuming enactment by July 1, 2012, as directed by the Chairman of the House Committee on the Budget

	By Fiscal Year, in Millions of Dollars												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012-2017	2012-2022
CHANGES IN DIRECT SPENDING ASSUMING ENACTMENT BY JULY 1, 2012													
Title I – Repeal of Certain ACA Funding Provisions													
Estimated Budget Authority	-3,960	-1,980	-3,860	-5,500	-5,460	-2,280	-1,250	-1,250	-1,500	-1,500	-2,000	-23,040	-30,540
Estimated Outlays	-230	-1,230	-4,480	-6,260	-5,830	-2,440	-1,090	-1,200	-1,320	-1,450	-1,670	-20,470	-27,200
Title II – Medicaid													
Estimated Budget Authority	-8,480	-1,690	-1,730	110	-1,900	-2,260	-2,050	-2,200	-1,330	-1,400	-5,710	-15,950	-28,640
Estimated Outlays	-180	-2,140	-1,800	-3,190	-2,000	-1,690	-2,050	-2,090	-1,280	-1,400	-5,710	-11,000	-23,530
Title III – Liability Reform													
Estimated Budget Authority	0	-100	-880	-3,070	-5,240	-6,510	-6,980	-7,450	-8,000	-8,570	-9,160	-15,800	-55,960
Estimated Outlays	0	-100	-880	-3,070	-5,240	-6,510	-6,980	-7,450	-8,000	-8,570	-9,160	-15,800	-55,960
Total Changes in Direct Spending													
Estimated Budget Authority	-12,440	-3,770	-6,470	-8,460	-12,600	-11,050	-10,280	-10,900	-10,830	-11,470	-16,870	-54,790	-115,140
Estimated Outlays	-410	-3,470	-7,160	-12,520	-13,070	-10,640	-10,120	-10,740	-10,600	-11,420	-16,540	-47,270	-106,690
CHANGES IN REVENUES ASSUMING ENACTMENT BY JULY 1, 2012													
Estimated Revenues [a]													
On-Budget	0	-10	0	-430	750	1,000	1,010	1,180	1,240	1,300	1,380	1,310	7,420
Off-Budget [b]	0	0	-190	-530	-100	210	330	390	400	420	440	-610	1,370
Total Changes	0	-10	-190	-960	650	1,210	1,340	1,570	1,640	1,720	1,820	700	8,790
INCREASE OR DECREASE (-) IN THE DEFICIT ASSUMING ENACTMENT BY JULY 1, 2012													
Net Effect on Deficits													
On-Budget	-410	-3,460	-7,160	-12,090	-13,820	-11,640	-11,130	-11,920	-11,840	-12,720	-17,920	-48,580	-114,110
Off-Budget [b]	0	0	190	530	100	-210	-330	-390	-400	-420	-440	610	-1,370
Total Changes	-410	-3,460	-6,970	-11,560	-13,720	-11,850	-11,460	-12,310	-12,240	-13,140	-18,360	-47,970	-115,480

Source: CBO and the staff of the Joint Committee on Taxation.

Note: Components may not sum to totals because of rounding; ACA = the Affordable Care Act.

a. Negative numbers denote a reduction in revenues and positive numbers denote an increase in revenues.

b. All off-budget effects would come from changes in revenues. (Payroll taxes for Social Security are classified as off-budget.)

BASIS OF ESTIMATE

In total, CBO and JCT estimate that enacting the Energy and Commerce Committee's recommendations would reduce direct spending by $104.6 billion, increase revenues by $8.8 billion, and reduce deficits by about $113.4 billion over the 2012-2022 period, assuming enactment on or near October 1, 2012 (see Table 1). Assuming enactment by July 1, 2012, the committee's recommendations are estimated to reduce direct spending by $106.7 billion, increase revenues by $8.8 billion, and reduce deficits by about $115.5 billion over the 2012-2022 period (see Table 2).

Title I – Repeal of Certain ACA Funding Provisions

Title I of the legislation would repeal several provisions of the Affordable Care Act, including grant authority for state exchanges, the Prevention and Public Health Fund, and funding for loans for the CO-OP program. CBO estimates that enacting the provisions in title I would reduce direct spending by $25.3 billion over the 2012-2022 period, assuming enactment on or near October 1, 2012; and by $27.2 billion over the same period, assuming enactment by July 1, 2012. In addition, enacting title I would reduce revenues by approximately $0.9 billion over the 2012–2022 period for both October 1, 2012, and July 1, 2012, enactment dates.

State Exchange Grants. The legislation includes a provision to eliminate the authority of the Secretary of HHS to provide grants to states for setting up health insurance exchanges. Section 1311 of the ACA provided for such grants in the amounts necessary for planning and establishing health insurance exchanges until January 1, 2015. Under current law, CBO estimates that $2.7 billion in grants will be provided to states over the 2012-2022 period. CBO expects that some of those funds will be obligated by the time this legislation is enacted and will be disbursed over time even if the legislation is enacted. Therefore, eliminating the authority to provide grants after the enactment date would generate a reduction in the disbursement of grants of $1.4 billion over the 2012-2022 period, CBO estimates. In addition, the repeal would lead to some delay in the establishment of insurance exchanges, resulting in changes in insurance coverage and additional changes in federal spending primarily for subsidies provided through health insurance exchanges. After taking into account such changes in coverage, CBO and JCT estimate that enacting this provision would reduce direct spending by $14.1 billion over the 2012-2022 period and would reduce net revenues by $0.9 billion over the same period.

Prevention and Public Health Fund. The ACA established the Prevention and Public Health Fund and provided authority for federal agencies to award grants from the fund to public and private entities for prevention, wellness, and public health activities. Federal agencies can award annual grants that total $1.0 billion in 2012 rising to $2.0 billion in 2022 and beyond. Title I would repeal the Prevention and Public Health Fund and rescind

any unobligated balances. CBO estimates that enacting this provision would reduce direct spending by $10.9 billion over the 2012-2022 period.

Consumer Operated and Oriented Plan Program. Title I also would rescind unobligated balances of the CO-OP program. The CO-OP program was established by the ACA to provide loans to new nonprofit health insurance issuers so that they may offer health insurance plans in the individual and small group markets. CBO estimates that enacting this provision would reduce direct spending by $0.3 billion over the 2012-2022 period.

Title II – Medicaid and CHIP

Title II would make several changes to Medicaid and CHIP. It would limit states' ability to tax health care providers, reduce payments to hospitals that serve a disproportionate share of poor and uninsured patients (known as DSH payments), repeal Medicaid and CHIP maintenance of effort requirements, limit Medicaid payments to the U.S. territories, and repeal the authority for HHS to award CHIP performance bonuses.

CBO estimates that enacting title II would reduce direct spending by $23.4 billion over the 2012-2022 period, assuming enactment on or near October 1, 2012; and by $23.5 billion over the same period, assuming enactment by July 1, 2012. In addition, enacting title II would reduce revenues by $0.8 billion over the 2012-2022 period for both the October 1 and July 1 enactment assumptions.

Revise Provider Tax Threshold. Under current law, states may not tax health care providers and return the tax revenues to those same providers through higher Medicaid payment rates or through other offsets and guarantees (known as a "hold harmless" arrangement). An exception to this provision is that the federal government will not deem a hold harmless arrangement to exist if the provider taxes collected from given providers are less than 6 percent of the providers' revenues. The legislation would lower the allowable percentage threshold of provider revenues to 5.5 percent starting in 2013. CBO estimates that enacting this provision would reduce direct spending by $11.3 billion over the 2012-2022 period.

Reduce DSH Payments. Under current law, Medicaid provides for payments to hospitals that serve a disproportionate share of low-income and uninsured individuals. The ACA reduced those payments beginning in 2014 and continuing through 2021. Payments in 2022 were unaffected. This provision would reduce DSH payments in 2022 from $12.1 billion to $7.9 billion, bringing those amounts in line with 2021 payments. CBO estimates that enacting this provision would reduce direct spending by $4.2 billion in 2022.

Repeal Medicaid and CHIP Maintenance of Effort (MOE) Requirements. As a condition of receiving federal Medicaid and CHIP payments, states must maintain the eligibility standards, methodologies, and procedures that were in place prior to enactment of the ACA with respect to children and adults in Medicaid and CHIP. The requirements for adults remain in effect until state health insurance exchanges are operational while the requirements for children remain in effect until 2019. The legislation would repeal the MOE requirements for adults and children in Medicaid and CHIP. CBO assumes that individuals losing Medicaid or CHIP coverage as a result of this provision would take up employment-based health insurance, exchange coverage, or become uninsured. Those changes in enrollment in Medicaid, CHIP, exchanges, and employer-based health insurance together would reduce direct spending by approximately $1.4 billion and reduce revenues by $0.8 billion over the 2012-2022 period.

Limit Medicaid Payments to Territories. The legislation would repeal provisions enacted under the ACA that increased Medicaid payments to the U.S. territories by raising their federal matching percentage and their capped allotments under the program. Under current law, CBO estimates that total Medicaid payments to the U.S. territories will be $12.4 billion over the 2012-2022 period with the Commonwealth of Puerto Rico expected to receive the majority of those payments. CBO estimates that eliminating the increased funding provided in the ACA would reduce direct spending by $6.1 billion over the 2012-2022 period, assuming enactment around October 1, 2012. (Assuming enactment by July 1, 2012, savings from this provision would be $6.3 billion between 2012 and 2022.)

Repeal CHIP Performance Bonuses. Under the CHIP statute, the Secretary of HHS awards bonus payments to states that meet two criteria. First, states must adopt any 5 of 8 specified program changes that generally facilitate enrollment in, and retention of, Medicaid and CHIP coverage for children. Second, states that have made such program changes must achieve specified enrollment targets for children's coverage in Medicaid. The legislation would repeal the bonus payment program as of the date of enactment. In addition, this legislation would rescind any unobligated balance remaining in the performance bonus fund. CBO estimates that enacting this legislation would reduce direct spending by $0.4 billion in 2013 (with no effect in any other years).

Title III – Liability Reform

The legislation would establish:

- A three-year statute of limitations for medical malpractice claims, with certain exceptions, from the date of discovery of an injury;

- A cap of $250,000 on awards for noneconomic damages;

- A cap on awards for punitive damages that would be the larger of $250,000 or twice the economic damages, and restrictions on when punitive damages may be awarded;

- Replacement of joint and several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury;

- Sliding-scale limits on the contingency fees that lawyers can charge;

- A safe harbor from punitive damages for products that meet applicable safety requirements established by the Food and Drug Administration; and

- Permission to introduce evidence of income from collateral sources (such as life insurance payouts and health insurance) at trial.

Over the 2012-2022 period, CBO and JCT estimate that enacting title III would reduce direct spending by about $56 billion and increase federal revenues by about $10.5 billion. The combined effect of those changes in direct spending and revenues would reduce federal deficits by almost $66.5 billion over that period, with changes in off-budget revenues accounting for $2.6 billion of that reduction.

Effects on National Spending for Health Care. CBO reviewed recent research on the effects of proposals to limit costs related to medical malpractice ("tort reform"), and estimates that enacting title III would reduce national health spending by about 0.5 percent.[1] That figure comprises a direct reduction in spending for medical liability premiums and an additional indirect reduction from slightly less utilization of health care services. CBO's estimate takes into account the fact that, because many states have already implemented some elements of the legislation, a significant fraction of the potential cost savings has already been realized. Moreover, the estimate assumes that the spending reduction of about 0.5 percent would be realized over a period of four years, as providers gradually change their practice patterns.

Revenues. CBO estimates that private health spending would be reduced by about 0.5 percent. Much of private-sector health care is paid for through employment-based insurance that represents nontaxable compensation. In addition, beginning in 2014, refundable tax credits will be available to certain individuals and families to subsidize health insurance purchased through new health insurance exchanges. (The portion of

1. See Congressional Budget Office, letter to the Honorable Orrin G. Hatch regarding CBO's Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice, (October 9, 2009). http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf.

those tax credits that exceed taxpayers' liabilities are classified as outlays, while the portions that reduce taxpayers' liabilities are recorded as reductions in revenues.)

Lower costs for health care arising from enactment of title III would lead to an increase in taxable compensation and a reduction in subsidies for health insurance purchased through an exchange. Those changes would increase federal tax revenues by an estimated $10.5 billion over the 2012-2022 period, according to estimates by JCT. Social Security payroll taxes, which are off-budget, account for $2.6 billion of that increase in revenues.

Direct Spending. CBO estimates that enacting title III would reduce direct spending for Medicare, Medicaid, the CHIP, the Federal Employees Health Benefits program, the Defense Department's TRICARE for Life program, and subsidies for enrollees in health insurance exchanges. We estimate those reductions would total roughly $56 billion over the 2012-2022 period.

For programs other than Parts A and B of Medicare, the estimate assumes that federal spending for acute care services would be reduced by about 0.5 percent, in line with the estimated reductions in the private sector.

CBO estimates that the reduction in federal spending for services covered under Parts A and B of Medicare would be larger—about 0.7 percent—than in the other programs or in national health spending in general. That estimate is based on empirical evidence showing that the impact of tort reform on the utilization of health care services is greater for Medicare than for the rest of the health care system.[2]

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

The bill contains an intergovernmental because it would preempt state laws that provide health care providers and organizations less protection from liability, loss, or damages. While the preemption would limit the application of state laws, it would impose no duty on states that would result in significant additional spending. Consequently, CBO estimates that any costs would fall well below the threshold established in UMRA for intergovernmental mandates ($73 million in 2012, adjusted annually for inflation).

2. One possible explanation for that disparity is that the bulk of Medicare's spending is on a fee-for-service basis, whereas most private health care spending occurs through plans that manage care to some degree. Such plans limit the use of services that have marginal or no benefit to patients (some of which might otherwise be provided as "defensive" medicine), thus leaving less potential for savings from the reduction of utilization in those plans than in fee-for-service systems.

Other Impacts

The bill would have mixed effects on the budgets of state, local, and tribal governments aside from the mandate effects noted above. CBO estimates that those governments, as employers, would save money as a result of lower health insurance premiums precipitated by the bill's liability reforms. In addition, state, local, and tribal governments that collect income taxes would realize increased tax revenues as a result of increases in workers' taxable income. CBO estimates that the bill's changes also would lead to reduced state spending in Medicaid by $20 billion over the 2012-2022 period. The legislation also would limit the amount that states would be able to raise through taxes on Medicaid providers, reducing one of the means by which states finance their share of Medicaid spending.

Other provisions in the bill would decrease the amount of resources that state, local, and tribal governments receive to establish health exchanges and to conduct prevention, wellness, and public health activities. In total, CBO estimates that the decrease in grant aid to states would exceed $12 billion over the 2012-2022 period. In addition, CBO estimates that enactment of the bill would reduce the amount of Medicaid payments that the U.S. territories receive by $6.1 billion over the same period.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The legislation contains several mandates on the private sector, including caps on damages and on attorney fees, the statute of limitations, and the fair share rule.[3] The cost of those mandates would exceed the threshold established in UMRA for private-sector mandates ($146 million in 2012, adjusted annually for inflation) in four of the first five years in which the mandates were effective.

PREVIOUS CBO ESTIMATE

On April 26, 2012, CBO transmitted a cost estimate for the Help Efficient, Accessible, Low-cost, Timely Healthcare Act as approved by the House Committee on the Judiciary on April 25, 2012. That legislation is substantially similar to title III of this legislation. However, this legislation would permit the introduction of evidence of income from collateral sources at trial. The version of medical liability reform approved by the Committee on the Judiciary did not contain that provision. Differences in the CBO cost estimates for title III of this legislation and the legislation approved by the Committee on the Judiciary reflect that difference in the two versions of such liability reform.

3. Under the fair share rule, a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.

ESTIMATE PREPARED BY:

Federal Costs: Sarah Anders, Tom Bradley, Jean Hearne, Stuart Hagen, Kirstin Nelson, Lisa Ramirez-Branum, and Rob Stewart
Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum
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ESTIMATE APPROVED BY:

Holly Harvey
Deputy Assistant Director for Budget Analysis

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

April 27, 2012

Honorable Fred Upton
Chairman
Committee on Energy
and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the Reconciliation Recommendations of the House Committee on Energy and Commerce.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Kirstin Nelson, who can be reached at 226-9010.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf

Enclosure

cc: Honorable Henry A. Waxman
Ranking Member

DISSENTING VIEWS

The Committee's recommendations to the House Budget Committee are in response to reconciliation instructions from a Republican-proposed budget, H. Con. Res. 112.[1] This budget slashes programs for the working class and poor in order to protect the defense industry and tax breaks for millionaires. Because Congressman Ryan's budget passed by the Republican majority refuses to take a balanced approach and refuses to ask millionaires to contribute to deficit reduction, this year's budget proposes to cut services that affect the middle class and most vulnerable individuals in the country. This unbalanced Republican budget would end the Medicare guarantee, cut the Medicaid program by 75% by 2050, and destroy jobs.

The reconciliation instructions directed the Energy and Commerce Committee to cut $96.7 billion out of programs in its jurisdiction over ten years. The Majority chose to comply with those instructions by making cuts to Medicaid, public health, and the Affordable Care Act. These cuts are in addition to draconian cuts proposed in the underlying Republican budget resolution and are intended to offset the cost of eliminating the sequester on defense spending.

These cuts proposed by the Majority most adversely affect vulnerable low-income Medicaid beneficiaries, would cause scores of Americans to lose health insurance coverage, and would set back efforts to promote prevention and improve health by cutting common sense investments like the Public Health and Prevention Fund. Savings are also achieved through wholesale and radical changes to the medical malpractice and tort liability laws of all 50 states. The Committee's recommendations cut health care by $114 billion over the next decade, and exceeded the Republican budget resolution's instructions by $17 billion.

TITLE I

Section 101: Repealing Mandatory Funding to States to Establish American Health Benefit Exchanges

Section 101 of the reconciliation recommendations from the Committee on Energy and Commerce to the House Budget Committee repeals mandatory funding provided to states in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges, cutting $14.5 billion over five and ten years or reducing the deficit by $15.4 billion over the decade when taking into consideration indirect revenue effects.

Private Insurance Marketplace Prior to Health Reform Exchanges

Private health coverage is provided primarily through employers. In 2010, about 170 million nonelderly people were insured through employer sponsored health insurance.[2] For the smallest firms, those with less than 10 workers, premiums were 18% higher than those paid by

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[1] H. Con. Res. 112.

[2] U.S. Census Bureau, *Highlights: 2012*, (September 14, 2011) (online at http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/highlights.html).

firms with 100 or more workers and may not include broker fees.[3] Increasing costs of health insurance have led some small employers to drop coverage, with the share of small business employees enrolled in employer-sponsored coverage decreasing from 43% to 36% from 1999-2009.[4]

People without access to employer-sponsored insurance may obtain health insurance on their own, usually through the individual health insurance market. Only 14 million nonelderly people bought health insurance in the individual or non-group market while 50 million people were uninsured.[5] About half the uninsured were self-employed or worked for a small business.[6]

Unlike employer-sponsored group coverage, in which eligibility in a group is guaranteed by federal and state laws and premiums are generally based on the risks associated with a group of beneficiaries, eligibility and initial premiums in the individual markets of many states are based largely on an individual's health status and risk characteristics.

The Commonwealth Biennial Health Insurance Survey found 43% of adults who shopped for coverage in the individual market found it very difficult or impossible to find a plan that fit their needs.[7] More than one-third of applicants were turned down by an insurance carrier or were charged a higher premium due to a health problem or were offered insurance that did not cover that health problem.[8]

Practices of denying sick people insurance, charging them more, or offering them coverage that does not cover the illnesses they had when they sought insurance protect insurer risk pools and help lower premiums. But they are detrimental to a vibrant, healthy, and financially secure marketplace. These practices limit meaningful access to coverage for people who have developed health problems and results in uncertainty in coverage for those who receive insurance. They also hamper movement from jobs where insurance is offered to self-employment or employment in a small business, resulting in job lock.

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[3] S. Collins, et al, *Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010* (September 2010) (online at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Sep/Small%20Business/1437_Collins_realizing_hlt_reform_potential_small_business_ACA_ib.pdf).

[4] HealthCare.gov, *Health Insurance Premiums: Past High Costs Will Become the Present and Future Without Health Reform* (Jan. 28, 2011) (online at http://www.healthcare.gov/center/reports/premiums01282011a.pdf).

[5] Kaiser Family Foundation, *Survey of People Who Purchase Their Own Insurance* (June 2010) (online at http://www.kff.org/kaiserpolls/upload/8077-R.pdf); and C. DeNavas, et al. *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, U.S. Census Bureau (Sept. 2010) (online at http://www.census.gov/prod/2010pubs/p60-238.pdf).

[6] *Healthcare: Statistics, Small Business and the healthcare Crisis*, Small Business Majority (online at http://www.smallbusinessmajority.org/small-business-research/statistics.php) (accessed April 25, 2011).

[7] S. Collins, et al, *Help on the Horizon*, Findings from the Commonwealth Biennial Health Insurance Survey of 2010 (March 2011) (online at http://www.commonwealthfund.org/~/media/Files/Surveys/2011/1486_Collins_help_on_the_horizon_2010_biennial_survey_report_FINAL_31611.pdf).

[8] *Id.*

American Health Benefit Exchanges

The enactment of the Affordable Care Act (ACA) in March 2010 started to put the American people back in charge of their health care by requiring insurance companies to be more transparent and accountable for their costs and actions. This law ended many of the worst insurance industry abuses in 2010, including arbitrary recessions of coverage when a person gets sick and denials of insurance for children with pre-existing conditions.[9] In 2014, additional insurance reforms will bring Americans new rights and benefits and increase the quality of their health care and lower their costs. These reforms include no discrimination in premiums based on gender, no denials for pre-existing conditions for anyone, coverage of basic set of benefits and services, and no annual and lifetime limits on coverage for essential health benefits.[10]

The successes of these reforms rely on the new health insurance exchange marketplaces that will be established in 2014 as required by the ACA. An exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. Exchanges will provide a transparent, competitive marketplace for individuals and small businesses to buy coverage.

The new marketplace will provide families and businesses advantages of pooling risk that were previously only available to the largest employers by creating a single risk pool within the individual and small business exchanges.[11] By pooling people together, reducing transaction costs, and increasing transparency, exchanges create more efficient and competitive markets for individuals and small employers. The new marketplace keeps intact America's employer-based system while expanding access to tens of millions of people. Tax credits will make coverage more affordable for low- and middle-income families and eligible small businesses.

Beginning with an open enrollment period in 2013, exchanges will help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices. Exchanges will assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs.[12] By providing one-stop shopping, exchanges will make purchasing health insurance easier and more transparent. Health plans offered in exchanges shall be required to be transparent and make disclosures of claims payment policies, enrollment and disenrollment data, data on denied claims, information on cost sharing and coverage, and more.[13]

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[9] The Patient Protection and Affordable Care Act is comprised of two public laws, The Patient Protection and Affordable Care Act, Public Law 111-148, and the Health Care Education and Reconciliation Act of 2010, Public Law 111-152.

[10] *Id.*

[11] Section 1312(c) of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

[12] Section 1311(b) and 1311(d)(4) of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

[13] Section 1311(e)(3) of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

When fully implemented, health plans offered through exchanges will compete based on price and quality rather than market segmentation and risk selection. This directly relates with prohibition on medical underwriting and rate reforms that would also take effect in 2014.[14] The non-partisan Congressional Budget Office (CBO) estimated that by 2022, approximately 26 million people will purchase their health insurance through exchanges.[15]

State versus Federal Exchanges

The ACA requires that exchanges be developed and operational in every state for individual and small businesses by January 1, 2014.[16] A state is first given the opportunity to set up a state exchange and can apply for grants for the establishment of this exchange. If the state does not elect to set up a state exchange, the Secretary of Health and Human Services (the Secretary) will set one up in the state for individuals and small businesses.

The state has significant flexibility in the type of exchange it would operate if it elects to establish a state exchange. The state could determine which insurers are permitted to offer products in the exchange. It could determine the variety of plans that could be offered, for example whether consumer driven health plans and health savings accounts are offered. The state could determine the governance structure. The state could determine whether to merge the individual and small group markets. The state could determine whether employers with over 50 employees are permitted into the exchange to purchase insurance over time. The state could determine their financing mechanism that will be used to operate the exchange in the future. The state could determine whether the exchange will be an active purchaser in selecting health plans to get the best price and quality for it citizens. The state could determine the role brokers and agents will play in helping consumers enroll in qualified health plans in the exchange. The state could determine how involved the exchange will be in enforcing health insurance market standards as a part of their certification in tandem with the state health insurance commissioner.

If the state does not elect to set up an exchange, which some states will not, the federal government will make these decisions and establish and operate an exchange in that non-electing state.

Oversight of Exchanges

An exchange may operate in multiple states, if each state agrees to the operation of the exchange and if the Secretary approves.[17] A state may have more than one exchange, called subsidiary exchanges, if each serves a geographically distinct area and the area served is adequately large.[18] If the Secretary determines before 2013 that a state will not have an exchange operational by 2014 or will not be able to implement the standards, the Secretary is

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[14] The Kaiser Family Foundation, *Focus on Health Reform,* (April 2010) (online at http://www.kff.org/healthreform/upload/7908-02.pdf).
[15] Congressional Budget Office, *Health Insurance Exchanges: CBO's March 2012 Baseline,* March 13, 2012.
[16] Section 1311 of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[17] Section 1311(f) of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[18] Id.

required (directly or through an agreement with a non-profit entity) to establish and operate an exchange in the state and to implement the standards.[19]

The Secretary, in coordination with the HHS Inspector General, will have authority to investigate exchanges. Exchanges will be subject to annual HHS audits.[20] If the Secretary finds serious misconduct, payment otherwise due to the exchange may be rescinded, up to 1% of such payments, until corrective actions are taken that are deemed adequate by the Secretary.[21] Payments made under the exchange provisions of the ACA are subject to the False Claims Act.[22] The Government Accountability Office is required to review the operations and administration of the exchange.[23] In addition, the Committee on Energy and Commerce, the Committee on Oversight and Government Reform, other congressional committees, and others can provide oversight of the implementation of the activities and expenditures under section 1311 of the Affordable Care Act.[24]

Funding for Exchanges

Section 1311 of the ACA requires the Secretary, within one year of enactment, to award grants to states to plan and establish exchanges.[25] By January 1, 2014, each state must have an exchange to facilitate access to qualified health plans. The grants are provided to states making progress in establishing an exchange, implementing ACA's private health insurance market reforms, and meeting other benchmarks. However, no grant may be awarded after January 1, 2015, and after this date, operations of the exchange must be self-sustaining using assessments on insurers or some other way to generate funds to support their operations.[26] In addition, the grants must be used solely for the activities and functions listed in section 1311.[27]

Thus far, the Center for Consumer Information and Insurance Oversight (CCIIO) has awarded over $600 million in exchange planning grants and early innovator grants to 49 states and the District of Columbia along with four territories.[28] States may use the exchange planning and establishment grants for a number of important planning activities, including research of their insurance markets, efforts to obtain the legislative authority to create exchanges, and steps

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[19] Section 1321 of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[20] Section 1313 of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[21] Id.
[22] Id.
[23] Id.
[24] Id.
[25] Section 1311 of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[26] Section 1311 of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[27] Section 1311 of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[28] U.S. Department of Health and Human Services, *Creating a New Competitive Marketplace: Health Insurance Exchange Establishment Grants Awards List* (Jan. 24, 2012) online at http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html).

to establish the governing structures of exchanges.[29] States can use the early innovator grants to develop model Information Technology (IT) systems to operate the functions of the exchange.[30] Such systems can be combined with state Medicaid systems and others, but all monies for the development of combined technology must be allocated according to the different programs. According to November 3, 2010, guidance from CMS, "State Exchange grants will provide 100 percent support for Exchange IT infrastructure and…90 percent matching rate will be available for the Exchange-related eligibility system changes as well as for those Medicaid system changes not directly related to the Exchanges."

Structure of Funding

The structure of the funding for the establishment of exchanges has been criticized as being an open ended mandatory funding stream. However, mandatory time limited funding is consistent with previous laws passed by both parties.

Having a mandatory and stable stream of funding for this central feature of the health insurance reforms is critical. Senator Harkin stated, in testimony for the record, that "[T]o ensure the success of the Affordable Care Act, we needed to guarantee that reliable and predictable funding would be available for key programs. As the Chairman of both the Senate Committee on Health, Education, Labor, and Pensions and the Appropriations Subcommittee for Labor, Health and Human Services, and Education, I understand the implications of this guarantee – that Congress should mandate appropriations for certain programs in the Affordable Care Act that are fundamental to its success. This is a process that Congress has done many times in the past in various areas and there has been no controversy. It is now clear that those who want to repeal the Act are seeking to starve these important elements of funds in an effort to derail health reform."

In fact, in this regard, the Affordable Care Act was little different from other laws passed by Congress in recent years. It included a mix of discretionary program authorizations and mandatory spending.[31] That mandatory spending was well-documented at the time of passage and included in each CBO score of the legislation from the summer of 2009 through passage in March 2010.

Two examples of laws considered by the Energy and Commerce Committee when it was last under the control of Republicans in the 108th and 109th Congresses illustrate how Congress has previously used mandatory appropriations. These laws are the Medicare Prescription Drug Improvement and Modernization Act (P.L. No. 108-173) and the Deficit Reduction Act (P.L. No. 109-171), both of which were spearheaded by Republican congressional leadership. These

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[29] U.S. Department of Health and Human Services, News Release: *HHS Announces New Resources to Help States Implement Affordable Care Act* (Jan. 20, 2011) online at http://www.hhs.gov/news/press/2011pres/01/20110120b.html).

[30] Healthcare.gov, *States Leading the Way on Implementation: HHS Awards "Early Innovator" Grants to Seven States* (online at http://www.healthcare.gov/news/factsheets/Exchanges02162011a.html) (accessed April 8, 2011).

[31] Mandatory spending (also called direct spending) encompasses all spending not passed in the annual appropriations bills.

laws contained billions of dollars of mandatory appropriations funding a wide array of government activities.[32]

The Medicare Prescription Drug Improvement and Modernization Act (P.L. No. 108-173) included specific mandatory appropriations, including an open ended but time limited mandatory appropriation for a drug assistance program. That program, like the exchange grants, served as a bridge until the full Medicare prescription drug benefit became effective.

Analysis and Impact of H.R. 1213

H.R. 1213 repeals the mandatory funding provided to states under the ACA to establish exchanges. This denies states the necessary funding to establish the new health insurance marketplace and undermines the work they have already done to implement exchanges. This legislation would rescind unobligated funds and would prohibit further funding, limiting states' ability to advance on the establishment of their exchanges.

According to testimony for the record from Alan Weil, Executive Director of the National Academy for State Health Policy, "[S]tates are doing their best to comply with the federal law and to implement the law in a manner that conforms to their own needs. Federal support for those activities is critical. One likely consequence of reduced federal funding is poor implementation, with state officials on the hook for failures that are not of their own making. Another likely consequence is states deciding to cede authority for implementation to the federal government—a decision most states would strongly prefer not to make."

Current budget deficits in most states have created difficult economic environments to establish state-based exchanges. Without grants from the Department of Health and Human Services, states will be forced to pay for exchange activities, along with outreach and education activities, on their own if they wish to establish a state run exchange. Exchange grants provide states the financial security needed to avoid wrestling with budget issues and worrying about self-sustainability before January 1, 2015. The inevitable result of enactment of this legislation is that a number of states that would prefer to run their own exchanges will be unable to do so, and the default to federal control will be more likely to occur. Yet states are best positioned to establish the new marketplace for their residents.

Already most states and the District of Columbia have shown an interest in setting up an exchange marketplace or sharing that responsibility with the federal government. A repeal of the exchange grants is effectively taking away from states the ability to set up exchanges or run important functions within a shared exchange.

Numerous groups have expressed their opposition to these proposals including the American Hospital Association, the American Heart Association, the American Cancer Society – Cancer Action Network, American Federation of Teachers, Easter Seals, Main Street Alliance, National Alliance on the Mental Illness, National Partnership for Women and Families, Paralyzed Veterans of America, National Disability Rights Network, and AARP among others.

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[32] Committee on Energy and Commerce, Democratic Staff of Henry A. Waxman, Ranking Member, *The Pitts Proposal to Block Mandatory Funding in the Affordable Care Act*, March 2011.

Amendments

Congressman Pallone offered an amendment to allow a state to receive exchange establishment grants if the governor of a state certifies that the state does not want the federal government to establish and operate an exchange within the state and wants to have the state establish and operate the exchange. The amendment was defeated on a party line vote.

Congress members Schakowsky, Gonzalez, and Eshoo offered additional amendment having to do with retaining funds for the purposes of helping small business get health insurance if they choose to offer it, ensuring qualified health plans do not have annual or lifetime limits on coverage, and providing authority to deny or modify excessive or unjustified premium increases by insurance companies. All amendments were defeated.

Section 102: Repealing Prevention and Public Health Fund

Section 102 of the Committee Prints[33] is identical to H.R. 1217, legislation to repeal the Prevention and Public Health Fund, as reported by the Committee on April 11, 2011,[34] and passed by the House on April 13, 2011.[35] Like H.R. 1217 itself, Section 102 should not become law.

Enacted in 2010, the ACA[36] expands access to health care for over 30 million Americans and improves health benefits for millions more who are already insured.[37]

But as valuable as it is, health insurance cannot do everything necessary to make our nation healthy. Even if other parts of the ACA make it possible for virtually everyone to be insured, there will still be a major role for public health. Moreover, there will be an ongoing need for funding for these public health activities.

"Public health" includes many different things:

- It is working with groups and whole communities to improve health, often more effectively than could be done between an individual provider and patient. Fluoridation of water for a town is, for instance, vastly better than simply filling every citizen's cavities. Exercise programs to prevent obesity are better than having to treat diabetes among people who become obese.

- It is tailoring health insurance and health care to prevent and diagnose disease early rather than simply treating it in its later stages. Immunizations are always better than outbreaks. Screening for hypertension is better than simply waiting for strokes.

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[33] Hereinafter cited as Section 102.
[34] House Committee on Energy and Commerce, *To Repeal the Prevention and Public Health Fund*, 112th Cong. (2011) (H. Rept. 112-57).
[35] Congressional Record, H2633-2646 (Apr. 13, 2011).
[36] The *ACA* is comprised of two public laws, Public Law No. 111-148 and Public Law No. 111-152.
[37] Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (Mar. 2012) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf).

- It is providing for safety-net services where the insurance market alone fails to do so. Community health centers, HIV-service providers, and breast and cervical cancer screening programs provide care to people who might not otherwise be able to find a provider. Health professions education programs can add to the primary care workforce when the market might produce only specialists. (Such programs will be even more necessary once the insurance expansion provisions of the ACA are implemented.)

- And, least glamorous but crucial, it is the infrastructure of daily disease control and health promotion. Closing down unsanitary restaurants is better than treating food poisoning. Compiling and studying epidemic trends can prevent major waves of disease.

The case might be made clearer by analogy: No community would be well-served if all its homeowners had fire insurance but there were no fire departments, firefighters, fire hydrants, smoke detectors, or indoor sprinklers. That very well-insured town would still burn to the ground. Insurance is necessary, but it is nowhere near sufficient.

The ACA addresses both approaches, with insurance and with public health. This required going beyond the investments in the law to provide health insurance to also include provisions to make significant public health investments.

It would be insufficient simply to authorize future appropriations for these activities while providing mandatory spending for coverage initiatives. While the Committees on Appropriations of both the House and the Senate have shown ongoing and great leadership in these public health programs, the budget allocations for them have been too tight to allow significant new initiatives of these sorts. Consequently, the ACA provides as firm a funding and organizational base for these services as possible – mandatory spending – because they are essential in making insurance efficient and productive and in making the nation healthier.

Among those programs designated for mandatory spending in the ACA is the Prevention and Public Health Fund (the Fund). Its purpose is "to provide for expanded and sustained national investment in prevention and public health programs."[38] It is the first and only federal program with dedicated, ongoing resources specifically designed to improve the public's health, and in turn, to make the United States a healthier nation.

The Fund is administered by the Secretary of the Department of Health and Human Services (HHS) and may be used to support "programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities."[39] When the Fund was initially created, it provided $5 billion in mandatory spending for these activities over the period FY 2010 through FY 2014 and $2 billion in mandatory spending each fiscal year thereafter (for a total of $15 billion for FY 2010 through FY 2019, and $17.75 billion for FY 2012 through FY 2021).

[38] ACA, Section 4002.
[39] *Id*.

Recent legislation has reduced these authorized funding levels by $6.25 billion for FY 2012 through FY 2021,[40] making it even more imperative to maintain both the Fund's mandatory spending mechanism and its currently-authorized spending amounts. Such resources are necessary to address the perpetual underfunding of prevention activities which by some estimates, account for only 3% of national health expenditures.[41] This view is supported by an Institute of Medicine (IOM) report released earlier this month that reaffirms the importance of building upon existing streams of public health funding – including the Prevention and Public Health Fund – to ensure our nation has an adequate infrastructure to improve health outcomes and to carry out other critical public health functions.[42]

Support for prevention has long been on a bipartisan basis. Members of this Committee from both sides of the aisle and across the political spectrum have spoken strongly in favor of this public health function.[43] Beyond the halls of Congress, this support is also widespread. A public opinion survey by Trust for America's Health and the Robert Wood Johnson Foundation found that 71% of Americans favored an increased investment in disease prevention.[44] And nearly 800 national, state, and local organizations support the Fund as a primary vehicle for making public health investments that would not only help to improve the public's health, but also create jobs and lower long-term health care costs.[45]

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[40] Middle Class Tax Relief and Job Creation Act of 2012, Public Law No. 112-96.

[41] Centers for Medicare and Medicaid Services, National Health Expenditure Data (online at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html?redirect=/NationalHealthExpendData/) (accessed Apr. 18, 2012).

[42] Institute of Medicine, *For the Public's Health: Investing in a Healthier Future* (Apr. 10, 2012) (online at www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx).

[43] See, *e.g.*, comments made by Rep. Pitts during the Committee markup of *Section 102*, House Committee on Energy and Commerce, Markup on *Proposed Matters for Inclusion in Reconciliation Recommendations*, 112th Cong., p. 90 (Apr. 25, 2012) (transcript of the proceeding):

- Rep. Pitts: "The goals of the Fund are laudable and there is no doubt that we must focus on preventing disease rather than simply treating people once they have begun ill."

See also comments made Reps. Pitts, Murphy, Matsui, and Cassidy in support of prevention efforts during the Committee markup of H.R. 1217, House Committee on Energy and Commerce, *Business Meeting to Markup H.R. 1217, To Repeal the Prevention and Public Health Fund*, 112th Cong., p. 242 (Apr. 5, 2011) (transcript of the proceeding):

- Rep. Pitts: "I am not against prevention and wellness";
- Rep. Murphy: "I believe all of us are pretty strongly in favor of anything that has to do with prevention";
- Rep. Matsui: "We are talking about having healthier Americans…."[M]ost people here truly believe that prevention is probably the best way to do this"; and
- Rep. Cassidy: "I strongly believe in many aspects of preventative medicine…".

[44] See http://healthyamericans.org/newsroom/releases/?releaseid=198 for a description of the poll's complete findings.

[45] Letter from Jeffrey Levi, PhD, Executive Director, Trust for America's Health (on behalf of 760 health-related organizations) to Chairman Fred Upton and Ranking Member Henry Waxman (Apr. 23, 2012) (on line athttp://healthyamericans.org/health-issues/wp-content/uploads/2012/04/Fund-Reconciliation-EC-April2012.pdf).

Prevention Fund Dollars at Work

The Prevention and Public Health Fund is one of a number of ACA initiatives that is already in place. Currently, all 50 states and the District of Columbia are receiving Fund support.[46]

In FY 2011, 61 states and communities serving approximately 120 million Americans received funding to implement evidence-based, community programs designed to reduce tobacco use, promote healthy living, prevent and control high blood pressure and high cholesterol, and address health disparities.[47] Twenty percent of funds went to support rural and frontier populations. The Fund has also been used to provide flu shots and other immunizations; improve HIV/AIDS prevention through testing and linkages to care; expand mental health and injury prevention programs; train the public health workforce; and strengthen the public health infrastructure necessary to track and respond to disease outbreaks and disasters.[48]

In general, the Fund is intended to provide support for programs generated at the local or community-based level. This is as it should be – communities know best what public health challenges they face and what interventions are most likely to work.

Prevention Dollars Produce High Value Outcomes

Preventable diseases cost the United States significant resources – in terms of unnecessary deaths, lost productivity, and enormous amounts of money. Indeed, over half of the deaths in this country are due to preventable causes such as tobacco use, diet and activity patterns, and alcohol use.[49] Chronic diseases consume an estimated 75% of the nation's $2 trillion health care spending each year[50], and cost employers $1,685 for each employee each year, or $225.8 billion annually in lost productivity.[51] Obesity alone costs $147 billion each year.[52] A stable, ongoing investment in prevention can help alleviate each of these burdens.

It is true that some life-saving prevention interventions actually involve expenditures. But so do most life-saving drugs and devices. We provide mandatory funding for drugs and devices through programs such as Medicare and Medicaid because steady and secure funding for these programs ensures that more Americans can live longer and healthier lives. Prevention

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[46] For a description of these activities and state-by-state information on the Fund, see Department of Health and Human Services, The Affordable Care Act's Prevention and Public Health Fund in Your State (online at www.healthcare.gov/news/factsheets/2011/02/prevention02092011a.html) (accessed Apr. 27, 2012).
[47] HHS, The Community Transformation Grants Program (online at http://www.healthcare.gov/news/factsheets/2011/09/community09272011a.html) (accessed Apr. 27, 2012).
[48] *Supra* note 14.
[49] McGinnis JM and Foege WH, *Actual Causes of Death in the United States*, JAMA, 270(18): 2207-2212 (Nov. 10, 1993).
[50] Centers for Disease Control and Prevention, *Chronic Disease: The Power to Prevent, the Call to Control, At-A-Glance* (2009).
[51] Centers for Disease Control and Prevention, Worker Productivity (online at www.cdc.gov/workplacehealthpromotion/businesscase/reasons/productivity.html) (accessed Apr. 27, 2012).
[52] Finkelstein EA, Trogdon JG, Cohen JW, *et al*., *Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates*, Health Affairs, 28(5): w822-w831 (2009).

efforts can also reduce the number of deaths and promote the health of Americans and should, therefore, also be supported through the mandatory spending mechanism.

Some forms of prevention do, of course, save money – immunizations, for example, are among our most cost-effective public health investments. Community-based interventions can be cost-effective as well. According to the researchers at the New York Academy of Medicine, an investment of $10 per person per year in proven community-based interventions to increase physical activity, improve nutrition, and prevent smoking can save the country more than $16 billion each year – a return of $5.60 for every $1 invested.[53] The Urban Institute estimates that certain proven community-based diabetes prevention programs can save as much as $191 billion over 10 years.[54] A recent Trust for America's Health report concludes that a reduction of body mass index rates (the measure for obesity) nationwide that meets the HHS target of 5% would save over $158 billion in10 years.[55]

Mandatory Spending

Despite the good and important work being done through the Fund, the health care savings it may help to produce, and the chronic underfunding of prevention activities in the past, Republicans are determined to bring the Fund to an end. They assert two principal arguments for their opposition to it: (1) the Fund's funding mechanism – mandatory spending; and (2) the Secretary's authority to determine how the Fund's monies will be allocated. The two arguments are interrelated; taken together, they present a misleading analysis of how the Fund is intended to operate.

ACA Section 4002(b) provides for mandatory funding for the Fund. It authorizes to be appropriated and appropriates specified funding levels for FY 2010 and beyond. ACA Section 4002(d) addresses the role of the congressional appropriations committees in specifying how the appropriated funds are to be used. This section clearly states that that these committees have explicit authority to allocate monies from the Fund (in accordance with the Fund's purpose to support prevention and other public health activities). Senator Harkin (author of ACA Section 4002) addressed this very issue in a letter to the Committee, making it clear that it is the job of congressional appropriators to make the resource allocation decisions.[56]

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[53] Levi, J. *et al.*, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, Trust for America's Health (Feb. 2009) (online at: http://healthyamericans.org/reports/prevention08/Prevention08.pdf).

[54] Berenson, R. *et al.*, *How We Can Pay for Health Reform*, Urban Institute and Robert Wood Johnson Foundation (July 2009) (online at: http://urban.org/uploadedpdf/411932_howwecanpay.pdf).

[55] Trust for America's Health, *Bending the Obesity Cost Curve: Reducing Obesity Rates by Five Percent Could Lead to More Than $29 Billion in Health Care Savings in Five Years* (Jan. 2012) (online at http://healthyamericans.org/assets/files/TFAH%202012ObesityBrief06.pdf).

[56] Testimony of Senator Tom Harkin (submitted for the record), Subcommittee on Health, Committee on Energy and Commerce, *Hearing on Setting Fiscal Priorities in Health Care Funding*, 112th Cong. (Mar. 9, 2011) (stating, "Contrary to misperceptions that it evades the appropriations process, the Fund was established . . . in such a way that appropriators direct how monies from the Funds are spent").

It is only when Congress fails to pass an HHS appropriations bill (or does not allocate the Fund in an appropriations bill) that the HHS Secretary would have the authority to designate which public health programs or activities would receive Fund support. While it is true that the Secretary has already exercised this authority, it is also true that she has deferred spending these monies when requested to do so by Congress.[57]

Contrary to what Republicans have suggested, monies from the Fund have been allocated and are being used in accordance with both the Fund's purpose[58] and the public health needs of the country as well as HHS rules and regulations.[59]

These points aside, we believe Republican arguments that have been made to end the Fund have been completely undermined by their own actions in recent weeks. During debate on *Section 102*, Republicans asserted the annual appropriations process is a more appropriate way to fund programs and activities supported by the Fund.[60] Yet, last month they voted overwhelmingly to reduce discretionary spending by $19 billion for FY 2013 – an amount below the limits they supported in the Budget Control Act[61] and voted earlier this month to endorse the

[57] See the letter from Senator Tom Harkin, Chairman, Senate Committee on Health, Education, Labor, and Pensions and Chairman, Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations to HHS Secretary Kathleen Sebelius (Jan. 4, 2011) in which he requested that the Secretary allocate monies in accordance with the prevention and public health priorities set forth in the proposed FY 2011 omnibus, year-long continuing resolution, including the Community Transformation Grants Program and tobacco prevention and control. The Secretary subsequently announced a spending plan for FY 2011 which closely tracked Chairman Harkin's request. (see HHS press release on line at www.hhs.gov/news/press/2011pres/02/20110209b.html). At the request of Rep. Denny Rehberg and Rep. Harold Rogers, the Secretary delayed allocation of resources from the Fund for FY 2011. (Letter from Chairman Denny Rehberg, Chair, House Committee on Appropriations and Chairman Harold Rogers, Chair, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, House Committee on Appropriations to HHS Secretary Kathleen Sebelius (Mar. 2, 2011)).

[58] The Section on Background and Need for Legislation for the majority views of this Committee report (*Committee Prints: Proposed Matters for Inclusion in Reconciliation Recommendations*) states the Fund has been used for dog neutering. HHS and CDC have confirmed that this statement is not accurate (e-mail from HHS to Democratic Staff, House Committee on Energy and Commerce (Apr. 25, 2012)). See also comments made by Rep. Schakowsky during the Committee markup on *Section 102*, House Committee on Energy and Commerce, Committee Prints*: Proposed Matters for Inclusion in Reconciliation Recommendations*, 112th Cong., p. 233 (Apr. 25, 2012) (transcript of the proceeding).

[59] The Section on Background and Need for Legislation for the majority views of this Committee report (*Committee Prints: Proposed Matters for Inclusion in Reconciliation Recommendations*) states that the Fund has been used to support construction activities. HHS guidance for the administration of Fund grants provides that "recipients may not use funding for construction." (HHS, Public Prevention Health Fund: National Dissemination and Support for Community Transformation Grants (online at www.grants.gov/search/search.do?oppId=99853&mode=VIEW) (accessed Apr. 27, 2012). To our knowledge, this prohibition has not been violated.

[60] See, *e.g.*, comments made by Rep. Guthrie(pp. 74-75) and Rep. Cassidy (pp. 99-100) during the Committee markup on *Section 102*, House Committee on Energy and Commerce, *Committee Prints: Proposed Matters for Inclusion in Reconciliation Recommendations*, 112th Cong., (Apr. 25, 2012) (transcript of the proceeding).

[61] U.S. House of Representatives, Roll Call Vote on Agreeing to H. Con. Res. 112 (March 29, 2012) (228 yeas, 191 nays).

Appropriations Committee recommendation to cut health, education, and labor programs by more than 40%.[62]

An Anti-Health Reform Ideological Agenda

In light of both the Fund's purpose and track record to date, it comes as a great disappointment that Republicans have continued to target this program for elimination.[63] Surely, this is not because of Republican assertions about the merits of discretionary spending versus mandatory spending or the need to protect Congress's prerogative to fund or not to fund health programs. Congress, Republicans and Democrats alike, makes those kinds of choices -- often difficult choices -- all of the time.[64] And given traditional bi-partisan support for prevention activities, Republican opposition cannot be based on the substance of the program.

Pure and simple, Section 102 represents the Republicans' unending attack to disrupt, dismantle, and ultimately destroy the ACA – even those programs that have been funded and are up and running, and even those that make good health policy sense, in or out of the health reform law.[65] What they have not been able to achieve whole cloth[66], Republicans are now attempting to do piece by piece. Section 102 puts the Prevention and Public Health Fund in the frontline of this ongoing assault.

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[62] House Committee on Appropriations, *Report on the Suballocation of Budget Allocations for Fiscal Year 2013*, 112th Cong. (Apr. 25, 2012) (online at http://appropriations.house.gov/UploadedFiles/FY13-FULLCOMMITTEE302b.pdf).

[63] In addition to passage of H.R. 1217 on Apr. 13, 2011 (Congressional Record, H2633-2646), House Republicans passed legislation (H.R. 3630) to reduce authorized Fund amounts by $11 billion over 10 years -- more than 60% of its funding -- as part of the payroll extenders legislation (Congressional Record, H8762-8824 (Dec. 13, 2011)). And despite the threat of a Presidential veto (Executive Office of the President, Office of Management and Budget, Statement of Administration Policy: H.R. 4628, *Interest Rate Reduction Act* (Apr. 27, 2012)), House Republicans also voted to eliminate the Fund as part of H.R. 4628 on Apr. 27, 2012, the day this report is scheduled to be filed.

[64] For examples of various federal programs that are supported through mandatory spending, see Committee on Energy and Commerce, Democratic Staff, *The Pitts Proposal to Block Mandatory Funding in the Affordable Care Act* (Mar. 9, 2011) (online at: http://democrats.energycommerce.house.gov/sites/default/files/image_uploads/Fact%20Sheet_03.09.11.pdf).

[65] Efforts in the House of Representatives to repeal or otherwise destroy individual parts of the ACA include: H.R. 5, *Protecting Access to Healthcare Act* (passed the House on Mar. 22, 2012 (Congressional Record H1453-1490; H1501-1519)); H.R. 1173, *Fiscal Responsibility and Retirement Security Act of 2011* (passed the House on Feb. 1, 2012 (Congressional Record H322-354)); H.R. 358, *Protect Life Act* (passed the House on Oct. 13, 2011 (Congressional Record, H6885-6903)); H.R. 1214, *To Repeal Mandatory Funding for School-Based Health Center Construction* (passed the House on May 4, 2011(Congressional Record H2969-2977)); H.R. 1216, *To Convert Funding for Graduate Medical Education in Qualified Teaching Centers from Direct Appropriations to an Authorization of Appropriations* (passed the House on May 25, 2011 (Congressional Record H3361-3388; H3396-3401; H3430-3434)); and H.R. 1217, *To Repeal the Prevention and Public Health Fund*) (passed the House on Apr. 13, 2011 (Congressional Record H2633-2647)). To date, none of these bills has been considered by the Senate.

[66] Although the House of Representatives has passed legislation to repeal the ACA, that legislation will not become law since the Senate has defeated the proposal. (H.R. 2 passed the House of Representatives in January 2011 (Congressional Record, H322-323 (Jan. 11, 2011)). The Senate defeated a similar proposal a month later. (Congressional Record S475 (Feb. 2, 2011)). In any case, President Obama has made clear that he will veto any such legislation (Executive Office of the President, Office of Management and Budget, Statement of Administration Policy: H.R. 2, *Repealing the Affordable Care Act* (Jan. 6, 2011) (online at www.whitehouse.gov/sites/default/files/omb/legislative/sap/112/saphr2r_20110106.pdf).

In our view, this is not where the Prevention and Public Health Fund should be. Rather, is should remain exactly where it is – at the forefront of helping to realign the nation's approach to health and health care, making Americans healthier and more productive.

Section 103: Rescinding Unobligated Balances for CO-OP Program

This provision repeals all unobligated appropriations made under section 1322 of the Affordable Care Act, the Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run, Health Insurance Issuers – also known as the Consumer Oriented and Operated Plans, or "CO-OPs." The CO-OP program offers low-interest loans to eligible private, nonprofit groups to help set up and maintain health plans.[67] Starting on January 1, 2014, CO-OPs will be able to offer health plans in the individual and small group insurance marketplaces in and outside the exchange.

A CO-OP is a nonprofit health insurer that is directed by its customers, uses profits for customers' benefit, and is designed to offer individuals and small businesses affordable, customer-friendly, and high-quality health insurance options. Specifically, health cooperatives are governed by their members and are focused on coordinating care and coverage for their beneficiaries. The most successful examples include HealthPartners in Minnesota, with 1.5 million members, and Group Health Cooperative in Washington State, with 700,000 members. Independent studies have placed these cooperatives in the ranks of the highest-performing health plans in the country in terms of providing value and quality care to their customers. [68]

CO-OPs may operate locally, state-wide, or in multiple states. CO-OPs must be licensed as issuers in each state in which they operate and are subject to state laws and regulations that apply to all similarly situated issuers.

When passed, the CO-OP loan program had $6 billion available to support loans.[69] The amounts available were cut by $2.2 billion by section 1857 of the Department of Defense and Full-Year Continuing Appropriations Act of 2011. This amount was further cut in the Consolidated Appropriations Act of 2012 by $400 million.

Thus, the CO-OP loan program has a $3.4 billion appropriation to support loans. Entities can apply for a start-up loan that must be repaid in five years or for solvency loans that must be repaid, with interest, in 15 years from the date of disbursement.

The first round of applications was due on October 17, 2011, and to date, a total of ten non-profits offering coverage in ten states have been awarded $845 million. These states include Maine, Oregon, South Carolina, Iowa, Nebraska, Montana, New Jersey, New Mexico, New

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[67] Terry Gardiner, et. al., *Realizing Health Reform's Potential: Innovative Strategies to Help Affordable Consumer Operated and Oriented Plans (CO-OPs) Compete in New Insurance Marketplaces*, (April 2012) (on-line at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Apr/1591_Gardiner_innovative_strategies_help_coops.pdf).

[68] Section 1322 of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

[69] Section 1322 of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

York, and Wisconsin. A list of the awardees is available at: http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html.

A second round of applications was due on January 3, 2012, and there will be subsequent quarterly application deadlines through December 31, 2012. Awards are announced on a rolling basis.

TITLE II

The provisions of title II would cut the Medicaid program by more than $24 billion over ten years. These proposals do nothing to improve quality or access to care; one section of this title would cause more than 300,000 children to lose coverage and allow states to cut one-third of the people covered by Medicaid and Children's Health Insurance Program (CHIP) off the programs. Numerous groups have expressed their opposition to these proposals including the National Governor's Association, the National Association of Community Health Centers, the Association of Community Affiliated Plans, American Academy of Pediatrics, the National Rural Health Association, Asian and Pacific Islander American Health Forum, and Families USA among others.

Section 201. Medicaid Provider Tax Threshold

This proposal would interfere with states' ability to fund Medicaid at a time when states, nearly universally, are struggling with budget challenges by limiting the amount of state Medicaid funds that can be raised by provider taxes. The Congressional Budget Office indicates this proposal would cut $11.3 billion in funding out of Medicaid over the next ten years. This restriction on states' ability to raise state Medicaid funding will result in cuts to Medicaid coverage, benefits, or provider payment rates.

It is important to note that provider taxes are supported by states and by providers because states use the money from these legitimate and permissible taxes to increase Medicaid provider payments, protect quality, and fund critical benefits and coverage for millions of Americans.

The score from the Congressional Budget Office only reflects the ***federal*** funding cut from the Medicaid program. The total funding cut from the program will be significantly greater than $11 billion. For a state in which the federal government and the state each bear 50% of Medicaid costs to achieve $1 in federal savings, total Medicaid expenditures in the state would have to fall by $2. To generate $11 billion in federal savings, this proposal would require more than $18.9 billion in cuts to state Medicaid programs.

Mr. Pallone offered an amendment that would protect state provider taxes that are used to fund quality nursing home care. Currently, at least 19 states have provider taxes on nursing facilities that would be affected by the Republican proposal to infringe on states' rights. Those states are Arkansas, California, Connecticut, Florida, Georgia, Idaho, Indiana, Maine, Maryland,

Mississippi, Missouri, Nevada, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, and Vermont.

This amendment was supported by the American Health Care Association (AHCA), which wrote, "On behalf of the American Health Care Association, the nation's largest association representing providers of quality long term care, we would like to express our support for the 'Protecting State Autonomy to Fund Quality Health Care' amendment…. It is essential to preserve states' ability to utilize this important funding mechanism. Your amendment is critical to nursing facilities because nearly 65% of our residents rely on Medicaid to pay for their care. You are to be commended for your leadership and commitment to America's seniors."[70]

Mr. Pallone's amendment was defeated by a vote of 21-29. With Medicaid expected to cover 17 million more Americans by 2021 as a result of health reform, we should not be making it harder for states to provide coverage through Medicaid. But that is exactly what this Republican bill would do.

Section 202. Rebasing State DSH Allotments for Fiscal Year 2022

The Medicaid disproportionate share hospital program (DSH) has been critical for America's safety net hospitals. The program provides support to hospitals to help cover the cost of care to the uninsured and to help make up for Medicaid payment shortfalls.
In the ACA, Congress reduced aggregate Medicaid DSH allotments by $0.5 billion in 2014, $0.6 billion in each of 2015 and 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. Congress extended the $4 billion reduction for aggregate DSH allotments for one additional year -- through 2021 -- in the Middle Class Tax Relief and Job Creation Act of 2012[71]. Section 202 would reduce the state disproportionate share hospital allotments to $4 billion for 2022. The President's FY 2013 budget proposed to rebase DSH allotments for 2021, but not for 2022.

The National Association of Public Hospitals (NAPH), which represents the nation's largest metropolitan safety net hospitals, reports that without Medicaid DSH and other safety net financing payments, its members would have seen a negative 12% margin in 2009. DSH payments help these facilities make ends meet. NAPH writes, "Drastic cuts to the Medicaid Program will only shift the cost burden to states, hospitals and other providers, and low-income beneficiaries ultimately hurting patients."[72]

The situation that these safety net hospitals will be facing ten years in the future is impossible to predict. It is irresponsible for Congress to cut payments to these critical providers so far into the future. Worse yet, cuts are being made for the sole purposes of extended or protecting tax breaks for the wealthiest and protecting the defense industry from cuts.

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[70] American Health Care Association letter to Congressman Pallone, April 24, 2012
[71] Public Law No. 112-96.

[72] National Association of Public Hospitals and Health Systems letter to Chairman Upton and Ranking Member Waxman, April 24, 2012.

Mr. Engel offered an amendment to strike section 202, protecting DSH funding for safety net hospitals in the future. This amendment was defeated on a party line vote.

Section 203: Repeal of Medicaid and CHIP Maintenance of Effort Requirements under ACA

The Affordable Care Act is about shared responsibility towards a healthier nation. Individuals, employers, and the federal and the state governments share that responsibility. The Medicaid and CHIP maintenance of effort is the state's responsibility requirement and protects access to healthcare for the most vulnerable populations.

This state responsibility provision requires that states not reduce coverage under Medicaid or CHIP through the state plan or waiver (until is expires) by implementing new eligibility reductions or changes to eligibility methodologies or procedures that would have the effect of reducing coverage beyond those that were in place at the time of the enactment of the Affordable Care Act.[73] The requirements are in place for Medicaid until the Secretary determines that the state exchanges are fully operational, which is expected to be January 1, 2014.[74] The requirements are in place for CHIP through September 30, 2019.[75]

The provision reduces spending by $1.4 billion over ten years, decreasing the deficit by only $600 million when the indirect revenue effects are considered.

Effect on Coverage

Section 203 would eliminate these protections for coverage and allow states to lower the eligibility standards they themselves enacted and cut people off their Medicaid and CHIP programs including low-income pregnant women, children, seniors, and individuals with disabilities living in their homes and in the community upon enactment.

According to CBO, this will cause at least 100,000 low-income pregnant women, children, seniors, and individuals with disabilities living in their homes and in the community to lose insurance in 2013, and cause at least 300,000 children in working families to lose insurance coverage in 2015. Becoming uninsured has dire consequences. According to the Institute of Medicine, uninsured children are 20 to 30% more likely to lack immunizations, prescription medications, asthma care, and basic dental care and are more likely than insured children to miss school due to health problems. Uninsured adults are 25% more likely to die prematurely than insured adults overall, and with serious conditions such as heart disease, diabetes, or cancer, their risk of premature death can be 40% to 50% higher.

The number of people in jeopardy of losing insurance is far greater than CBO's projections of what states might do – one-third of the Medicaid and CHIP beneficiaries would be

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[73] Section 2001(b) and Section 2101(b) of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[74] Section 2001(b) of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[75] Section 2101(b) of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

at risk if this provision passed into law. That includes 14.1 million children, 8 million adults, 2.8 million low-income seniors, and 2.3 million individuals with disabilities according to Georgetown University Center for Children and Families.[76]

Exception in Cases of State Budget Deficits

States are exempted from these stability requirements for nonpregnant, nondisabled adults with incomes above 133% of the federal poverty level starting in January 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year.[77] This exception recognizes the difficult budget situations facing a number of states.

The Maintenance of Effort and Program Integrity

The maintenance of effort requirements allow states to make changes to their enrollment policies and procedures to be responsive to loopholes that emerge that subvert Medicaid eligibility rules. In a letter to Ranking Member Waxman, former CMS Administrator Don Berwick says, "the MOE provisions do not hinder States in their efforts to fight fraud and abuse in the Medicaid and CHIP programs."[78]

However, CMS has to be cautious that states are actually addressing a documented program integrity issue with any proposed changes to eligibility standards. Otherwise a state could be erecting a barrier to Medicaid eligibility in violation of law.

According to the Centers for Medicare and Medicaid Services, "[T]here is extensive evidence that eligibility methods and procedures are strong determinants of whether eligible individuals can actually gain and retain coverage. Our experience working with States suggests States can meet their program integrity objectives consistent with the MOE provisions."[79]

Medicaid and the Economy

Cutting Medicaid eligibility is not saving money; it is abdicating responsibility and shifting costs to beneficiaries and providers while undermining the economic recovery. Cutting eligibility will undermine all the progress made in the last few years and turn back the clock on the money invested in covering kids. Children's coverage levels are the highest ever due to Medicaid and CHIP where 22 million or 28% of all children are covered.

In addition, every one dollar cut from Medicaid means up to $2.76 cut from the state economy. [80] Loss of federal Medicaid dollars means loss of healthcare jobs and healthcare economic activity - moving states in exactly the wrong direction from economic recovery.

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[76] The Center for Children and Families, Georgetown University Health Policy Institute, *Eliminating Medicaid and CHIP Stability Provisions (MOE): What's at Stake for Children and Families*, February 2011.
[77] Section 2001(b) and Section 2101(b) of The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.
[78] Letter from CMS Administrator Don Berwick to Congressman Henry Waxman, July 21, 2012.
[79] Centers for Medicaid, CHIP ad Survey and Certification, SMDL# 11-009, August 5, 2011.
[80] Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid in State Economies: A Look at the Research*, (January 2009) (on-line at http://www.kff.org/medicaid/upload/7075_02.pdf).

Amendments

Congresswoman Baldwin offered an amendment to repeal this provision citing the number of people, including 300,000 children, who would lose insurance coverage as a result of this provision. Congressman Markey offered an amendment focused on the effects of this amendment on disabled children, seniors, and widows. Both were defeated on a party line vote.

Section 204: Medicaid Payments to Territories

The Territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands) operate under different rules for their Medicaid program than the 50 states and the District of Columbia. The Territories are not required to cover the same eligibility groups and use different financial standards in determining eligibility compared to the states. Medicaid programs in the Territories are also subject to annual federal spending caps. All five territories typically exhaust their caps prior to the end of the fiscal year. Once the cap is reached, the Territories assume the full costs of Medicaid services or, in some instances, may suspend services or cease payments to providers until the next fiscal year. The Territories receive a 55% federal matching rate.

Section 204 of the Republican proposal would repeal paragraph (5) of section 1108(g) of the Social Security Act, which provided $6.3 billion in additional Medicaid funding for the Territories. Thus far, more than $300 million in additional funding has been provided to the Territories for 2011 and 2012 through this additional funding stream, which is outside of the capped allotment.

The Republican cuts to Medicaid in the Territories would make it more difficult for the Territories to support health coverage under Medicaid. Already, the Medicaid program in these areas is underfunded compared with the need. For example, if Puerto Rico's matching rate were calculated according to the formula used for the 50 states, its matching rate would be 83%, not the 55% in current law. Residents in these areas have much less access to private insurance than people in the rest of the United States; for example in Puerto Rico, only 42% have private insurance, compared to 65.8% in the United States overall.[81]

This funding provided to the Territories through the Affordable Care Act would help reduce the federal Medicaid funding shortfalls, allowing these areas to better serve low-income residents' health and long-term care needs. As a result of past funding inequalities, the Territories have been unable to serve their low income residents to the same extent as states on the mainland. For example, Puerto Rico's Medicaid income eligibility limit for parents in a family of four is effectively just 36% of the poverty line, compared to 63% for working parents in the median U.S. state. Puerto Rico covers *children* in families of four up to 71% of the

[81] Center on Budget and Policy Priorities, *House Bill Would Cut Medicaid Funding For Puerto Rico by About $5.5 Billion Through 2020*, (April 25, 2012).

poverty line; today, in nearly all states, Medicaid and CHIP cover children up to at least 200% of the poverty line.[82]

Representative Christensen offered an amendment in Committee to strike this section of the Republican bill. In a letter to Representative Upton dated April 20, she joined the other Territorial Representatives in writing, "As a result of chronic underfunding by the federal government, too many patients in the territories receive inadequate care, too many providers in the territories are not adequately compensates for their services, and too much of the financial burden associated with health care delivery must be borne by the territorial governments themselves."[83] Representative Christensen's amendment was defeated on a party line vote.

Barton Amendment to Repeal the CHIP Performance Bonus Payments

In addition to the proposed $24 billion cuts to the Medicaid program in the underlying committee print, Congressman Barton offered another amendment to rescind $8.3 billion in performance bonus payments authorized in the CHIP.

When the CHIP was reauthorized in 2009, the law included special incentive payments – a performance bonus program – to encourage states to find and enroll all eligible children.

These performance bonus payments help offset the costs states incur when they enroll lower income children in Medicaid. In order to qualify for the bonus payments, states have to streamline their enrollment systems by implementing 5 of 8 enrollment "best practices," and surpass an enrollment target for covering children in Medicaid. These best practices are things like 12 month continuous eligibility, use of a joint application for Medicaid and CHIP, and express lane eligibility.

The number of children with health insurance has climbed over the past three years since this program was created in the CHIP reauthorization. Prior to the reauthorization, 91% of all children had health insurance. By 2011 an additional 1.2 million children had coverage, bringing children's coverage levels to 93%.[84]

States have continued to make significant progress in simplifying their programs and covering more children – despite the budgetary challenges many states are facing. That is why this bonus money is so important. These children that are being helped are in the poorest, lowest income families. They are children who, without Medicaid coverage, are unlikely to get their medical needs met.

The performance bonus program is set to end in 2013, even though CHIP is authorized through 2015. Mr. Barton's amendment would eliminate the funding in the successful performance bonus program in 2013. Eliminating the program, rather than continuing it, will hurt states' efforts to improve children's coverage.

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[82] Id.
[83] Letter from Representatives Pierluisi, Christensen, Bordallo, Faleomavaega to Chairman Upton, April 20, 2012.
[84] ASPE Issue Brief, "1.2 Million Children Gain Insurance Since Reauthorization of Children's Health Insurance Program," December 22, 2011.

Each year, progress in enrolling eligible but uninsured children has increased. Only 10 states received bonuses (totaling $37 million) in the first year, 2009. This past year, 2011, 23 states received a total of $296 million in bonus payments.

Maryland, Virginia, Wisconsin, Colorado and Oregon were the top recipients in 2011 of the bonus funding for their success in reaching eligible but unenrolled children. This past year, a number of states qualified for the bonus payments for the first time – Connecticut, Georgia, Montana, North Carolina, North Dakota, South Carolina, and Virginia.[85] States are beginning to get the streamlined procedures in place that will help boost enrollment of eligible children.

Mr. Sarbanes offered a second degree amendment to the amendment offered by Mr. Barton. This amendment is exactly the kind of policy that this Committee would pursue if the Republican leadership was interested in making progress in reducing the number of uninsured and covering all children to give them a healthy start.

Mr. Sarbanes' amendment would ensure that the Children's Health Insurance Program Reauthorization Act (CHIPRA) performance bonus program, currently slated to end in 2013, could continue through the life of the CHIP program. It would ensure that the performance bonus money remains available for states that have success in finding and enrolling eligible children in health insurance coverage. As a result of efforts by Maryland under the performance bonus program, Mr. Sarbanes' home state enrolled an additional 41,000 children in Medicaid in 2011. Twenty-two other states have received CHIP performance bonus payments by simplifying their programs in order to enroll more low-income children than projected in Medicaid. Mr. Sarbanes' second degree amendment was defeated on a party line vote.

Baldwin Amendment on Medicare Negotiation of Prescription Drug Prices

Congresswoman Baldwin's amendment repeals the prohibition on the Secretary from negotiating prescription drug prices for the seniors in the Medicare program and requires the Secretary to negotiate and get the best prices she can on behalf of the nearly 50 million people in Medicare. The amendment was ruled out of order as being non-germane.

TITLE III

Title III of the Committee Prints[86] is identical to H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011,[87] as reported by the Committee on May 23, 2011.[88] Like H.R. 5 itself, Title III should not and will not become law.[89] And for good

[85] CHIPRA Performance Bonuses: A History (FY 2009-FY2011), (on-line at www.insurekidsnow.gov).

[86] Hereinafter cited as *Title III*.
[87] Hereinafter cited as the *HEALTH Act*.
[88] House Committee on Energy and Commerce, *HEALTH Act*, 112th Cong. (May 23, 2011), (H. Rept. 112-39, Part 2).
[89] A slightly different version of the *Health Act* passed the House of Representatives on Mar. 22, 2012 as part of the *Protecting Access to Health Care (PATH) Act* (Congressional Record, H1517-1519). To date, the Senate has not acted on this legislation and is not expected to do so.

reason. It is one-sided. It will not "fix" the problems it purports to address. And in one-fell swoop, it completely up-ends literally centuries of state law. Pure and simple -- and contrary to the argument put forth by the bill's leading sponsor, H.R. 5/Title III is not "meaningful [medical malpractice] reform."[90]

This is not to suggest that medical malpractice is not a problem in this country. It is. On this point members on all sides of the issue agree.[91] But it is also complex and complicated and therefore, deserving of a very thoughtful and measured response. H.R. 5/Title III is anything but that.

Congresses of the past share this belief. Indeed, since the 107th Congress, legislation identical or similar to H.R. 5/Title III has repeatedly failed to reach the President's desk.[92] Its failure to become law under Democratic or Republican Congresses and Presidents alike is itself a verdict on its merits and efficacy.

We do not believe the case has been made for this House, for this Congress, or for this President to follow a different course of action. While the current state-based system for dealing with medical malpractice is far from perfect, in our view, it is the framework through which appropriate modifications and improvements should be developed and implemented. A "one-size-fits-all" approach -- the very vision of H.R. 5/Title III -- not only tears this system down; it also imposes upon the states, a new, untried, and untested legal structure with little regard for the potential consequences.

There are many particulars in the legislation and the arguments of its advocates to which we object. The views expressed here focus only on those specifics that received extensive attention during the Committee's consideration of the legislation:

- the mis-representation of the California law upon which H.R. 5/Title III is supposedly based;
- H.R. 5/Title III's wholesale preemption of state medical malpractice law;
- its broad and expansive scope that goes beyond traditional medical malpractice; and
- its unparalleled protections for manufacturers of drugs and medical devices approved by the Food and Drug Administration (FDA).

As such, and in recognition of the thorough and thoughtful analysis of all aspects of the legislation by those members of the Committee on the Judiciary opposed to the legislation, as

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[90] Rep. Phil Gingrey, *The HEALTH Act: A Real Reform Option* (online at: http://gingrey.house.gov/News/DocumentSingle.aspx?DocumentID=240791 (accessed on May 19, 2011).

[91] See, *e.g.*, remarks of Rep. Frank Pallone (p. 12); Rep. Joe Pitts (p. 18); and Rep. Michael Burgess (p. 29) during the Committee markup of H.R. 5 (House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong. (May 10, 2011) (transcript of the proceeding) and Ranking Member Henry Waxman (House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., p. 21 (May 11, 2011) (transcript of the proceeding).

[92] House Committee on the Judiciary, *HEALTH Act*, Dissenting Views, 112th Cong., p. 88 (Mar. 17, 2011) (H. Rept. No. 112-39, Part 1).

well as our shared jurisdiction with that committee over H.R. 5/Title III, we incorporate by reference herein the dissenting views included in the report filed by the Committee on the Judiciary on H.R. 5.[93] We concur in those views and stand with these colleagues in wholly rejecting this legislation.

Background And Overview

A medical malpractice claim is an allegation of harm or injury caused by a health care provider. A medical malpractice lawsuit is a civil (*i.e.*, non-criminal) action in which an individual making such an allegation seeks damages against those health care providers the individual believes is legally responsible or liable for the harm or injury that has occurred. Medical malpractice liability arises when a health care provider engages in negligence or an intentional wrongdoing.[94] "The general difference between an action based in negligence and one based in intentional tort [wrongdoing] is that a 'medical procedure poorly performed might constitute negligence, while a medical procedure correctly performed that was not consented to might constitute an intentional tort.'"[95]

Traditionally, the principals of medical malpractice liability and the procedures for the conduct of medical malpractice lawsuits have been governed by state law.[96] In fact, it has always been that way.

Periodically, however, Congress has engaged in a debate about various aspects of medical malpractice, generally in response to sharply rising medical malpractice insurance premiums for physicians as well as reports of activities strongly associated with such increases – the difficulty of doctors in some specialties obtaining any malpractice coverage at all and the decision of many physicians to leave the practice of medicine altogether because the insurance they could secure was too expensive.[97] Reform the system and premium charges will subsequently fall, resulting in good things for doctors, for their patients, and for the nation's health care bill – so the argument has gone. This flawed logic apparently failed to sway past Congresses, which chose not to act upon it.

Sponsors of the HEALTH Act/Title III have put forth the same defective reasoning, stating that H.R. 5/Title III "will . . . bring down the cost of medical malpractice insurance which will reduce the overall cost of health care in this country,"[98] and making lower malpractice insurance premiums one of the driving forces behind the legislation.[99] Yet, data indicate that

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[93] House Committee on the Judiciary, *HEALTH Act*, Dissenting Views, 112th Cong., pp. 88-120 (Mar. 17, 2011) (H. Rept. No. 112-39, Part 1).
[94] See Garner, BA (editor-in-chief), *Black's Law Dictionary* (9th ed. 2009), ("malpractice: medical malpractice") (available online at: http://www.westlaw.com); and Keeton, WP, Dobbs, DB, Keeton, RE, and Owen, DG, *Prosser and Keeton on Torts* (5th ed. 2004), pp. 185-187 (West Group, Hornbook Series).
[95] Congressional Research Service, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, Rept. No. R41661, p. 2 (Mar. 28, 2011).
[96] *Id*. at Summary.
[97] Congressional Research Service, *Medical Malpractice: Background and Legislation in the 112th Congress*, Rept. No. R41693, p. 1 (Apr. 26, 2011) (report updated Mar. 16, 2012).
[98] Remarks of Rep. Phil Gingrey, House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., p. 151 (May 11, 2011) (transcript of the proceeding).
[99] *HEALTH Act*, Section (2)(b)(2); *Title III*, Section 301(b)(2).

today, the overall medical liability insurance market is not in crisis.[100] They also show it is the direct regulation of insurance companies -- and not a cap on non-economic damages (one of the core elements of H.R. 5/Title III) -- that is responsible for the reductions in insurance premiums that have been seen.[101]

Nor is there is compelling evidence that H.R. 5/Title III will achieve the other major goals articulated by its advocates[102] – to eliminate the practice of so-called defensive medicine;[103] to "put the focus back on patients;"[104] and to significantly reduce health care costs.[105]

Despite the poor prognosis for success of the approach taken by H.R. 5/Title III, and as previously acknowledged, we believe medical malpractice is a very real and significant concern that requires appropriate attention. Malpractice insurance premiums remain high in some parts of the country.[106] The justice system does not always work as it should. Many legitimate malpractice cases are never filed and when they are, in some instances, severely injured

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[100] Congressional Research Service, *Medical Malpractice: Background and Legislation in the 112th Congress*, Rept. No. R41693, p. 1 (Apr. 26, 2011) (report updated Mar. 16, 2012); Testimony of Joanne Doroshow, Executive Director, Center for Justice & Democracy, House Committee on Energy and Commerce, *Hearing on the Cost of the Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 25 (Apr. 6, 2011) (transcript of the proceeding).

[101] This is precisely what happened in the state of California. After the state's cap on non-economic damages for medical malpractice cases was enacted in 1975 as part of MICRA, malpractice premium rates rose by some 450%. They only dropped in 1988 when state Proposition 103 was passed, setting up a state regulatory process for insurance rates. (Testimony of Joanne Doroshow, Executive Director, Center for Justice & Democracy, House Committee on Energy and Commerce, *Hearing on the Cost of the Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 51 (Apr. 6, 2011) (transcript of the proceeding)).

[102] *HEALTH Act*, Section (2)(b); *Title III*, Section 301(b).

[103] Congressional Research Service, *Medical Malpractice: Background and Legislation in the 112th Congress*, Rept. No. R41693, pp. 4-5; 7 (Apr. 26, 2011) (report updated Mar. 16, 2012); Testimony of Allen B. Kachalia, MD, JD, Medical Director, Brigham and Women's Hospital (p. 34) and Joanne Doroshow, Executive Director, Center for Justice & Democracy (p. 70), House Committee on Energy and Commerce, *Hearing on the Cost of the Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong. (Apr. 6, 2011) (transcript of the proceeding).

[104] Rep. Phil Gingrey, *The HEALTH Act: A Real Reform Option* (online at: http://gingrey.house.gov/News/DocumentSingle.aspx?DocumentID=240791 (accessed on May 19, 2011). See Testimony of Allen B. Kachalia, MD, JD, Medical Director, Brigham and Women's Hospital, House Committee on Energy and Commerce, *Hearing on the Cost of the Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 34 (Apr. 6, 2011) (transcript of the proceeding). See also the 2009 letter to Senator Orrin Hatch from the Congressional Budget Office (CBO) on the effects of medical malpractice reform in which CBO stated that ". . . imposing limits on [the right to sue for damages that result from negligent health care] might be expected to have a negative impact on health outcomes." (Letter from Douglas W. Elmendorf, Director, Congressional Budget Office to Senator Orrin G. Hatch, p. 5 (Oct. 9, 2009) (online at: http://cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf)).

[105] Congressional Research Service, *Medical Malpractice: Background and Legislation in the 112th Congress*, Rept. No. R41693, pp. 4-5 (Apr. 26, 2011) (report updated Mar. 16, 2012).

[106] See, *e.g.*, Testimony of Troy M. Tippetts, MD, Past President, American Association of Neurological Surgeons, House Committee on Energy and Commerce, *Hearing on the Cost of the Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act of 2011*, 112th Cong., p.115-116 (Apr. 6, 2011) (transcript of the proceeding); and comments of Rep. Tim Murphy during the Committee markup of H.R. 5 (Remarks of Rep. Tim Murphy, House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., p. 43 (May 11, 2011) (transcript of the proceeding)).

individuals do not receive just compensation; in others, damages appear to be excessive.[107] These issues can and should be addressed in the proper forum.

But beyond all this lies the root problem of medical malpractice – medical errors. As summarized succinctly by Congressional Research Service experts, "medical errors can lead to injury, and injury is the medical basis on which a malpractice claim is made."[108] Such mistakes appear to be at an all-time high. For example, a recent study from the leading journal Health Affairs indicates that the number of confirmed serious, adverse events occurring in hospitalized patients is at least ten times higher than previously reported, with such events taking place in one-third of hospital admissions.[109]

H.R. 5/Title III makes no attempt to address this fundamental issue. Shockingly, other than improving the exchange of information, reducing medical errors and improving patient care is not even listed among the purposes of the legislation.[110] Moreover, proponents of the HEALTH Act/Title III specifically rejected an amendment offered at the Committee markup on H.R. 5 that would have included the achievement of these goals in that section of the bill.[111] This makes no sense given that experts on all sides of the malpractice issue agree: We must address medical mismanagement as part of any fundamental reform of our health care system.[112]

The ACA[113] takes on this challenge. It includes several provisions designed to improve patient safety and reduce unnecessary medical errors.[114] The Administration has already begun

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[107] Testimony of Allen B. Kachalia, MD, JD, Medical Director of Quality and Safety, Brigham and Women's Hospital, House Committee on Energy and Commerce, *Hearing on the Cost of the Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 32 (Apr. 6, 2011) (transcript of the proceeding).

[108] Congressional Research Service, *Medical Malpractice: Background and Legislation in the 112th Congress*, Rept. No. R41693, p. 6 (Apr. 26, 2011) (report updated Mar. 16, 2012).

[109] Classen DC, Resar R, Griffin F, Federico F , Frankel T, Kimmel N, Whittington JC, Frankel A, Seger A and James BC, *'Global Trigger Tool' Shows That Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured*, Health Affairs, 30, No.4 (2011):581-589.

[110] *HEALTH Act*, Section 2(b); *Title III*, Section 301(b).

[111] House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., pp. 201-207; 229-237 (amendment offered by Rep. Ed Towns) (May 11, 2011) (transcript of the proceeding).

[112] "Reform should address how well the malpractice system improves the quality of care that we provide. After all, this is one of the system's main goals." (Testimony of Allen B. Kachalia, MD, JD, Medical Director of Quality and Safety, Brigham and Women's Hospital, House Committee on Energy and Commerce, *Hearing on the Cost of the Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 33 (Apr. 6, 2011) (transcript of the proceeding)).

[113] The *ACA* is comprised of two public laws, P.L. 111-148 and P.L. 111-152.

[114] See, *e.g.*, *ACA* Section 2702 (Medicaid payment adjustment for health care-acquired conditions); Section 3001 (hospital value-based purchasing program); Section 3008 (Medicare payment adjustment for conditions acquired in hospitals); Section 3011 (national strategy to improve health care quality); Section 3012 (interagency working group on health care quality); Section 3013 (quality measure development); Section 3014 (quality measurement); Section 3015 (quality data collection; public reporting); Section 3021 (Center for Medicare and Medicaid Innovation); Section 3025 (hospital readmissions reduction program); Section 3026 (community-based care transitions program); Section 3501 (health care delivery system research; quality improvement technical assistance); Section 3503 (medication management services in treatment of chronic disease); and Section 3508 (demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals).

to use these authorities to address patient safety in a significant fashion.[115] When fully implemented and evaluated, theses types of measures are expected to have a positive impact on the medical malpractice situation as it exists today.

In the meantime and in recognition of the immediate desire to address a number of medical malpractice concerns, the *ACA* also provides $50 million for demonstration projects to allow states to develop, implement, and evaluate alternatives to current malpractice litigation practices and procedures.[116] HHS is now in the process of implementing such projects. In addition, the President's budget proposal for FY 2013 calls for $250 million in state medical malpractice demonstration projects to be administered by the Department of Justice.[117] This demonstration project approach to malpractice reform has also been endorsed by a 2010 study on behalf of the Medicare Payment Advisory Commission (MedPAC).[118]

We believe these efforts, combined with those designed to improve patient outcomes, form the basis for real and truly meaningful medical malpractice reform that can have a substantial impact on health care costs. They should be given every opportunity to proceed and succeed. As currently structured, H.R. 5/Title III cannot produce the same results. In our view, then, once again, the legislation should be turned back and put aside.

H.R. 5/Title III Is Not MICRA

Since its introduction, proponents of the HEALTH Act/Title III have suggested that it is modeled on the Medical Injury Compensation Reform Act (MICRA),[119] medical malpractice legislation that was enacted in California in 1975.[120] At best, this is an unintentional misreading of the California law; at worse, it is an attempt to mislead members into believing that a vote for H.R. 5/Title III is a vote for MICRA. As the plain language of H.R. 5/Title III makes clear, this is simply not true.

The differences between MICRA and H.R. 5/Title III on a number of key issues are stark and important:

- *MICRA applies only to cases involving a doctor, a nurse, or a hospital (and similar health care providers).*

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[115] For a description of these initiatives, see HHS, *Partnership for Patients: Better Care, Lower Costs* (Dec. 14, 2011) (online at: http://www.healthcare.gov/news/factsheets/partnership04122011a.html).
[116] *ACA*, Section 10607.
[117] U.S. Department of Justice, FY 2013 Performance Budget, Office of Justice Programs (Feb. 2012) (on line at: http://www.justice.gov/jmd/2013justification/pdf/fy13-ojp-justification.pdf).
[118] Mello MM, Kachalia A, *Evaluation of Options for Medical Malpractice System Reform*, MedPAC, No. 10-2 (Apr. 2010).
[119] *MICRA* is codified at different sections within the California Code. See Cal. Business and Professions Code, Section 6146; Cal. Civil Code, Sections 3333.1 and 3333.2; and Cal. Code of Civil Procedure, Section 667.7
[120] See, *e.g.*, Section on Background and Need for Legislation for this Committee report (*Committee Prints: Proposed Matters for Inclusion in Reconciliation Recommendations)*; Internal Memorandum from Committee Staff to Members of the House Committee on Energy and Commerce, *Full Committee Markup on May 10-11, 2011*, p. 5., in which Committee staff state: "H.R. 5 mirrors the provisions of MICRA . . . ."; and comments of Rep. Joe Pitts during the Committee markup of H.R. 5. (Remarks of Rep. Joe Pitts, House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., pp. 18-19 (May 10, 2011) (transcript of the proceeding).

The Health Act/Title III is breathtaking in its scope. Its provisions -- including caps on non-economic and punitive damages -- cover all "health care lawsuits," providing protections not only for physicians and hospitals, but also for nursing homes, insurance companies, health maintenance organizations, medical device manufacturers, and pharmaceutical companies.[121] This approach goes far beyond what is typically contemplated as a medical malpractice case.

- *MICRA applies only to cases of professional negligence and not other causes of action.*

H.R. 5/Title III takes in all "health care liability actions . . . regardless of the theory of liability" on which a lawsuit is based.[122] This includes cases of intentional wrongdoing -- cases in which a patient does not consent to a medical or health care service -- as well as negligence.

- *MICRA does not include any limitations on claims brought against pharmaceutical and medical device companies.*

Except in rare instances, the HEALTH Act/Title III provides complete immunity from punitive damages to manufacturers of drugs and devices that have been approved by the FDA or that are generally recognized as being safe and effective in accordance with FDA standards.[123] Such blanket immunity is virtually unprecedented.[124]

- *MICRA does not cap punitive damages or require special action before punitive damages can be awarded.*

H.R. 5/Title III includes a cap on punitive damages – $250,000 or twice the amount of non-economic damages, whichever is greater.[125] Moreover, H.R. 5/Title III establishes special procedures and conditions that must be met before punitive damages can be sought in a lawsuit,[126] making it far more difficult for such damages to be awarded.

- *MICRA restricts its limitations on attorney contingency fees only to cases brought against health care providers*.

The HEALTH Act/Title III imposes limits on contingency fees for attorneys involved in a much broader spectrum cases, including those in which a claim is brought against a pharmaceutical or medical device manufacturer.[127] Such limits, in effect, create hurdles for an injured party to obtain the best possible legal representation.

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[121] *HEALTH Act*, Section 9(9); *Title III*, Section 308(9).
[122] *HEALTH Act*, Section 9(8); *Title III*, Section 308(8)
[123] *HEALTH Act*, Section 7(c); *Title III*, Section 306(c).
[124] Generally speaking, punitive damages cannot be assessed against vaccine manufacturers under the National Vaccine Injury Compensation Program (established in Title 21 of the Public Health Service Act) in those vaccine injury cases in which an injured person rejects compensation and elects to file a lawsuit in court. However, as discussed in these views on the issue of states' rights, we believe the Compensation Program is a unique and special initiative, completely distinguishable from the *HEALTH Act*/*Title III*.
[125] *HEALTH Act*, Section 7(b)(2); *Title III*, Section 306(b)(2).
[126] *HEALTH Act*, Section 7(a); *Title III*, Section 306(a).
[127] *HEALTH Act*, Section 5; *Title III*, Section 304.

These dramatic differences between the two pieces of legislation -- along with others -- illustrate just how misguided and deceptive it is to assert that H.R. 5/Title III is a MICRA look-alike. Moreover, these distinctions highlight the extreme nature of H.R. 5/Title III. Indeed, the HEALTH Act/Title III not only goes far beyond what is covered and considered by MICRA; it is, in fact, a constellation of reforms that when taken together in a single package, constitutes a radical transformation of the nation's tort system and not simply medical malpractice reform. Such transformation is neither necessary nor warranted and certainly is not what MICRA stands for.

H.R. 5/Title III Is an Assault On States' Rights

At its core, H.R. 5/Title III is a wholesale refutation of the federalist approach to medical malpractice liability under which states have traditionally developed their own law and established their own rules to govern these kinds of cases.[128] Every state is affected by the legislation and, despite suggestions to the contrary, no state will be able to keep its current malpractice law intact.[129]

Such action is troubling on many fronts. Of greatest concern perhaps -- beyond the bill's direct and unjustified attack on states' rights -- is the magnitude of what is contemplated under the legislation.

In one form or another, all 50 states have addressed the issue of medical malpractice liability and no two states have come out in exactly the same place. Instead, each state has developed a process and set of procedures for medical malpractice cases that best meet the needs of its citizens and own legal system. Thus, for example, some states have enacted caps on damages in malpractice cases; other states have laws or even constitutional provisions that specifically prohibit them. The same can be said for many of the other reforms included in the HEALTH Act/Title III such as those related to joint and several liability, statutes of limitations, attorney contingency fees, and periodic payments for awards. [130]

No state, however, has attempted to capture every action against "a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based"[131] under the umbrella of a single medical malpractice reform initiative. No state, then -- not a single one -- has in place the "new world" malpractice order set out in H.R. 5/Title III.

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[128] States have traditionally set their own rules and procedures for dealing with other health-related matters, *e.g.*, licensure of medical professionals and the regulation of health insurance.

[129] "I have heard or been briefed that Section 11 [state flexibility] of H.R. 5 does protect the states' rights, but if you read it, it is extremely restrictive, and most states that have medical liability or medical malpractice reform laws will have this federal law supersede it. Read Section 11. It is a one size fits all." (Remarks of Rep. Lee Terry, House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., p. 26 (May 10, 2011) (transcript of the proceeding)).

[130] Congressional Research Service, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, Rept. No. R41661 (Mar. 29, 2011).

[131] *HEALTH Act*, Section 9(7); *Title III*, Section 308(7).

The sweep of H.R. 5/Title III is simply stunning. In short, advocates of the HEALTH Act/Title III would have the federal government strike down the medical malpractice law of all 50 states[132] and replace it with their own, uniform, first-of-a-kind version of what that law should be. It comes as no surprise, then, that the bipartisan National Conference of State Legislatures strongly opposes the legislation and concludes that "federal malpractice legislation is unnecessary."[133]

The inconsistency of this vision cannot go unmentioned. By and large, proponents of H.R. 5/Title III are the very same Committee members who have staunchly spoken out in favor of states rights – at times even with respect to medical malpractice law.[134] Yet, in this instance, they have squarely turned their backs on this principal. This reincarnation is stunning as well.[135]

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[132] The *HEALTH* Act/*Title III* allows for only two exceptions under which state law would not be preempted: (a) state law that provides greater procedural or substantive protections for health care providers and organizations than those found in the legislation (*HEALTH Act*, Section 11(b)(2)); *Title III*, Section 310(b)(2)); and (b)state law that specifies an exact dollar figure for a cap on either non-economic or punitive damage – such figures would remain untouched, regardless of their amount (*HEALTH Act*, Section 11(c); *Title III*, Section 3120(c)). The former demonstrates the one-sided approach of the *HEALTH Act*/*Title III* – state laws that protect health care providers and organizations are preserved while state laws that protect patients and consumers are tossed out.

[133] Letter from Assemblyman William Horne (NV) and Rep. Jerry Madden (TX), National Conference of State Legislatures, to Rep. Joe Pitts and Rep. Frank Pallone (Apr. 4, 2011) (online at: http://www.ncsl.org/default.aspx?tabid=22497).

[134] See, *e.g.*, the debate over the amendment offered by Rep. Tammy Baldwin during the Committee markup of both H.R. 5 and *Title III*. The text of that amendment reads: "Nothing in this Act shall be construed to modify or preempt any substantive or procedural state law governing medical malpractice or medical liability cases or to impair state authority regarding legal standards or procedures used in medical malpractice or medical product liability cases." This language is identical to that found in Section 2(c) of H.R. 816, *Provider Shield Act of 2011*, introduced by Rep. Phil Gingrey, the primary sponsor of H.R. 5/*Title III*, in February 2011. Yet Rep. Gingrey, along with two other co-sponsors of H.R. 816, Reps. Tim Murphy and Michael Burgess -- as well other proponents of the *HEALTH Act*/*Title III* -- voted against the Baldwin amendment. (House Committee on Energy and Commerce, *Markup on Committee Prints: Proposed Matters for Inclusion in Reconciliation Recommendations*, 112 Cong., pp. 218-225; 353-360; *Markup on H.R. 5, HEALTH Act*, 112th Cong., pp. 6-65 (amendment offered by Rep. Tammy Baldwin) (May 11, 2011) (transcript of the proceedings)). These members went on to reject a narrower amendment to carve out and preserve only state constitutional provisions that address medical malpractice liability. (House Committee on Energy and Commerce, *Markup on Committee Prints: Proposed Matters for Inclusion in Reconciliation Recommendations*, 112 Cong., pp. 226-235; 360-374; House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., pp. 66-88 (amendment offered by Rep. John Barrow) (May 11, 2011) (transcript of the proceedings)).

During the markup on H.R. 5 Rep. Lee Terry emphasized how support for H.R. 5 is inconsistent with support for states rights: "It seems ironic to me that as someone who passionately opposed the nationalization of our health care based on the fact that this was extreme federalism and usurps states' rights that now, because it is politically expedient for us on this side of the aisle, that we are now engaging in that same philosophical conduct." (Remarks of Rep. Lee Terry, House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., p. 26 (May 10, 2011) (transcript of the proceeding)). Rep. Terry's point is underscored in an op-ed piece against H.R. 5, penned by Professor Randy Barnett of Georgetown University Law Center at the very time the Committee report on H.R. 5 was filed. Professor Barnett is a well-known and ardent opponent of the ACA who has twice this year testified against the law before Congress, co-authored the National Federation of Independent Business's *amicus* brief on the constitutionality of the Act for the 11th Circuit Court of Appeals, and has appeared with Republicans to promote its repeal. In his op-ed piece, Professor Barnett states:

> But tort law -- the body of rules by which persons seek damages for injuries to their person and property -- has always been regulated by the states, not the federal government. Tort law is at the heart of what is called the 'police power' of states'. . . . Indeed, if Congress

HEALTH Act/Title III proponents cite two statutes in support of their federalist approach to medical malpractice reform[136] -- the Federal Torts Claim Act (FTCA)[137] and the National Childhood Vaccine Injury Act[138] -- as examples of congressional intervention in medical malpractice liability. We submit that neither law is on point.

Enacted in 1946, the FTCA was established to provide a mechanism through which the federal government could be sued and held liable for damages in civil or tort actions. (Until then, under our traditional common law borrowed from the British, the government enjoyed sovereign immunity, meaning that it could never be held liable for claims, regardless of its degree of culpability.) The FTCA partially waives the government's sovereign immunity by authorizing civil suits (with some exceptions) to be brought against the United States and making federal employees acting within the scope of their employment immune from liability – that is, it makes the United States liable for torts of its employees to the extent private employers are liable under state law for the torts of their employees.

In contrast to the HEALTH Act/Title III, the FTCA does not create federal tort law; it simply makes the federal government subject to state tort law. The law of the state in which the misconduct occurs governs both the substantive and procedural aspects of FTCA cases.

> can now regulate tort law, which has always been at the core of state powers, then Congress, and not the states, has a general police power. . . . While I strongly support reforming our malpractice laws to protect honest doctors from false claims and out-of-control state juries, this reform must come at the state level, as it has in recent years. Constitutional law professors have long cynically ridiculed a 'fair-weather federalism' that is abandoned whenever it is inconvenient to someone's policy preferences. If House Republicans ignore their pledge to America to assess the Constitution themselves, and invade the powers 'reserved for the states' affirmed by the Tenth Amendment, they will prove my colleagues right.

Barnett, R, *Tort Reform and the GOP's Fair-Weather Federalism*, Washington Examiner (May 21, 2011).
It is also noteworthy that during Committee consideration of H.R. 5, one proponent of the bill pointed to the efforts of Mississippi Governor Haley Barbour in enacting a "comprehensive tort reform law that has significantly reshaped our [Mississippi] medical liability system" as a model Congress should "emulate." (Remarks of Rep. Gregg Harper, House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., p. 47 (May 10, 2011) (transcript of the proceeding)). Yet Governor Barbour is on record before the Committee in opposing federal legislation that would preempt state medical malpractice law. (Committee on Energy and Commerce, *Hearing on the Consequences of Obamacare: Impact on Medicaid and State Health Care Reform*, 112th Cong., p. 111 (Mar. 1, 2011) (transcript of the proceeding)).

[135] We are compelled to comment as well on the inconsistency concerning the assertions of H.R. 5/*Title III* advocates regarding the legislation's constitutional authority. They cite Article I, Section 8, Clause 3 of the Constitution as the basis for the legislation, stating that "health-care related lawsuits are activities that affect interstate commerce" and argue that such lawsuits contribute to the high costs of health care. (Statement of Rep. Phil Gingrey, Congressional Record, H434 (Jan. 24, 2011)). Yet, for past two years, supporters of the *HEALTH Act/Title III* have argued precisely the opposite with respect to the *ACA* – that its provisions violate the Constitution's Commerce Clause even though, they too, are designed to address the high costs of health care.

[136] See, *e.g.*, the comments of Rep. Brian Bilbray (pp. 23-24); Rep. Phil Gingrey (p. 25); and Rep. Bill Cassidy (pp. 31-32) on this point during the Committee markup on H.R. 5. (House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., (May 11, 2011) (transcript of the proceeding)).

[137] United States Code, Title 28, Chapter 171.

[138] Public Health Service Act, Title 21, Subtitle 2.

Congress can, however, place limitations on its waiver of sovereign immunity. It has, for example, not waived sovereign immunity for punitive damages, so no individual can collect such damages from the federal government. Under the FTCA specifically, Congress has capped attorney fees and requires that individuals seeking redress against the federal government first file an administrative claim with the appropriate federal agency before bringing a lawsuit in federal court. But once that lawsuit is initiated, state law will fully apply, including state law regarding the award of non-economic damages.[139] Under H.R. 5/Title III, a completely different set of rules -- those established under the legislation -- would be used instead.[140]

The National Childhood Vaccine Injury Act does not work either as a justification for H.R. 5/Title III. Created in 1986, this statute established a new "no-fault" system to compensate individuals who have been injured by vaccines routinely administered to children. Unlike H.R. 5/Title III, the scope of this law is quite narrow and targeted. It was enacted to address two very specific and overriding concerns with which the federal government has a direct interest: "(a) the inadequacy -- from both the perspective of vaccine-injured persons as well as vaccine manufacturers -- of the [then current] approach to compensating those who have been damaged by a vaccine; and (b) the instability and unpredictability of the childhood vaccine market.[141] As discussed in our Introduction to these dissenting views, we do not believe supporters of H.R. 5/Title III have made the same kind of compelling argument to rationalize direct federal intervention into the issue of medical malpractice liability. Nor do we believe that the legislation is designed to adequately address that problem.

But beyond their differences in purpose and scope is the primary substantive distinction between H.R. 5/Title III and the vaccine compensation law. Under the National Childhood Vaccine Injury Act, injured patients who meet the relevant and relatively generous eligibility criteria are awarded compensation from a fund supported by a federal tax on specified vaccines. Those who are dissatisfied with their awards may take their claim to court.

It is true that such claims are litigated under special rules and limitations that, like the HEALTH Act/Title III, affect state tort law. But those rules and limitations must be understood in the context of the larger National Childhood Vaccine Injury Program which, as previously noted, makes federally supported compensation -- including economic and non-economic damages -- available to injured persons. H.R. 5/Title III does not, of course, include a compensation component; it merely changes the rules under which compensation can be

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[139] The following example illustrates how the *FTCA* interacts with state law. A doctor employed by a federally-qualified health center in Delaware commits medical malpractice on one of the center's patients. Since the doctor is a federal employee, the patient cannot sue either the health center or the doctor directly, but can file a claim against the federal government under the procedures set forth in the *FTCA*. Under those procedures, the patient must first file an administrative claim with HHS. If the patient is not satisfied with the determination made by HHS, she may then file a medical malpractice cause of action against the government in the U.S. District Court of Delaware. That action will be based on Delaware state law which does not cap non-economic damages.

[140] See *HEALTH Act*, Section 9(8); *Title III*, Section 308(8) which defines "health care liability action" to include malpractice cases brought in federal as well as state court. Moreover, the *HEALTH Act*/*Title III* specifically supersedes provisions of the *FTCA* related to damages, attorney contingency fees, statutes of limitations, and periodic payments of awards. (*HEALTH Act*, Section 11(a); *Title III*, Section 310(a)).

[141] House Committee on Energy and Commerce, *National Childhood Vaccine Injury Act of 1986*, 99th Cong., p. 7 (Sept. 26, 1986) (H. Rept. 99-908, Part 1).

awarded, making it far more difficult for justice to be best served. The difference between the two pieces of legislation in this regard could not be more profound.

In sum, H.R. 5/Title III is unprecedented in its approach to, and in its reach and impact on, state medical malpractice liability law – for no justified end. And there is no relevant federal statute which legitimately serves as its prototype. In our view, then, this legislation -- on these grounds alone -- should be rejected.

H.R. 5/Title III Reaches Too Far and Protects Too Many

As described in our Background and Overview to these dissenting views, medical malpractice typically refers to negligent wrongdoing by health professionals, resulting in harm to a patient. As we also discussed, H.R. 5/Title III goes well beyond this understanding to include all health care liability actions involving "a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based."[142] Such a broad, expansive and sweeping perspective of medical malpractice is not to be found in the law books of any of the 50 states. H.R. 5/Title III simply goes too far.

Three areas that H.R. 5/Title III touches directly received considerable attention during the Committee's initial deliberations over the legislation:

- the HEALTH Act/Title III's inclusion of intentional torts;
- its protections for nursing homes; and
- the inclusion of lawsuits involving FDA-approved drugs and medical devices.

Here we address the first two issues; the last is discussed separately in the section, H.R. 5/Title III Is An Unwarranted Windfall for Pharmaceutical and Medical Device Companies.

Intentional Harms

In the context of medical malpractice, an intentional tort or wrongdoing occurs when a patient does not consent to a procedure or service – even if it is performed or provided correctly. In such cases, the health care provider is "generally alleged to have intentionally acted in a fashion that ultimately caused harm to the patient."[143] Intentional torts include claims such as assault, sexual assault and rape, battery, false imprisonment (unlawfully holding someone against her or his will), invasion of privacy, conversion (theft), misrepresentation, and fraud.[144]

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[142] *HEALTH Act*, Section 9(7); *Title III*, Section 308(7).
[143] Congressional Research Service, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, Rept. No. R41661, p. 2 (Mar. 28, 2011).
[144] See Garner, BA (editor-in-chief), *Black's Law Dictionary* (9th ed. 2009) ("battery: tort"); ("tort: intentional tort") (available online at: http://www.westlaw.com); and Keeton, WP, Dobbs, DB, Keeton, RE, and Owen, DG, *Prosser and Keeton on Torts* (5th ed. 2004), pp. 33-54 (West Group, Hornbook Series).

Except in those instances in which a claim is based upon criminal liability,[145] the HEALTH Act/Title III affords its liability protections to those who have committed these and similar kinds of acts, including conduct that results in egregious injury or even death to patients. Nothing in the Committee's deliberations over H.R. 5/Title III -- not a shred of testimony presented at the Health Subcommittee hearing or any point of debate made during the Committee markup of either H.R. 5 or Title III -- documents or justifies this position. This is yet another example of how extreme H.R. 5/Title III is in its approach to medical malpractice reform.

Consider these real world examples:

- Dr. Ben D. Ramaley, a Connecticut obstetrician/gynecologist, substituted his own sperm for that of a patient's husband during an artificial insemination procedure. The couple went on to have a set of twins, only to learn after their birth and a subsequent paternity test that the treating physician (and not the husband) was the biological father. The state's Department of Public Health fined the doctor $10,000 for "using the wrong man's sperm" in the procedure, but allowed him to keep an unrestricted license to practice medicine. The couple's medical malpractice lawsuit against the physician was settled, but there is no record of Dr. Ramaley's ever facing criminal charges.[146]

- Dr. Kermit Gosnell, a Pennsylvania physician, performed late term abortions on minority and low-income women -- many of whom were pregnant for the first time -- without informing the mothers he was doing so. He falsified ultrasounds used to determine the duration of the pregnancy and taught his staff to hold the probe in such a way that the fetuses looked smaller. Few, if any, of the women who were sedated during the procedure knew that their babies had been delivered alive. And because they were misled about the length of their pregnancies, none of them was given the opportunity to make an informed choice about what to do about their pregnancy. Dr. Gosnell is now facing criminal charges, but has not yet been found guilty of any crime. At least 46 lawsuits have been filed against him in the past.[147]

- Mildred Taylor, who suffered from Alzheimer's disease, but was otherwise healthy, was a resident at the Prestige Assisted Living facility in Marysville, California. On June 24, 2004, the wheelchair-bound, 98-year old was falsely imprisoned when she was left outside overnight by facility staff. No one made any attempt to find her, even though staff knew she was not in her room. No one called Ms. Taylor's family and no one contacted the police to report her missing. She was not found until the next morning when her body temperature had dropped to 93 degrees and her right leg had become severely swollen. Ms. Taylor remained bed-ridden and debilitated until her death less than one month later. The California

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[145] *HEALTH Act*, Section 9(7); *Title III*, Section 308(7).
[146] Greenwich Times, *Doctor Uses Wrong Man's Sperm to Produce Twins* (Nov. 12, 2009) (online at: http://www.ctpost.com/default/article/Doctor-uses-wrong-man-s-sperm-to-produce-twins-215345.php).
[147] MSNBC, *'House of Horrors' Alleged at Abortion Clinic* (Jan. 19, 2011) (online at: http:www.msnbc.msn.com/id41154527/ns/us_news-crime_and_courts/t/house-horrors-alleged-abortion-clinic/); *ABC News, Alleged Victim Calls Philadelphia Abortion Doc Kermit Gosnell a 'Monster'* (Jan. 25, 2011) (online at: http://abcnews.go.com/US/alleged-victim-calls-philadelphia-abortion-doctor-kermit-gosnell/story?id=12731387).

Department of Social Services cited Prestige for violating Ms. Taylor's rights, but did not even fine the company.[148]

In each of these cases, a "health good or service" -- as that term is defined in H.R. 5/Title III[149] -- was provided, arguably bringing them within the purview of the legislation. In the instance of Mildred Taylor, we think our position is made even stronger by the comments found in the majority views of the Committee report on H.R. 5 that the term "health care goods and services" is intended to include those "involving the assessment or care of the health of human beings" as well as the "monitoring, supervision, and provision of direct assistance to claimants."[150]

Supporters of the HEALTH Act/Title III point to the legislation's exclusion of actions constituting criminal liability as the basis for arguing that examples such as these and those discussed during the Committee markup on H.R. 5[151] would fall outside the reach of H.R. 5/Title III. But intentional tort is not the same as criminal liability. In criminal cases, individuals must be selected for prosecution, tried in a court of law, and successfully convicted using a standard of proof that is appropriately high – proof beyond a reasonable doubt. In contrast, many incidents of intentional tort -- even if they meet the elements of a crime -- are never reported, let alone prosecuted.[152] Indeed, Dr. Ramaley does not appear to ever have faced criminal charges; Dr. Gosnell has not yet been convicted of anything.[153] And it is unclear how an entity such as a nursing home could be charged with a crime in case like Mildred Taylor's. We submit that under H.R. 5/Title III, these health care providers could escape significant civil liability as well.[154]

Advocates of H.R. 5/Title III also maintain that even in the absence of criminal activity, cases like these are not protected under the legislation because they are extreme and non-therapeutic in nature and thus do not meet the definition of a health care good or service.[155] We struggle to find text in the legislation that supports this argument. At the very least, the language is ambiguous on the point. Regardless, there is no bright line here. Consider, for example, the situation in which a psychiatrist has consensual sex with a patient because he believes -- and convinces the patient -- that this is the best way to "treat" her emotional problems. Do the

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[148] Appeal Democrat, *Suit Filed in Death of Patient* (June 9, 2005) (online at: http://www.appeal-democrat.com/news/prestige-15049-taylor-lawsuit.html).
[149] *HEALTH Act*, Section 9(12); *Title III*, Section 308(12).
[150] House Committee on Energy and Commerce, *HEALTH Act*, 112th Cong., p. 28 (H. Rept. 112-39, Part 2).
[151] House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., pp. 103-106 (May 11, 2011) (transcript of the proceeding).
[152] This is especially true with regard to sexual assaults. See U.S. Department of Justice, Bureau of Justice Statistics, *Rape and Sexual Assault: Reporting to the Police and Medical Attention, 1992-2000* (Aug. 2002) (online at: http://bjs.ojp.usdoj.gov/content/pub/pdf/rsarp00.pdf).
[153] NBC10 Philadelphia, *Gosnell in Court on Drug Charges* (Apr. 26, 2012) (online at www.nbcphiladelphia.com/news/local/Gosnell-Pill-Mill-Abortion-Doctor-149141535.html).
[154] This argument made by H.R. 5/*Title III* advocates is undercut further by the very language of the legislation which lists among the factors to be considered in determining punitive damages "any criminal penalties imposed on [a party] as a result of the conduct complained of. . . ." (*HEALTH Act*, Section 7(b)(1)(E); Title III, Section 306((b)(1)(E)). If criminal acts are outside the scope of H.R. 5/*Title III*, how can such acts be taken into account in determining punitive damages under the legislation?
[155] House Committee on Energy and Commerce, *Markup of H.R. 5, HEALTH Act*, 112th Cong., pp. 196-199 (May 11, 2011) (transcript of the proceeding).

protections of H.R. 5/Title III apply in any subsequent malpractice lawsuit brought by the patient? Again, based upon the text of the legislation, we believe the answer is unclear at best.

Supporters of the HEALTH Act/Title III argue further that the availability of punitive damages in cases in which "malicious intent to injure"[156] occur should address any concerns we have about the inclusion of intentional torts in this legislation because, in their view, such actions are *de facto*, ones of this character.[157] We are not comforted at all by this assertion; indeed, we believe it is Orwellian.

The purpose of the provisions of H.R. 5/Title III on punitive damages is to limit them or cut them out altogether. Although "malicious intent to injure" is one ground upon which an injured person may seek punitive damages, the punitive damages procedural hurdles[158] and monetary limits in the bill -- $250,000 or two times the amount of economic damages awarded[159] -- still apply. Moreover, this argument ignores other features of the legislation that may adversely affect an individual who has experienced an intentional tort and seeks compensation for the wrong that has occurred.[160] In sum, we believe it is unconscionable for the federal government to place these kinds of restrictions on anyone -- such as those individuals described in the cases above -- who have been injured as a result of an intentional tort.

We find these provisions of the legislation particularly troublesome because during the debate over the issue of intentional torts during the markup of H.R. 5, there appeared to be consensus among the members who participated that these activities are not the stuff of traditional medical malpractice cases. And so it was especially disappointing that an amendment to clarify and resolve the matter was not adopted. Under that amendment, intentional torts would be removed from the scope of the bill.[161] Much to our amazement and consternation, the amendment was resoundly defeated, keeping intact liability protections for actions that -- regardless of one's position on medical malpractice reform -- never should have been a part of the HEALTH Act/Title III in the first place.

Nursing Homes and Other Health Care Entities

H.R. 5/Title III covers lawsuits brought against not only providers such as physicians or hospitals -- the typical medical malpractice situation -- but also cases involving "health care organizations," including nursing homes, health maintenance organizations (HMOs), and health insurance companies.[162] As such, these entities are entitled to the liability protections afforded under the bill, including the caps on non-economic and punitive damages.

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[156] *HEALTH Act*, Section 7(a); *Title III*, Section 306(a).
[157] House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., pp. 193-194 (May 11, 2011) (transcript of the proceeding).
[158] *HEALTH Act*, Section 7(a); *Title III*, Section 306(a).
[159] *HEALTH Act* Section 7(b)(2); *Title III*, Section 306(b)(2).
[160] Such an example is the elimination of the legal standard of joint and several liability which allows injured persons to sue all responsible parties and recover from each one in proportion to the degree of fault, or to sue any one party and recover the entire amount of damages. (*HEALTH Act*, Section 4(d); *Title III*, Section 303(d)).
[161] House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., pp. 190-200; 222-229 (amendment offered by Ranking Member Henry Waxman) (May 11, 2011) (transcript of the proceeding).
[162] HEALTH Act, Sections 9(7) and 9(10); Title III, Section 308(7) and 308(10).

We have found no credible evidence to support the inclusion of these entities within the range of the HEALTH Act/Title III. Nursing homes, HMOs, and insurance companies were not even discussed during the Health Subcommittee hearing on the legislation. And the debate in the Committee markup on H.R. 5 did nothing to persuade us to see the need to include these organizations within the realm of "medical malpractice reform."

In fact, our concern over the inclusion of these businesses in H.R. 5/Title III has only grown. This is especially true with respect to nursing homes which continue to be the subject of countless cases of negligence and even intentional wrongdoing. According to a Government Accountability Office (GAO) report on this topic, the proportion of nursing homes with serious quality problems remains unacceptably high, despite a decline in the incidence of such reported problems. Actual harm or more serious deficiencies were cited for 20% or some 3500 nursing homes during an 18-month period.[163] A more recent GAO report concludes that serious care problems in nursing homes continue to be of concern.[164] These findings were reinforced by the several examples provided during the debate over this issue in the Committee markup on H.R. 5.[165]

Supporters of the legislation contend that liability protections are necessary for nursing homes to decrease their liability costs and increase access to liability insurance coverage.[166] But a 2010 study conducted by the same firm whose work was cited in support of this argument during the Committee markup of H.R. 5 suggests that these issues have been largely resolved. In fact, according to this study, the average annual loss (*i.e.*, expenses related to liability insurance claims) per nursing home bed *decreased* from $1,710 in 2001 to $1,270 in 2009.[167] And an article in Insurance Journal on the study concluded that "liability insurance pricing and availability for long term care providers are good and getting better" and attributed this trend to a new-found emphasis on quality of care.[168]

With regard to the impact of tort reform on these promising results, study documents observe that "while long term care liability costs are stable across much of the nation, Arkansas, Tennessee, and West Virginia are experiencing high expenses -- known as loss costs -- related to insurance claims."[169] In the context of the HEALTH Act/Title III, it is worth noting that two of

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[163] GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, pp. 3-4, GAO-03-561 (July 2003).
[164] GAO, *High-Risk Series: An Update*, p. 159, GAO-11-278 (Feb. 2011).
[165] House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., pp. 103-105 (May 11, 2011) (transcript of the proceeding).
[166] See, *e.g.*, the comments of Rep. Pete Olson during the markup of H.R. 5 on this point. (Remarks of Rep. Pete Olson, House Committee on Energy and Commerce, *Markup of H.R. 5, HEALTH Act*, 112th Cong., pp. 106-108; 110-113 (May 11, 2011) (transcript of the proceeding)).
[167] Aon Risk Solutions, *2010 Long Term Care General Liability and Professional Liability Actuarial Analysis* (Aug. 2010) (online at: http://img.en25.com/Web/AON/LTC%20Benchmark%20Study_2010_FINAL.pdf).
[168] Insurance Journal, *Growth, Stability and Changes in Store for Long Term Care Market* (Nov. 14, 2010) (online at: http://www.insurancejournal.com/magazines/mag-features/2010/11/14/160493.htm).
[169] Aon Risk Solutions, *Highest Long Term Care Liability Costs in Arkansas, Tennessee and West Virginia: Aon Study Costs Across the Rest of the Nation Remain Stable* (Aug. 5, 2010) (online at: http://ir.aon.com/phoenix.zhtml?c=105697&p=irol-newsArticle&ID=1457169&highlight=).

these states -- Arkansas and West Virginia -- have both enacted some form of tort reform;[170] yet, according to this study, the insurance market in these states remains turbulent. This suggests that such reform is not the cure-all advocates of H.R. 5/Title III would have us believe.

Thus, we remain unconvinced that nursing homes (or any other health care organization)[171] should receive the unprecedented protections provided to them under the HEALTH Act/Title III. In this respect, too, the legislation is unnecessarily and inappropriately broad in its scope and therefore, should be rejected.

H.R. 5/Title III Is an Unwarranted Windfall for Pharmaceutical And Medical Device Companies

H.R. 5/Title III sweeps so-called "medical products," or FDA-approved drugs, biologics, and devices into its overly broad span. Lawsuits involving drugs and medical devices are not the kind of cases that are traditionally considered medical malpractice cases, which are ostensibly the subject of the legislation. A typical "medical malpractice" lawsuit is one filed by an injured patient against his or her treating physician. In contrast, cases involving medical products are filed by patients who are injured -- and often killed -- by defective drugs and medical devices against large, extremely well-resourced pharmaceutical or medical device companies.[172]

The primary rationales advanced by supporters of the legislation[173] simply do not apply to lawsuits relating to FDA-approved drugs and medical devices. For instance, proponents of the HEALTH Act/Title III argue that it is necessary to curtail the practice of defensive medicine.[174] They claim the legislation will bring down the cost of medical malpractice insurance[175] and also fix doctor shortages caused by liability exposure.[176]

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[170] Insurance Journal, *Growth, Stability and Changes in Store for Long Term Care Market* (Nov. 14, 2010) (online at: http://www.insurancejournal.com/magazines/mag-features/2010/11/14/160493.htm)).

[171] Physician groups supporting H.R. 5/*Title III* have in the past argued fervently in favor of ensuring that HMOs are held fully accountable for injuries that occur to their patients. (See, *e.g.*, the position of the American Medical Association on this issue. (American Medical News, *Both Sides Ready for HMO Liability Fight* (Feb. 2004) (on line at: http://www.ama-assn.org/amednews/2004/02/16/gvsb0216.htm)). Their endorsement of the legislation would appear to undercut that concern.

[172] Testimony of Brian Wolfman, JD, Visiting Professor of Law, Georgetown University Law Center, House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on The Cost of Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 5 (Apr. 6, 2011).

[173] As discussed in the Background and Overview section of these dissenting views, we do not believe H.R. 5/*Title III* will achieve any of the primary goals set forth by its supporters.

[174] *See, e.g.*, the comments of Rep. Joe Pitts during the Committee markup of H.R. 5. (Remarks of Rep. Joe Pitts, House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., p. 18 (May 9, 2011) (transcript of the proceeding)).

[175] *See, e.g.*, the comments of Rep. Phil Gingrey during the Committee markup of H.R. 5. (Remarks of Rep. Phil Gingrey, House Committee on Energy and Commerce, *Markup on H.R. 5, HEALTH Act*, 112th Cong., p. 151 (May 10, 2011) (transcript of the proceeding)).

[176] *See, e.g.*, comments of Rep. Olson (pp. 214-215; 225) and Rep. Gingrey (p. 221) during the markup of *Title III* (House Committee on Energy and Commerce, *Markup on Committee Prints: Proposed Matters for Inclusion in Reconciliation Recommendations*, 112 Cong.) and comments of Rep. Tim Murphy during the Health Subcommittee hearing on H.R. 5. (House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on The Cost of*

Absolutely no justification has been asserted during the Committee's deliberations on the legislation for H.R. 5/Title III's inclusion of medical products. On the contrary, there was much debate about the danger and inappropriateness of covering drugs and devices, particularly during the testimony of Professor Brian Wolfman at the Health Subcommittee's hearing on H.R. 5.[177]

In our view, the HEALTH Act/Title III will have an especially devastating impact on patients injured by defective or inadequately labeled drugs and devices. For instance, in addition to failing to fully compensate victims of dangerous drugs and devices for their non-economic damages, H.R. 5/Title III's $250,000 cap on non-economic damages would make it very difficult for these individuals to retain competent counsel who would be willing to take on the typical large, and well endowed pharmaceutical or medical device company.[178] Most individuals who are injured by these products cannot begin to pay for the out-of-pocket expenses necessary to finance a potentially massive lawsuit against a drug or device manufacturer.[179] Instead, they rely upon a contingency system in which an attorney is willing to represent them in exchange for a certain percentage of any final recovery in the case.[180] Particularly in cases that are complex and difficult or include very well-financed defendants, a limit of $250,000 in non-economic damages would be insufficient to enable most attorneys to afford the protracted litigation process such cases involve.[181]

In his testimony at the Health Subcommittee hearing on H.R. 5, Professor Wolfman provided a disturbing illustration of this concern.[182] He described a conversation he had with the attorney who represented Diana Levine, the injured party (plaintiff) in the 2009 U.S. Supreme Court case, *Wyeth v. Levine*.[183] Ms. Levine brought a lawsuit against Wyeth, one of the country's largest pharmaceutical companies, having lost her arm by amputation after receiving an inadequately labeled Wyeth drug.[184] After years of litigation, Ms. Levine's case was eventually heard by the Supreme Court, which affirmed that persons injured by an inadequately labeled FDA-approved drug can sue the manufacturer of that product.[185]

Subsequent to the Court's decision, Professor Wolfman spoke with Ms. Levine's lawyer. Professor Wolfman asked the attorney if he would have taken the *Levine* case if there had been a $250,000 limit on non-economic damages; after a long pause, the attorney hesitantly responded

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Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act, 112th Cong., pp. 101; 104 (Apr. 6, 2011) (transcript of the proceedings)).

[177] House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on The Cost of Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., pp. 51-52; 104-107; 117-121 (Apr. 6, 2011) (transcript of the proceeding).

[178] Testimony of Brian Wolfman, JD, Visiting Professor of Law, Georgetown University Law Center, House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on The Cost of Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 5 (Apr. 6, 2011).

[179] *Id.*

[180] *Id.*

[181] *Id.*

[182] *Id.* at 12.

[183] *Wyeth v. Levine*, 129 S.Ct. 1187 (2009).

[184] *Id.*

[185] *Id.*

"no."[186] Unquestionably, then, had the provisions of H.R. 5/Title III been in place during the litigation, Ms. Levine might well have lost out in securing the stellar and long-term representation she was able to obtain under current law. Thus, as the *Levine* case clearly demonstrates, the adverse effects of the kinds of caps found in the HEALTH Act/Title III go beyond simply imposing an artificial dollar amount on damages.

The limits H.R. 5/Title III puts on attorney contingency fees would only exacerbate this problem. With draconian caps on the amount that an attorney could collect through his or her contingency contracts in place, most plaintiffs' attorneys would be financially unable to take on complex product liability cases involving drugs and devices.[187] Mr. Wolfman's testimony about his conversation with the attorney in the *Levine* case underscores this point as well.

As introduced, H.R. 5 would also abolish punitive damages in cases pertaining to FDA-approved drugs and devices, except in the most limited circumstances.[188] Specifically, H.R. 5 would prohibit punitive damages in cases in which a drug or device either received FDA approval or is "generally recognized among qualified experts as safe and effective."[189]

Because much information is gained about the safety and effectiveness of drugs and devices after they are on the market and in use by a broad population of people, it is misguided to tie the availability of punitive damages to these products' initial FDA approval. Indeed, most product liability lawsuits regarding drug safety relate to information that was not presented to the FDA at the time of the drug's approval.[190] But under the HEALTH Act/Title III, even a manufacturer that fails to exercise due diligence and investigate reports of a safety problem could be immunized from punitive damages.

Although an amendment was adopted during the Committee markup of H.R. 5 that would permit an award of punitive damages in cases in which the defendant caused the drug or device to be misbranded or adulterated,[191] H.R. 5/Title III would still have the effect of severely restricting the availability of punitive damages in lawsuits involving medical products.

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[186] Testimony of Brian Wolfman, JD, Visiting Professor of Law, Georgetown University Law Center, House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on The Cost of Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 12 (Apr. 6, 2011).

[187] *Id*. at 19.

[188] Under Section 7(c)(4) of the *HEALTH Act*, punitive damages may be awarded in such cases only when a person: (a) before or after premarket approval, clearance, or licensure of the medical product at issue, knowingly misrepresented to or withheld from the FDA information that is required to be submitted under the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act (regulation of biological products) that is material and is causally related to the harm which the injured party allegedly suffered; or (b) made an illegal payment to an official of the FDA for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product.

[189] H.R. 5, Section 7(c)(1)(A)(ii); *Title III*, Section 306(c)(1)(A)(ii).

[190] Testimony of Brian Wolfman, JD, Visiting Professor of Law, Georgetown University Law Center, House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on The Cost of Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 20 (Apr. 6, 2011).

[191] House Committee on Energy and Commerce, *Markup of H.R. 5, HEALTH Act*, 112th Cong., pp. 162-164 (amendment offered by Rep. John Dingell) (May 11, 2011) (transcript of the proceeding). That amendment is included in *Title III* as Section 306(c)(4)(C).

Punitive damages have a unique and specific function: They serve to punish exceptionally outrageous, deliberate, or harmful misconduct, and to deter both the wrongdoer and others from engaging in similar misconduct in the future.[192] By severely limiting punitive damages in drug and device cases, H.R. 5/Title III places all of us in danger because in effect, it removes the most potent and effective means of deterring bad actors. There is simply no justification for this drastic action.

This is especially true in light of FDA's recognition of the valuable role state-based litigation plays in complementing the agency's regulation of drugs and medical devices.[193] FDA is on record in finding that drug and device lawsuits help to uncover post-market safety risks that are unknown to the agency at the time of approval. Indeed, as a former FDA chief counsel has stated: "FDA regulation of a device cannot anticipate and protect against all safety risks to individual consumers. Even the most thorough regulation of a product such as an important medical device may fail to identify potential problems presented by the product. Regulation cannot protect against all possible injuries that might result over time."[194]

Drug and medical device manufacturers will always be better positioned and better equipped than the FDA to know the safety profile of their products, since they develop and manufacture the products, typically receive safety reports about the products first, and are required to alert the FDA to any product-related risks they uncover. FDA, on the other hand, is responsible for overseeing the safety of hundreds of thousands of drugs and medical devices. The U.S. Supreme Court recognized this reality in *Wyeth v. Levine*, in which it found: "The FDA has limited resources to monitor the 11,000 drugs on the market, and manufacturers have superior access to information about their drugs, especially in the post-marketing phase as new risks emerge."[195] Simply put: H.R. 5/Title III would weaken the tort system's critically important layer of consumer protection.

For these reasons and more, it is irresponsible -- even dangerous -- to sweep drug and medical device cases within the scope of the HEALTH Act/Title III. In our view, such lawsuits should continue to stand on their own -- subject to the substantive and procedural law that now governs them -- so as to help ensure that these products remain as safe as possible while at the same time, providing the opportunity for adequate compensation for those individuals who have been harmed.

Conclusion

Our colleagues on the Committee on the Judiciary who also filed dissenting views on H.R. 5 have summed up our own views quite well:

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[192] Testimony of Joanne Doroshow, Executive Director, Center for Justice & Democracy, House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on The Cost of Medical Liability System Proposals for Reform, Including H.R. 5, HEALTH Act*, 112th Cong., p. 32 (Apr. 6, 2011).

[193] Kessler, D and Vladeck D, *A Critical Examination of the FDA's Efforts to Preempt Failure-to-Warn Claims*, Georgetown Law Journal, 96:461, 463 (Jan. 2008) (online at: http://www.georgetownlawjournal.org/issues/pdf/96-2/Kessler&Vladeck.PDF).

[194] Porter, MJ, *The Lohr Decision: FDA Perspective and Position*, Food & Drug Law Journal, 52:7, 11 (Jan. 1997).

[195] *Wyeth v. Levine*, 129 S. Ct. 1187 (2009).

> Collectively, the 'reforms' proposed by H.R. 5 would limit a patient's ability to recover compensation for damages caused by medical negligence, defective products, and irresponsible insurance practices. In addition to raising core issues of fairness, H.R. 5 preempts the law in all 50 states, with little regard for the consequences. The legislation was designed more than 20 years ago to resolve an insurance 'crisis', but all available evidence shows that the insurance market is not in crisis today. H.R. 5 does not make insurance more available, does not cut spending to any appreciable degree, and does not address issues of access to justice or patient safety. Because H.R. 5 solves few problems facing Americans and exacerbates many real ones, we believe the Congress should reject this bill.[196]

We concur in this assessment of the HEALTH Act/Title III and join with these colleagues in opposing this legislation.

[196] House Committee on the Judiciary, *HEALTH Act*, Dissenting Views, 112th Cong., p. 118 (Mar. 17, 2011) (H. Rept. No. 112-39, Part 1).

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