AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

112TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
112–470

SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012

R E P O R T

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 5652

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 201 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2013

together with

MINORITY VIEWS

MAY 9, 2012.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012

112TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
112–470

SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012

REPORT

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 5652

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 201 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2013

together with

MINORITY VIEWS

MAY 9, 2012.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

74–116 WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office, http://bookstore.gpo.gov. For more information, contact the GPO Customer Contact Center, U.S. Government Printing Office. Phone 202–512–1800, or 866–512–1800 (toll-free). E-mail, gpo@custhelp.com.

COMMITTEE ON THE BUDGET

PAUL RYAN, Wisconsin, *Chairman*

SCOTT GARRETT, New Jersey
MICHAEL K. SIMPSON, Idaho
JOHN CAMPBELL, California
KEN CALVERT, California
W. TODD AKIN, Missouri
TOM COLE, Oklahoma
TOM PRICE, Georgia
TOM McCLINTOCK, California
JASON CHAFFETZ, Utah
MARLIN A. STUTZMAN, Indiana
JAMES LANKFORD, Oklahoma
DIANE BLACK, Tennessee
REID J. RIBBLE, Wisconsin
BILL FLORES, Texas
MICK MULVANEY, South Carolina
TIM HUELSKAMP, Kansas
TODD C. YOUNG, Indiana
JUSTIN AMASH, Michigan
TODD ROKITA, Indiana
FRANK C. GUINTA, New Hampshire
ROB WOODALL, Georgia

CHRIS VAN HOLLEN, Maryland,
Ranking Minority Member
ALLYSON Y. SCHWARTZ, Pennsylvania
MARCY KAPTUR, Ohio
LLOYD DOGGETT, Texas
EARL BLUMENAUER, Oregon
BETTY McCOLLUM, Minnesota
JOHN A. YARMUTH, Kentucky
BILL PASCRELL, JR., New Jersey
MICHAEL M. HONDA, California
TIM RYAN, Ohio
DEBBIE WASSERMAN SCHULTZ, Florida
GWEN MOORE, Wisconsin
KATHY CASTOR, Florida
HEATH SHULER, North Carolina
KAREN BASS, California
SUZANNE BONAMICI, Oregon

PROFESSIONAL STAFF

AUSTIN SMYTHE, *Staff Director*
THOMAS S. KAHN, *Minority Staff Director*

CONTENTS

	Page
Introduction	3
Committee Oversight Findings	10
Title I—Committee on Agriculture:	
Transmittal Letter	15
Brief Explanation	19
Purpose and Need	19
Section-by-Section	23
Committee Consideration	24
Reporting the Bill—Roll Call Votes	25
Committee Oversight Findings	25
Performance Goals and Objectives	25
Constitutional Authority Statement	25
Budget Act Compliance (Congressional Budget Office Estimate)	25
Changes in Existing Law	31
Minority Views	41
Title II—Committee on Energy and Commerce:	
Transmittal Letter	45
Purpose and Summary	49
Background and Need for Legislation	49
Hearings	56
Committee Consideration	57
Committee Votes	57
Committee Oversight Findings	78
Statement of General Performance Goals and Objectives	78
New Budget Authority, Entitlement Authority, and Tax Expenditures	78
Earmarks	78
Committee Cost Estimate	78
Congressional Budget Office Estimate	78
Federal Mandates Statement	88
Advisory Committee Statement	88
Constitutional Authority Statement	88
Applicability to Legislative Branch	88
Section-by-Section Analysis of the Legislation	88
Changes in Existing Law Made by the Bill, as Reported	92
Dissenting Views	108
Title III—Committee on Financial Services:	
Transmittal Letter	151
Purpose and Summary	154
Background and Need for Legislation	155
Hearings	160
Committee Consideration	163
Committee Votes	163
Constitutional Authority Statement	169
Committee Oversight Findings	169
Performance Goals and Objectives	170
New Budget Authority, Entitlement Authority, and Tax Expenditures	171
Committee Cost Estimate	171
Congressional Budget Office Estimate	171
Federal Mandates Statement	182
Advisory Committee Statement	182
Applicability to Legislative Branch	183
Earmark Identification	183

Page

Title III—Committee on Financial Services—Continued
Section-by-Section Analysis of the Legislation 184
Changes in Existing Law 191
Dissenting Views 358

Title IV—Committee on the Judiciary:
Transmittal Letter 363
Summary of the Major Policy Decisions in the Legislation 365
Background and Need for the Legislation 365
Report Language: Section-by-Section 412
Advisory on Earmarks 413
Committee Oversight Findings 413
Constitutional Authority Statement 413
Committee Votes 413
Changes in Existing Law 414
Performance Goals 414
Congressional Budget Office Estimate 415
Dissenting Views 421

Title V—Committee on Oversight and Government Reform:
Summary of the Major Policy Decisions in the Legislation 455
Section-By-Section 456
Committee Oversight Findings 456
Committee Votes 457
Performance Goals 457
Congressional Budget Office Estimate 457
Changes in Existing Law 462
Dissenting Views 469

Title VI—Committee on Ways and Means:
Transmittal Letter 473
Subtitle A:
Summary and Background 475
Legislative History 476
Explanation of Provision 476
Votes of the Committee 479
Budget Effects of the Provisions 480
Other Matters To Be Discussed Under the Rules of the House 486
Changes in Existing Law Made by the Budget Reconciliation Legislative Recommendation as Transmitted 487
Dissenting Views 489
Subtitle B:
Summary and Background 493
Explanation of Provision 494
Votes of the Committee 495
Budget Effects of the Provisions 496
Other Matters To Be Discussed Under The Rules of the House 499
Changes in Existing Law Made by the Legislative Recommendations, as Transmitted 501
Dissenting Views 503
Subtitle C:
Summary of the Major Policy Decisions in the Legislation 505
Report Language: Section-by-Section 513
Committee Oversight Findings 513
Constitutional Authority Statement 513
Committee Votes 514
Congressional Budget Office cost estimate 514
Changes in Existing Law (Ramseyer Submission) 517
Dissenting Views 539

Votes of the Committee 541
Statement on Committee Oversight Findings 546
Performance Goals and Objectives 547
Constitutional Authority Statement 547
Advisory Committee Statement 547
Applicability to the Legislative Branch 547
Federal Mandates Statement 547
Advisory on Earmarks 547

Page
Changes in Existing Law Made by the Bill as Reported 547
Committee Cost Estimate 547
Appendix: Revenues 553
Minority Views 559
H.R. 5652, Sequester Replacement Reconciliation Act of 2012 573

112TH CONGRESS
2d Session

HOUSE OF REPRESENTATIVES

REPORT
112–470

SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012

PROVIDING FOR RECONCILIATION PURSUANT TO SECTION 201 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2013

MAY 9, 2012.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. RYAN, from the Committee on Budget, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 5652]

The Committee on the Budget, to whom reconciliation recommendations were submitted pursuant to subsection (a) of section 201 of House Concurrent Resolution 112, the concurrent resolution on the budget for fiscal year 2013, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

Introduction

The Path to Prosperity budget that passed the U.S. House of Representatives on March 29, 2012 set in motion a process to reprioritize certain across-the-board spending reductions enacted as part of the Budget Control Act of 2011 [BCA]. This process, called reconciliation, consists of a special procedure to give expedited consideration to bills enacting the spending, revenue, and debt policies contained in the budget resolution.

To trigger these expedited procedures, *The Path to Prosperity* included reconciliation instructions calling on six House committees to achieve specified amounts of deficit reduction from programs within their jurisdictions. This Reconciliation Act consists of the legislation they have recommended to achieve the same deficit reduction required by the BCA, but without the haphazard cuts—especially to national security—that an across-the-board approach would entail.

THE BUDGET CONTROL ACT OF 2011

In mid-2011, as the nation approached the statutory limit on how much it could legally borrow, the Obama administration asked Congress for a "clean piece of legislation" to increase the government's legal borrowing authority without any spending cuts to match.[1]

House Republicans refused to give the President the blank check he requested. Instead, Speaker of the House John Boehner insisted that any increase in the debt ceiling be accompanied by a greater amount of spending reduction. Speaker Boehner made clear on May 9, 2011 that, "Without significant spending cuts and reforms to reduce our debt, there will be no debt limit increase. And the cuts should be greater than the accompanying increase in debt authority the President is given."[2]

Once it became clear that Congress would not rubber-stamp his requested increase in the debt ceiling, President Obama announced that he would not accept a debt-ceiling deal that did not include large tax increases on American families and businesses.[3]

House Republicans succeeded in protecting hardworking taxpayers by preventing the President from securing a bill containing tax hikes. Instead, a bipartisan agreement was forged to reduce the deficit by putting an upper limit on discretionary spending and to set in motion a framework to achieve additional savings. The BCA

[1] Brian Patrick, "Debt Limit Tick Tock," Blog Update, Office of Majority Leader Eric Cantor, August 1, 2011. *http://majorityleader.gov/blog/2011/08/debt-limit-tick-tock.html*

[2] Remarks by House Speaker John Boehner. Economic Club of New York. May 9, 2011. *http://www.speaker.gov/News/DocumentSingle.aspx?DocumentID=240370*

[3] Patrick, "Debt Limit Tick Tock."

paired a $2.1 trillion increase in the public debt limit with equivalent deficit reduction over the ensuing 10 years.

The BCA called for deficit reduction in three phases:

1. First, it established caps on discretionary spending, achieving approximately $917 billion in savings over 10 years.

2. Second, it established and called upon a Joint Select Committee on Deficit Reduction (JSCDR) to produce legislation with at least an additional $1.2 trillion in deficit reduction.

3. Third, it established an automatic sequestration process to force spending reductions in the event the JSCDR did not produce a deficit-reduction bill or Congress refused to pass it. This "sequester" would result in immediate discretionary spending reductions effective January 2, 2013.

Understanding each component of the BCA is critical to understanding the fiscal impact of the law as a whole. The BCA's pre-sequester spending caps reduced discretionary spending for fiscal year 2013 to a maximum of $1.047 trillion. Some, including Senate Majority Leader Harry Reid, are still insisting that House Republicans are obligated to pass fiscal year 2013 spending bills at these levels.[4]

But Congress is no longer operating in a pre-sequester world. Last November, the JSCDR announced that it could not reach agreement on a deficit-reduction bill by the statutory deadline, thus triggering the sequester. Congress is now operating in a post-sequester world—one in which discretionary spending for fiscal year 2013 is capped at $949 billion. Every non-exempt defense account will be cut proportionally for a total of $55 billion, or 10 percent, and every non-exempt non-defense account will be cut proportionally for a total of $43 billion, or 8 percent, in January 2013 unless Congress acts to replace this sequester by reprioritizing the savings.

These across-the-board and arbitrary cuts would be devastating to America's defense capabilities. Leaders of both parties agree that sequester savings should be reprioritized. On August 4, 2011, then-director of the Office of Management and Budget (now White House Chief of Staff) Jack Lew wrote that the sequester was not intended to be implemented: "Make no mistake: the sequester is not meant to be policy. Rather, it is meant to be an unpalatable option that all parties want to avoid."[5]

THE JOINT SELECT COMMITTEE ON DEFICIT REDUCTION

While both parties have expressed their desire to avoid the consequences of the sequester, there is profound disagreement over how. This disagreement was evident in the JSCDR's failure to produce a deficit-reduction bill last year.

Despite the good-faith effort on the part of committee Republicans to avoid the sequester (and, by extension, to avoid its disproportionate impact on defense), the negotiations exposed a fundamental lack of seriousness by some in Washington regarding the

[4] Naftali Bendavid, "Fight Breaks Out Over 2013 Budget Cuts," Wall Street Journal, March 14, 2012. *http://blogs.wsj.com/washwire/2012/03/14/fight-breaks-out-over-2013-budget-cuts/*

[5] Jack Lew, "Security Spending in the Deficit Agreement," August 4, 2011. *http://www.whitehouse.gov/blog/2011/08/04/security-spending-deficit-agreement* (accessed March 19, 2012).

need to control government spending and address the structural drivers of the debt. As JSCDR Co-Chairman Jeb Hensarling made clear, Democrats on the committee "were unwilling to agree to anything less than $1 trillion in tax hikes—and unwilling to offer any structural reforms to put our health care entitlements on a permanently sustainable basis." [6]

Committee Democrats refused to address the problem, so the problem remains. Therefore, the immediate question of how to reprioritize sequester savings—and the larger challenge of averting a debt-fueled economic crisis—have become central to this year's budget debate during this year's budget season.

THE PRESIDENT'S FISCAL YEAR 2013 BUDGET

The President's fiscal year 2013 budget calls on Congress to replace the sequester, but it does not make a specific proposal to turn the sequester off. It assumes that the sequester does not occur, but it does not lay out a specific path forward to avoid its consequences. The President's budget includes tax increases and spending cuts (including a $487 billion reduction in defense spending), which it claims are enough to offset the sequester—but it includes a net spending increase that consumes nearly all of its claimed deficit reduction.

This approach is deeply flawed, for three reasons. First, it imposes a net tax increase on American families and businesses of $2.0 trillion. Washington's fiscal imbalance is overwhelmingly driven by runaway spending, not insufficient tax revenue, and reducing the deficit by taking more from hardworking Americans would simply slow the economy, reduce job opportunities, and ultimately prove counterproductive as a deficit-reduction strategy.

Second, despite the large tax increase, the President's budget also contains a net spending increase of $1.4 trillion, for a total of only $605 billion in deficit reduction. The rest of the President's deficit-reduction claims are based on discredited budget gimmicks, including almost $1 trillion in "savings" that come from projecting current wartime spending in Iraq and Afghanistan out for the next 10 years, then proposing not to spend that money, even though it was never requested and was never going to be spent.

And third, much of the President's actual spending reduction comes from cutting too deeply into the Defense Department. Although the President's budget does not cut defense as deeply as the sequester would, these cuts would still jeopardize the capability of the U.S. military.

THE SENATE'S LACK OF A BUDGET

It has been three years since the Senate passed a budget, and the legal deadline for passing a congressional budget resolution this year has already passed. Yet there has been no indication that Senator Reid plans to put forward an alternative plan for prioritizing spending, much less for averting the sequester. Instead, he continues to insist that Congress is still operating in a pre-sequester world, even though the President's own budget admits that

[6] Hensarling, Jeb. "Why the Super Committee Failed," Wall Street Journal, November 22, 2011. *http://online.wsj.com/article/SB10001424052970204531404577052240098105190.html*

"the sequester was triggered and will take effect in January 2013 if no action is taken."[7] Senator Reid's approach has been the very definition of inaction. There is a better way forward.

The Path to Prosperity Approach: REPRIORITIZE SAVINGS THROUGH RECONCILIATION

Pursuant to the *Path to Prosperity* budget resolution, the House has advanced a series of reforms that replace across-the-board cuts scheduled in law with common-sense reforms that take steps to address government's unsustainable autopilot spending.

Six House Committees have advanced legislation that will:

1. Stop Abuse, by Ensuring that Individuals are Actually Eligible for the Taxpayer Benefits They Receive;
2. Eliminate Government Slush Funds and Stop Bailouts;
3. Control Runaway, Unchecked Spending;
4. Restrain Spending on Government Bureaucracies; and
5. Reduce Waste and Duplicative Programs.

The savings from these reforms will replace the arbitrary discretionary sequester cuts and lay the groundwork for further efforts to avert the spending-driven economic crisis before us.

Below is an outline of the reforms being advanced by the six committees (Agriculture, Energy and Commerce, Financial Services, Judiciary, Oversight and Government Reform, and Ways and Means) that received reconciliation instructions under the budget resolution.

1. STOP ABUSE BY ENSURING THAT INDIVIDUALS ARE ACTUALLY ELIGIBLE FOR THE TAXPAYER BENEFITS THEY RECEIVE

A troubling trend has emerged in recent years, in which eligibility restrictions intended to focus limited government resources on those who need them most have been systematically weakened or have broken down due to loopholes in the law. This Reconciliation Act protects aid for those who need it by making sure that taxpayer dollars are not going to those who don't qualify for assistance.

- It eliminates a loophole that has allowed individuals to qualify for food stamps on such flimsy pretexts as receiving a brochure from another government program.
- It eliminates a loophole that allows individuals to increase their food-stamp benefits by as much as $130 a month for receiving as little as $1 in federal utility assistance.
- It stops the practice of sending the refundable portion of the Child Tax Credit to individuals who are ineligible to work in the United States.
- It requires anyone who receives an overpayment of health insurance subsidies under the Democrats' health care law to repay the full amount of the overpayment.

[7] "Fiscal Year 2013 Budget of the U.S. Government," Office of Management and Budget, February 2012. *http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf*

2. ELIMINATE GOVERNMENT SLUSH FUNDS AND STOP BAILOUTS

Recent legislation has all too often ceded too much power to unaccountable bureaucrats, and has just as often provided them with access to taxpayer money in ways that fuel wasteful spending and bailouts. This Reconciliation Act targets these indefensible slush funds and automatic subsidies for elimination.

• It protects taxpayers by eliminating the Wall Street bailout fund included as part of the 2010 Dodd-Frank financial overhaul.

• It terminates the Obama Administration's ineffective housing bailouts, which have become the target of widespread and bipartisan criticism for actually making matters worse for homeowners.

• It reforms the National Flood Insurance Program to increase financial accountability by requiring the program to sufficiently cover risks.

• It eliminates the unaccountable government health slush fund created by the Democrats' health care law.

3. CONTROL RUNAWAY, UNCHECKED SPENDING

Federal programs across the board experienced an explosion of funding in recent years. Federal spending on food stamps has increased by 267 percent over the last decade—with part of that expansion coming from President Obama's failed 2009 stimulus law. Medicaid spending is up 86 percent over the last ten years. And the Democrats' health care law would increase spending by $1.6 trillion over the next ten years. This Reconciliation Act takes measures to stop the spending spree and restrain spending growth in the future.

• It repeals automatic increases in food-stamp benefits enacted as part of the President's failed stimulus law.

• It repeals a provision of the Democrats' health care law that allows the Secretary of Health and Human Services unprecedented authority to spend "such sums as necessary" for grants to states to comply with the law.

• It defunds the health law's "CO-OP" program, which disburses government subsidized loans—50 percent of which, according to the Office of Management and Budget, will never be repaid.

• It gives states more freedom and flexibility to tailor Medicaid to the needs of their unique populations.

• It prevents provisions of the health law from exacerbating problems with Medicaid's current matching formula, which gives states and territories a perverse incentive to grow the program and little incentive to save.

4. RESTRAIN SPENDING ON GOVERNMENT BUREAUCRACIES

The federal government has added 149,000 new workers since the President took office. Such a rapid expansion of government weighs on private-sector employment, because it requires either higher taxes now or higher borrowing now and higher taxes later. This Reconciliation Act aims to slow the federal government's unsustainable growth, reduce the public-sector bureaucracy, and reflect the growing frustration of workers across the country at the privileged rules enjoyed by government employees.

• It eliminates the ability of the newly created Consumer Financial Protection Bureau and Office of Financial Research to set their own budgets.

• It requires Federal employees to more equitably share in the cost of their retirement benefits.

• It eliminates the provision that pays Federal workers a special benefit if they retire early.

5. REDUCE WASTE AND DUPLICATIVE PROGRAMS

Annual examinations of wasteful spending conducted by the Federal government's independent auditors routinely reach the same conclusion: Government agencies and departments are rife with examples of waste, duplication and overlap.[8] This Reconciliation Act protects taxpayers and reduces spending by eliminating wasteful and duplicative programs.

• It repeals the outdated and duplicative Social Services Block Grant, whose missions have been supplanted by dozens of newer Federal programs.

• It begins the process of consolidating the dozens of overlapping and duplicative Federal employment training programs by eliminating 50/50 cost-sharing for an employment training program tied to food stamps.

• It reforms the medical liability system by reining in unlimited lawsuits and thereby making health care delivery more accessible and affordable for families.

• It removes incentives that encourage states to add to their Medicaid rolls through careless processes that lead to billions in overpayments.

THE SEQUESTER REPLACEMENT ACT OF 2012

By targeting fraud, eliminating slush funds, restraining runaway spending, reforming bureaucracies, and ending wasteful and duplicative programs, this Reconciliation Act provides a responsible way to achieve all of the 2013 spending reductions required by the BCA. With—and only with—the enactment of this targeted, carefully prioritized spending reduction, Congress can move to the second part of this task: replacing the across-the-board sequester before it jeopardizes the security of American families and the safety of our troops.

A separate piece of legislation, the Sequester Replacement Act of 2012 [SRA], would achieve this task by amending the BCA to replace the sequester for fiscal year 2013 with the spending reductions enacted through the Reconciliation Act. To safeguard against an end-run around the Reconciliation Act, the SRA stipulates that it would only take effect upon enactment of the reconciliation bill.

The SRA takes additional steps to protect the U.S. military and veterans and to lock in spending savings for the American taxpayer:

• It clarifies that veterans programs are not subject to sequester.

• It lowers the BCA's discretionary caps to levels set in the House-passed *Path to Prosperity* budget.

---

[8] 2012 Annual Report: Overlap and Fragmentation, Achieve Savings, and Enhance Revenue, Government Accountability Office, March 2012. *http://www.gao.gov/products/GAO-12-342SP*

• It closes a potential loophole that would otherwise allow Congress to enact large direct spending increases by counting Reconciliation Act savings as an offset.

• It eliminates the fiscal year 2013 sequester of mandatory spending on national defense.

In late 2011, the President issued a veto threat against any legislation overturning the sequester unless fully offset. The President called on Congress to develop an alternative: "The only way these spending cuts will not take place is if Congress gets back to work and agrees on a balanced plan to reduce the deficit by at least $1.2 trillion. That's exactly what they need to do. That's the job they promised to do. And they've still got a year to figure it out."[9]

With passage of the Reconciliation Act and the SRA, the House will have done its job. These bills take the responsible step of offsetting the cost (approximately $78 billion) of replacing the automatic across-the-board discretionary spending cuts that are scheduled to occur on January 2, 2013 through sequestration. The additional savings achieved through reconciliation beyond the $78 billion (over $237 billion in the next ten years) would further reduce the deficit. And this approach provides a blueprint for replacing the rest of the sequester with responsible, targeted spending reduction in the years ahead.

THE NEED FOR WILLING PARTNERS TO MOVE FORWARD

This Reconciliation Act provides a clear solution that can be implemented quickly to replace the sequester. It does so by using an expedited procedure to reduce lower-priority spending. This solution cuts through the gridlock in Washington to start eliminating excessive autopilot spending immediately. It protects taxpayers, and it would shield the U.S. military from a crippling, 10 percent across-the-board reduction in its funding.

Unfortunately, the House needs willing partners to implement this solution—and the Senate Democratic leadership's only plan has been to oppose solutions put forward in the House. U.S. troops and their families should not have to suffer because the Democratic Party's leaders refuse to lead. House Republicans will continue to show a way forward by directly addressing the nation's most urgent fiscal and economic challenges. It is not too late for Americans to choose a better path.

Under the Congressional Budget Act, the Budget Committee cannot amend this reconciliation bill. However, there are two changes the Committee intends to seek at the Rules Committee. First, the Committee supports the incorporation of the Sequester Replacement Act (HR 4966) in this Reconciliation bill. Second, the Committee supports a technical amendment to the Committee on Oversight and Government Reform's submission to ensure that the taxpayer receives the full savings from the proposed federal retirement reforms.

---

[9] Statement by the President on the Supercommittee, November 21, 2011, the White House. *http://www.whitehouse.gov/the-press-office/2011/11/21/statement-president-supercommittee*

OVERSIGHT HEARINGS AND FINDINGS

Pursuant to clause 3(c)(1) of Rule XIII of the Rules of the House of Representatives, the oversight findings of the Committee on the Budget and recommendations are set forth in this section. In addition, the oversight findings of each committee of jurisdiction are included at the appropriate places in this committee report.

The Committee on the Budget held nine hearings in 2012 that have informed the Committee's work on the FY 2013 budget resolution including reconciliation legislation reported pursuant to that budget resolution. (A complete list of these hearings is included below.) The Budget Committee staff has also engaged in intensive discussions with executive branch, congressional, and private sector experts to consider the implications of the deficit and debt crisis facing the country and the best means of reducing current and future deficits. These hearings and consultations informed the committee's reconciliation instructions to each of the six authorizing committees. In particular, the recent rapid growth of means-tested entitlements through benefit and eligibility expansions poses a budget problem that this reconciliation bill begins to address.

The Committee on the Budget has also inquired into the operation and implications of the sequester required by the Budget Control Act. The Office of Management and Budget is the lead agency responsible for implementing any sequester and witnesses from this agency have twice testified before the Budget Committee this year. Unfortunately, in both the February 15 and April 25 hearings, the administration declined to provide specific information in response to Members' questions relating to what the administration's specific proposal is to avoid the sequester and how the administration would implement the sequester if legislation is not enacted by January 2, 2013. In a third attempt to fill the remaining information gaps, the Chairman of the Committee on the Budget wrote to Acting OMB Director Zients on April 26, requesting additional information by May 4 on how the administration would execute the sequester required by the Budget Control Act. To date Acting Director Zients has not responded.

The Committee intends to continue to conduct active oversight of the execution and implementation of the Budget Control Act over the course of 2012 as it works to avoid the negative consequences of a sequester, while ensuring that significant deficit reduction is not delayed.

2012 OVERSIGHT HEARINGS OF THE COMMITTEE ON THE BUDGET

Date	Topic	Witnesses
Feb. 1	Budget and Economic Outlook	Doug Elmendorf, CBO Director
Feb. 2	The State of the U.S. Economy	Ben Bernanke, Federal Reserve Board Chairman
Feb. 15	The President's FY 2013 Budget Request	Jeffrey Zients, OMB Acting Director
Feb. 16	The President's FY 2013 Revenue and Economic Policy Proposals	Timothy Geithner, Secretary of the Treasury
Feb. 28	Strengthening Health and Retirement Security	Stephen Goss, Actuary, Social Security Administration Rick Foster, Actuary, Center for Medicare & Medicaid Services

2012 OVERSIGHT HEARINGS OF THE COMMITTEE ON THE BUDGET—Continued

Date	Topic	Witnesses
Feb. 29	The Department of Defense and the FY 2013 Budget	Leon Panetta, Secretary of Defense General Martin Dempsey, Chairman of the Joint Chiefs of Staff
Mar. 8	Members' Day	Members of Congress
April 17	Strengthening the Safety Net	Private Sector Experts on Federal Safety Net Programs
April 25	Replacing the Sequester	Danny Werfel, OMB Controller Susan Poling, GAO Deputy General Counsel

TITLE I—THE COMMITTEE ON AGRICULTURE

LETTER OF TRANSMITTAL

COMMITTEE ON AGRICULTURE,
Washington, DC, April 27, 2012.

Hon. PAUL RYAN,
Chairman, Committee on the Budget,
Washington, DC.

DEAR MR. CHAIRMAN: I am transmitting herewith the recommendations of the Committee on Agriculture with respect to the reconciliation bill for fiscal year 2013, provided under House Concurrent Resolution 112, the Concurrent Resolution on the Budget for Fiscal Year 2013 and as modified by H. Res. 614.

The enclosed recommendations were adopted by this Committee in a business meeting on April 18, 2012, in the presence of a quorum. Enclosed please find a hard copy of the Committee's recommendations on Title I—Agriculture; Section-by-Section; Purpose and Need; Committee Consideration; CBO score; and the remainder of the contents as required, including a set of Minority Views.

With best wishes, I am

Sincerely,

FRANK D. LUCAS,
Chairman.

Enclosure.

TITLE I—THE COMMITTEE ON AGRICULTURE

TABLE OF CONTENTS

	Page
Brief Explanation	19
Purpose and Need	19
Section-by-Section	23
Committee Consideration	24
Reporting the Bill—Roll Call Votes	25
Committee Oversight Findings	25
Performance Goals and Objectives	25
Constitutional Authority Statement	25
Budget Act Compliance (Congressional Budget Office Estimate)	25
Changes in Existing Law	31
Minority Views	41

TITLE I—AGRICULTURAL PROGRAMS

BRIEF EXPLANATION

The Agricultural Reconciliation Act of 2012 reduces spending within the jurisdiction of the Committee on Agriculture as required by 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, as passed by the House of Representatives on March 29, 2012, as modified by H. Res. 614.

PURPOSE AND NEED

The House Budget Resolution, H. Con. Res. 112, as modified by H. Res. 614, included reconciliation instructions directing the Committee on Agriculture to report changes in laws within its jurisdiction that result in savings over fiscal years 2012 through 2013, fiscal years 2012 through 2017, and fiscal year 2012 through 2022, with estimates of $7.7 billion, $19.7 billion, and $33.2 billion respectively.

The nation faces a severe debt crisis with approximately $16 trillion in federal debt and counting. The House is doing its part to take a serious, common sense look at all programs and spending trends across the entire federal budget in order to address our nation's mounting debt. It is unrealistic to think that we can meet these pressing challenges without reducing federal spending. As in previous reconciliation bills, the Committee on Agriculture has shown willingness to do its part to ensure our nation's fiscal well being.

The Supplemental Nutrition Assistance Program (SNAP), formerly known as the food stamp program, has seen an unprecedented growth in participation and cost over the past ten years, now accounting for almost 80 percent of the Committee's mandatory spending. Since 2002, the cost of SNAP has nearly tripled, increasing by 270 percent while participation has more than doubled. Consequently, the Committee agreed to achieve our directed savings by reducing SNAP spending by $35.8 billion over ten years, which represents only a four percent cut to the program. When programs within the Committee's jurisdiction soar well beyond historical participation and spending patterns, it is the Committee's duty to know why these programs are seeing such a surge and take action if necessary.

These changes to SNAP are reasonable and credible approaches that will increase the integrity of the program. The provisions passed by the House Committee on Agriculture will close program loopholes, significantly reduce waste and abuse within the program, eliminate costs that taxpayers can no longer afford, and ensure the program continues to serve those who are most in need

of food assistance according to the rule of law. It is the Committee's clear intent that none of the provisions passed by the Committee prevent families who qualify for assistance under SNAP law from receiving their benefits.

The first provision closes a loophole in SNAP regarding how Low Income Home Energy Assistance Program (LIHEAP) payments interact with SNAP benefit calculation. Current law allows low-income households receiving any amount of LIHEAP assistance, even $1, to automatically qualify for the SNAP Standard Utility Allowance (SUA). In the last several years, approximately 16 states and the District of Columbia have been taking advantage of this loophole to bring more SNAP benefits to their states.

In practice, if a participant receives $1 in LIHEAP, they can automatically deduct the SUA from their income. Therefore, their net income is reduced, and they subsequently receive a higher amount in SNAP benefits. According to a newsletter provided by the U.S. Department of Health and Human Services, Administration for Children and Families, an annual $1 LIHEAP benefit in New York will provide an average monthly hike in SNAP benefits of $131 for nearly 90,000 households in New York City. Similarly, an Associated Press article reported that the state of Washington sent out $1 LIHEAP checks to trigger an additional $43 million in SNAP benefits. The agreed to provision will end this egregious practice that uses the interaction between LIHEAP and SNAP to abuse the program. Under this provision, LIHEAP payments will no longer automatically trigger the SUA deduction, thus saving the taxpayers $14.3 billion over ten years.

States also have the option of using "categorical eligibility," or automatic eligibility, which allows those receiving benefits from other specified low-income assistance programs to be eligible for SNAP. These other programs are Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), or other state general assistance programs. TANF assistance can be in the form of cash or non-cash benefits (i.e. informational brochures, or access to an informational 800-number). When states implement categorical eligibility, these households do not need to meet SNAP asset or gross income tests. As of May 1, 2012, 43 jurisdictions (40 States, the District of Columbia, Guam, and the U.S. Virgin Islands) have implemented "broad-based" categorical eligibility. These jurisdictions generally make all households with incomes below a state-determined income threshold eligible for SNAP.

This Administration has been actively encouraging states to implement this policy as demonstrated through various U.S. Department of Agriculture (USDA) memos. One memo dated March 18, 2010, states, "With broad-based categorical eligibility, state agencies can effectively raise the income limit and raise or eliminate the asset test. A de facto elimination of the asset test through broad-based categorical eligibility saves administrative costs because state agencies do not have to devote staff time towards verifying assets, and makes it easier for families to apply for SNAP because they do not have to provide verification of their assets."

There was public outrage when the press reported that two lottery winners, both receiving more than $1 million in winnings, were also found to have been receiving SNAP assistance, even after

collecting their winnings. When lottery winners choose to receive one lump sum payment for their winnings, that money is considered an asset. Under broad-based categorical eligibility, there are 38 states that do not verify assets when determining SNAP eligibility, thus creating a loophole for lottery winners and anyone with substantial assets. This reform to SNAP law would put an end to lottery winners receiving SNAP as states will have to review assets in determining SNAP eligibility.

The Cincinnati Enquirer also printed an article that proves how wasteful states can be with taxpayer dollars when they implement broad-based categorical eligibility and no longer take into account assets. The article reports that a woman qualified for $500 a month in SNAP benefits after she lost her job, even though she had $80,000 in her bank account, a paid-off $311,000 home, and a Mercedes.

This provision would restrict categorical eligibility to only those households receiving cash assistance from SSI, TANF, or a state-run General Assistance program, saving taxpayers $11.7 billion over ten years. Merely, receiving a TANF-funded brochure or a referral to an "800" number telephone hotline would no longer automatically make a household SNAP eligible. It is estimated that 3.9 percent of the 46.4 million people currently enrolled in SNAP would be affected by this provision. Those who no longer have categorical eligibility status under the amended provision would have the opportunity to be reviewed for SNAP eligibility independent of their status as a TANF beneficiary. And those who receive cash assistance from SSI, TANF, or a state-run General Assistance program will still be categorically eligible for SNAP. By refining the eligibility requirements, this proposal ensures that those most in need will continue to receive assistance.

Third, the Committee followed the example from the previous majority and agreed to terminate an artificial increase in SNAP benefits. The American Recovery and Reinvestment Act (ARRA) included an across-the-board increase in SNAP benefits effective in April 2009. The ARRA effectively replaced the increase in SNAP benefits that occurs based on annual food-price inflation indexing. The ARRA benefit originally terminated after FY2018, when food-price inflation was estimated to "catch up" with the ARRA increase. The Congressional Budget Office (CBO) originally projected the ARRA increase to last through FY 2018 at an additional benefit cost of $57 billion.

In the 111th Congress, when the Democrat majority needed to pay for other "priorities," including a teacher's union bailout and increasing school meal standards, the ARRA SNAP increase was cut twice to offset these other two laws. They achieved their offsets by moving up the ARRA termination date to March 31, 2014, to cut $11.9 billion from SNAP to help pay for P.L. 111–226. Then they moved the ARRA termination date to October 31, 2013, to cut $2.5 billion from SNAP to help pay for P.L. 111–296. While many Democrats have talked about restoring these cuts, an overwhelming majority of Democrats voted for both the laws that benefited from an offset from SNAP benefits totaling almost $14.5 billion.

This provision terminates the ARRA increase on July 1, 2012, and reinstates the law that calculates SNAP benefits based on

food-price inflation, rather than an arbitrary number. SNAP benefits will still be able to rise with the growing cost of food as stated in SNAP law. Rather than redirect these funds towards more bureaucracy, this provision will provide $5.9 billion towards deficit reduction.

Next, the Committee agreed to eliminate the cost share for the SNAP Employment and Training (E&T) program. While States are technically required to provide E&T programs, the program has been historically underutilized. For example, fewer than 7 percent of all SNAP recipients participated in a SNAP E&T program in FY2009.

States have great flexibility in how they implement their program and who they serve; relatively few SNAP participants are subject to work requirements. Recently, almost half of the states have been exercising their authority to exempt all SNAP recipients from participation in E&T and operate their programs on an entirely voluntary basis, which means participants are choosing whether or not they want to participate in this program.

In addition to being underutilized, this program is duplicative. According to a GAO report from January 2011, almost all federal E&T programs overlap with at least one other program in that they provide similar services to similar populations. GAO reported there are 47 federal E&T programs at an annual cost of $18 billion.

For the SNAP E&T program, states receive a combination of formula grants and reimbursements for qualifying expenses. Currently, $90 million per year is allocated to the states under a formula to fund their respective E&T programs. In addition to the formula grants, the federal government will provide reimbursements to states of up to 50 percent for administrative costs as well as E&T participant expenses directly related to participation in the program. This portion of funding is referred to as the 50–50 cost share funds, and is not capped.

Because the FY2012 Agriculture Appropriations Act reduced the federal grant funding from $90 million to $79 million, the Committee agreed to continue the grant funding at $79 million per the appropriations law. While the federal grant funding has been subject to rescissions, the Committee kept the formula grants to assist states in administering the program. However, the Committee eliminated the 50–50 cost share reimbursement for SNAP E&T. States can continue to invest their own funding as well as leverage funding from the public and private sector as they currently do; this provision would no longer allow USDA to provide the reimbursement, saving taxpayers $3.1 billion over ten years.

The Committee also passed a provision to eliminate indexing on the SNAP nutrition education program. States provide nutrition education to SNAP participants to encourage them to make healthy food choices within a limited budget and to choose a physically active lifestyle. Current funding for this program is $375 million and indexed for inflation each fiscal year. The Committee agreed to keep the base funding for this program and eliminate indexing, saving $546 million over ten years. Given the federal deficit, it is no longer fiscally responsible to allow programs to grow on "autopilot" year after year.

Finally, the Committee eliminated state performance bonuses, saving $480 million over ten years. States are responsible for administering the SNAP program and it is their duty to process applications in a timely manner, ensure households receive the accurate amount of SNAP benefits, and make certain the program is administered in the most effective and efficient manner. When a state receives a bonus from USDA, there is no requirement that they reinvest the funds back into SNAP; it can simply be absorbed into the state's budget. In this economic climate it is very difficult to justify awarding states bonuses for practices that should be the daily operating procedure. This provision would end bonuses that are given to states for essentially doing their job.

While the SNAP program comprises almost 80 percent of the Committee on Agriculture's mandatory spending, these reductions only account for about 3.5 percent of total spending over ten years. Every one of these provisions represents common sense and good government in a time that requires fiscal restraint. The Committee closed loopholes, reduced waste and abuse, and ended arbitrary policies that are artificially inflating the costs of the program.

Some states have taken great liberties in administering the program, as encouraged by this Administration, and those practices must end. Encouraging states to stretch policies beyond the original intent of the law further proves this Administration has no regard for ensuring hard-earned taxpayer dollars are spent wisely.

Other laws and programs have been circumventing SNAP law for far too long that simply add more costs to the program. These provisions return the program to the purpose of the original SNAP law and prevent other programs from becoming the de facto administrator of SNAP. The changes made to SNAP in the 2008 farm bill remain fully intact and will continue to benefit SNAP participants.

There is no denying that SNAP provides important support for many Americans and these provisions further protect that program. The Committee wants to ensure the integrity of this program so we can continue to provide nutrition assistance for those who are in need. Under these provisions, any household that qualifies for SNAP and meets the SNAP eligibility requirements will continue to be eligible for and receive benefits from the program. The Committee on Agriculture is better targeting the program to serve those in need while continuing the long standing tradition that the Committee has always been willing to do its part to ensure the fiscal well being of our nation.

SECTION-BY-SECTION

Sec. 101. Short title

Section 101 is the short title.

Sec. 102. ARRA Sunset at June 30, 2012

Section 102 amends the American Recovery and Reinvestment Act of 2009 (ARRA) by terminating on July 1, 2012 the increased Supplemental Nutrition Assistance Program benefits provided under the Act.

Sec. 103. Categorical eligibility limited to cash assistance

Section 103 amends the Food and Nutrition Act of 2008 to restrict categorical eligibility for the Supplemental Nutrition Assistance Program to only those households receiving cash assistance through other low-income assistance programs.

Sec. 104. Standard utility allowances based on the receipt of energy assistance payments

Section 104 amends the Food and Nutrition Act of 2008 by striking a provision that requires a state agency using a standard utility allowance to provide the allowance to each household that receives any payment under the Low Income Home Energy Assistance Act of 1981.

Sec. 105. Employment and training; workfare

Section 105 amends the Food and Nutrition Act of 2008 by striking a provision that provides a cost share to states for certain expenses incurred in operating an employment and training program.

Sec. 106. End State Bonus Program for the Supplemental Nutrition Assistance Program

Section 106 amends the Food and Nutrition Act of 2008 by eliminating the performance bonuses provided to states for effectively administering the Supplemental Nutrition Assistance Program.

Sec. 107. Funding of employment and training programs

Section 107 amends the Food and Nutrition Act of 2008 by reducing the allocation to State agencies to carry out employment and training programs for fiscal year 2013 to $79,000,000.

Sec. 108. Turn off indexing for nutrition education and obesity prevention

Section 108 amends the Food and Nutrition Act of 2008 by eliminating indexing on the Nutrition Education and Obesity Prevention Grant Program.

Sec. 109. Extension of Authorization of Food and Nutrition Act of 2008

Section 109 amends the Food and Nutrition Act of 2008 by extending the authorization for appropriations to carry out the Act through fiscal year 2013.

Sec. 110. Effective dates and application of amendments

Section 110 provides the effective dates of the amendments.

COMMITTEE CONSIDERATION

The Committee on Agriculture met, pursuant to notice, with a quorum present, on April 18, 2012, to consider the Agricultural Reconciliation Act of 2012, with respect to the instructions provided under H. Con. Res. 112, the Concurrent Resolution on the Budget, as modified by H. Res. 614.

Chairman Lucas offered an opening statement as did Ranking Member Peterson. Without objection the Agricultural Reconcili-

ation Act was placed before the Committee for consideration, a first reading of the bill was waived and it was opened for amendment at any point.

Discussion occurred and there being no amendments, Mr. Goodlatte offered a motion that the Committee favorably report the bill to the Committee on the Budget for insertion in the Reconciliation Bill. By voice vote, the motion was agreed to.

Mr. Peterson reserved the right for minority views to be included with the report for submission to the Budget Committee.

Chairman Lucas advised Members that pursuant to the rules of the House of Representatives that Members have 2 calendar days to file such views with the Committee.

Without objection, staff were given permission to make any necessary clerical, technical or conforming changes to reflect the intent of the Committee.

Chairman Lucas thanked all the Members and adjourned the meeting.

REPORTING THE BILL—ROLL CALL VOTES

In compliance with clause 3(b) of rule XIII of the House of Representatives, Agricultural Reconciliation Act of 2012 was reported by voice vote with a majority quorum present. There was no request for a recorded vote.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee on Agriculture's oversight findings and recommendations are reflected in the body of this report.

PERFORMANCE GOALS AND OBJECTIVES

With respect to the requirement of clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the performance goals and objections of this legislation are to reduce spending within the jurisdiction of the Committee on Agriculture as required by H. Con. Res. 112, the Concurrent Resolution on the Budget for Fiscal Year 2013 and as modified by H. Res. 614.

CONSTITUTIONAL AUTHORITY STATEMENT

The Committee finds the Constitutional authority for this legislation in Article I, section 8, clause 18, that grants Congress the power to make all laws necessary and proper for carrying out the powers vested by Congress in the Constitution of the United States or in any department or officer thereof.

BUDGET ACT COMPLIANCE (SECTIONS 308, 402, AND 423)

The provisions of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a)(1) of the Congressional Budget Act of 1974 (relating to estimates of new budget authority, new spending authority, new credit authority, or increased or decreased revenues or tax expenditures) are not considered applicable. The estimate and comparison required to be prepared by the Director of the Congressional Budget Office under clause 3(c)(3) of

rule XIII of the Rules of the House of Representatives and sections 402 and 423 of the Congressional Budget Act of 1974 submitted to the Committee prior to the filing of this report are as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 23, 2012.

Hon. FRANK D. LUCAS,
Chairman, Committee on Agriculture,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the Agricultural Reconciliation Act of 2012.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Kathleen FitzGerald.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

Agricultural Reconciliation Act of 2012

Summary: The Agricultural Reconciliation Act of 2012 would make several changes to the Supplemental Nutrition Assistance Program (SNAP) and extend its authorization for one year. CBO estimates that enacting this legislation would reduce direct spending by $5.6 billion in 2013 and by $33.7 billion over the 2013–2022 period, relative to CBO's March 2012 baseline projections. Those estimates are based on CBO's assumption that the legislation will be enacted on or near October 1, 2012.

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 SNAP proposals would result in greater reductions in direct spending than those estimated assuming an October 1 enactment date. Under the alternative assumption of a July 1 enactment date, CBO estimates that the SNAP proposals would reduce direct spending by $7.8 billion over the 2012–2013 period and $35.8 billion over the 2012–2022 period.

The legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of the Agricultural Reconciliation Act of 2012 is shown in the following table (on pages 2 and 3). The costs of this legislation fall within budget function 600 (income security)

	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 OCTOBER 1, 2012													
Changes to SNAP Eligibility and Benefits:													
Standard Utility Allowances:													
Estimated Budget Authority	0	−750	−1,470	−1,490	−1,500	−1,470	−1,450	−1,450	−1,460	−1,470	−1,470	−6,680	−13,980
Estimated Outlays	0	−750	−1,470	−1,490	−1,500	−1,470	−1,450	−1,450	−1,460	−1,470	−1,470	−6,680	−13,980
Restrict Categorical Eligibility:													
Estimated Budget Authority	0	−620	−1,245	−1,255	−1,255	−1,235	−1,210	−1,195	−1,180	−1,170	1,155	−5,610	−11,520
Estimated Outlays	0	−615	−1,240	−1,255	−1,255	−1,235	−1,210	−1,195	−1,180	−1,170	1,155	−5,600	−11,510
Benefit Increase Sunset: [a]													
Estimated Budget Authority	0	−4,084	−289	0	0	0	0	0	0	0	0	−4,372	−4,372
Estimated Outlays	0	−4,084	−289	0	0	0	0	0	0	0	0	−4,372	−4,372
Interaction Effects:													
Estimated Budget Authority	0	140	25	20	20	20	20	20	20	20	20	225	325
Estimated Outlays	0	140	25	20	20	20	20	20	20	20	20	225	325
Changes to Other SNAP Activities:													
Employment and Training:													
Estimated Budget Authority	0	−256	−295	−299	−305	−311	−317	−324	−331	−338	−346	−1,466	−3,121
Estimated Outlays	0	−256	−295	−299	−305	−311	−317	−324	−331	−338	−346	−1,466	−3,121
Awards and Grants:													
Estimated Budget Authority	0	−68	−74	−80	−87	−95	−104	−114	−124	−135	−145	−404	−1,026
Estimated Outlays	0	−68	−74	−80	−87	−95	−104	−114	−124	−135	−145	−404	−1,026
Total Changes in Direct Spending:													
Estimated Budget Authority	0	−5,638	−3,347	−3,104	−3,127	−3,091	−3,061	−3,063	−3,075	−3,093	−3,096	−18,307	−33,694
Estimated Outlays	0	−5,633	−3,342	−3,104	−3,127	−3,091	−3,061	−3,063	−3,075	−3,093	−3,096	−18,297	−33,684
CHANGES IN DIRECT SPENDING ASSUMING ENACTMENT JULY 1, 2012 (Per the Direction of the Chairman of the House Committee on the Budget)													
Changes to SNAP Eligibility and Benefits:													
Standard Utility Allowances:													
Estimated Budget Authority	−30	−1,070	−1,470	−1,490	−1,500	−1,470	−1,450	−1,450	−1,460	−1,470	1,470	−7,030	−14,330
Estimated Outlays	−30	−1,070	−1,470	−1,490	−1,500	−1,470	−1,450	−1,450	−1,460	−1,470	1,470	−7,030	−14,330
Restrict Categorical Eligibility:													
Estimated Budget Authority	−25	−875	−1,245	−1,255	−1,255	−1,235	−1,210	−1,195	−1,180	−1,170	−1,155	−5,890	−11,800
Estimated Outlays	−25	−870	−1,240	−1,255	−1,255	−1,235	−1,210	−1,195	−1,180	−1,170	−1,155	−5,880	−11,790

	By fiscal year, in millions of dollars—												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012–2017	2012–2022
Benefit Increase Sunset:[a]													
Estimated Budget Authority	−675	−5,000	−289	0	0	0	0	0	0	0	0	−5,963	−5,963
Estimated Outlays	−675	−5,000	−289	0	0	0	0	0	0	0	0	−5,963	−5,963
Interaction Effects:													
Estimated Budget Authority	10	205	25	20	20	20	20	20	20	20	20	300	400
Estimated Outlays	10	205	25	20	20	20	20	20	20	20	20	300	400
Changes to Other SNAP Activities:													
Employment and Training:													
Estimated Budget Authority	0	−256	−295	−299	−305	−311	−317	−324	−331	−338	−346	−1,466	−3,121
Estimated Outlays	0	−256	−295	−299	−305	−311	−317	−324	−331	−338	−346	−1,466	−3,121
Awards and Grants:													
Estimated Budget Authority	0	−68	−74	−80	−87	−95	−104	−114	−124	−135	−145	−404	−1,026
Estimated Outlays	0	−68	−74	−80	−87	−95	−104	−114	−124	−135	−145	−404	−1,026
Total Changes in Direct Spending:													
Estimated Budget Authority	−720	−7,064	−3,347	−3,104	−3,127	−3,091	−3,061	−3,063	−3,075	−3,093	−3,096	−20,453	−35,840
Estimated Outlays	−720	−7,059	−3,342	−3,104	−3,127	−3,091	−3,061	−3,063	−3,075	−3,093	−3,096	−20,443	−35,830
Memorandum:													
Spending for SNAP Under CBO's March 2012 Baseline	80,993	81,986	79,886	80,048	79,679	78,089	76,637	75,388	74,274	73,497	72,624	480,682	853,102

Notes: Components may not sum to totals because of rounding.
SNAP = Supplemental Nutrition Assistance Program.
[a] The benefit increase, originally provided in the American Recovery and Reinvestment Act, was previously designated as spending for an emergency requirement.

Basis of estimate: For the purposes of this estimate, CBO assumes the bill will be enacted on or near October 1, 2012, as shown in the first panel of the table (above). 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 on the second panel of the table (on the next page).

Changes to SNAP Eligibility and Benefits

The Agricultural Reconciliation Act of 2012 would make several changes to the amount of SNAP benefits that households receive as well as eligibility for the program. In particular, the legislation would change the terms for granting heating and cooling (utility) allowances under SNAP, restrict the automatic extension of SNAP eligibility for individuals in households that receive assistance under certain other federal programs, and accelerate the sunset date for enhanced SNAP benefits pursuant to a provision enacted in the American Recovery and Reinvestment Act of 2009 (ARRA). Together, those provisions would reduce direct spending by about $29.5 billion over the 2012–2022 period, assuming enactment on October 1, 2012; and by about $31.7 billion over the same period under the July 1 enactment assumption.

Standard Utility Allowances. Under current law, households qualify for a Heating and Cooling Standard Utility Allowance (HCSUA) if they provide proof that they pay heating or cooling expenses or receive assistance through the Low-Income Home Energy Assistance Program (LIHEAP). The Agriculture Committee's proposal would eliminate the automatic qualification for those allowances for SNAP households who receive energy assistance. Some states currently send nominal LIHEAP benefit amounts (typically between $1 and $5, and typically only once per year) to SNAP participants to automatically qualify them for the utility allowance. The value of the HCSUA is used, along with other factors, to determine the amount of housing expenses that households can deduct from their income.

The legislation would eliminate that automatic qualification and require all households to provide proof that they paid heating or cooling expenses to claim the utility allowance. CBO estimates that under this provision about 1.3 million households would have their SNAP benefits reduced by an average of $90 per month. CBO estimates that about 80 percent of households with reduced benefits would be those that qualify for the HCSUA under current law through their receipt of nominal LIHEAP benefits (as described above). We estimate that this provision would reduce direct spending by $14.0 billion over the 2012–2022 period, assuming enactment on October 1, 2012. (Assuming a July 1, 2012, enactment date, CBO estimates that this provision would reduce direct spending by $14.3 billion over the 2012–2022 period.)

Restrict Categorical Eligibility. Individuals in households in which all members receive cash assistance from the Temporary Assistance to Needy Families Program (TANF), Supplemental Security Income, or similar state cash assistance programs are considered automatically eligible for SNAP and are not subject to the program's income and asset requirements. States currently have the

option to extend such *categorical eligibility* to households that receive or are eligible to receive non-cash services through TANF.

The legislation would restrict categorical eligibility to only households receiving cash assistance. Based on data from the Department of Agriculture, CBO estimates that about 1.8 million people per year, on average, would lose benefits if they were subject to SNAP's income and asset tests. In addition, about 280,000 school-age children in those households would no longer be automatically eligible for free school meals through their receipt of SNAP benefits. Assuming enactment on October 1, 2012, CBO estimates that this provision would lower direct spending by $11.5 billion over the 2012–2022 period. (We estimate the reduction would be $11.8 billion for a July 1, 2012, enactment date.)

Benefit Increase Sunset. The maximum SNAP benefit is determined by the cost of the Thrifty Food Plan—a basket of goods selected by the Department of Agriculture to provide a nutritious diet—published in June of each year. The American Recovery and Reinvestment Act of 2009 raised the maximum SNAP benefit in 2009 by 13.6 percent and held it at that amount until the annual inflation adjustment exceeded that amount. Subsequent legislation established a sunset date of October 31, 2013, for this increase. ARRA designated this temporary benefit increase as an emergency requirement.

The legislation would accelerate the sunset date for the ARRA benefit increase to June 30, 2012. Based on discussions with states, CBO expects that states would need about two months to implement the benefit calculation change in their payment systems. As a result, we assume that the effective date for the change in benefits will be after August 31, 2012. CBO estimates that in fiscal year 2013, the maximum benefit for a household of four would be $34 lower than it would have been under current law. In total, CBO estimates enacting this provision would reduce direct spending by nearly $6.0 billion if the legislation is enacted by July 1, 2012, but the savings would drop to $4.4 billion if the legislation is not enacted until October 1, 2012.

Interaction Effects. Changes to standard utility allowances and benefit amounts set by ARRA would reduce benefit amounts that households receive; restricting categorical eligibility would reduce the total number of households receiving SNAP. Therefore, the estimated savings from each provision would be reduced if all three were enacted simultaneously. Accounting for the interactions of those provisions, CBO estimates that the total savings would decline by $325 million over the 2013–2022 period for an assumed enactment on October 1, 2012. (CBO estimates that the interaction effect would be $400 million for the July 1 enactment date.)

Changes to Other SNAP Activities

The Agricultural Reconciliation Act of 2012 also would make changes to the level of administrative and award funding under SNAP. Finally, it would reauthorize SNAP through fiscal year 2013. Those changes would reduce direct spending by about $4.1 billion over the 2012–2022 period for both enactment date assumptions.

Employment and Training Funding. Under current law, states receive a base grant to fund employment and training activities for SNAP participants. In addition, the federal government shares costs above that amount with states on a matching basis. The legislation would eliminate the authority for the federal government to provide such additional funds above the base grant level. As a result of that reduction in funding, CBO estimates that a small number of nondisabled adults without children, who are subject to a work requirement in order to receive SNAP benefits, would lose eligibility if states scale back their employment and training activities. In total, CBO estimates that this provision would lower direct spending by $3.1 billion over the 2012–2022 period.

Awards and Grants. The proposal also would eliminate $48 million in annual funding for awards to states with high or improved performance in administering SNAP. The legislation also would eliminate the annual inflation adjustment of grants to states for nutrition education. CBO estimates that these two provisions together would reduce direct spending by $1.0 billion over the 2012–2022 period.

Program Extensions. The Food, Conservation, and Energy Act of 2008 authorized SNAP through 2012. The reconciliation proposal would extend the program through the end of fiscal year 2013. Under the assumptions underlying CBO's March 2012 baseline projections, we estimate that extending the program for one year would result in outlays of $82 billion in 2013. Pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, this extension is assumed in CBO's current baseline projections and has no cost relative to that baseline.

Estimated impact on state, local, and tribal governments: For large entitlement programs such as SNAP, UMRA defines an increase in the stringency of conditions as an intergovernmental mandate if the affected governments lack authority to offset those costs while continuing to provide required services. The legislation would decrease federal payments to states for administering employment and training services under SNAP. CBO estimates that the decrease in federal aid would total $256 million in 2013 and $3.1 billion over the 2012–2022 period. However, because states have flexibility to amend their employment and training services to offset those costs, the decrease in federal aid would not impose an intergovernmental mandate as defined in UMRA.

Estimated impact on the private sector: The legislation contains no new private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Costs: Kathleen FitzGerald and Emily Holcombe; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Jimmy Jin.

Estimate approved by: Peter H. Fontaine, Assistant Director for Budget Analysis.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

* * * * * * *

DIVISION A—APPROPRIATIONS PROVISIONS

* * * * * * *

GENERAL PROVISIONS—THIS TITLE

SEC. 101. Temporary Increase in Benefits Under the Supplemental Nutrition Assistance Program. (a) MAXIMUM BENEFIT INCREASE.—

(1) * * *

(2) TERMINATION.—The authority provided by this subsection shall terminate after [October 31, 2013] *June 30, 2012*.

* * * * * * *

FOOD AND NUTRITION ACT OF 2008

* * * * * * *

ELIGIBLE HOUSEHOLDS

SEC. 5. (a) Participation in the supplemental nutrition assistance program shall be limited to those households whose incomes and other financial resources, held singly or in joint ownership, are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet. Notwithstanding any other provisions of this Act except sections 6(b), 6(d)(2), and 6(g) and section 3(n)(4), [households in which each member receives benefits] *households in which each member receives cash assistance* under a State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.), supplemental security income benefits under title XVI of the Social Security Act, or aid to the aged, blind, or disabled under title I, X, XIV, or XVI of the Social Security Act, shall be eligible to participate in the supplemental nutrition assistance program. Except for sections 6, 16(e)(1), and section 3(n)(4), households in which each member receives benefits under a State or local general assistance program that complies with standards established by the Secretary for ensuring that the program is based on income criteria comparable to or more restrictive than those under subsection (c)(2), and not limited to one-time emergency payments that cannot be provided for more than one consecutive month, shall be eligible to participate in the supplemental nutrition assistance program. Assistance under this program shall be furnished to all eligible households who make application for such participation.

* * * * * * *

(e) DEDUCTIONS FROM INCOME.—

(1) * * *

* * * * * * *

(6) EXCESS SHELTER EXPENSE DEDUCTION.—

(A) * * *

* * * * * * *

(C) STANDARD UTILITY ALLOWANCE.—

(i) * * *

* * * * * * *

[(iv) AVAILABILITY OF ALLOWANCE TO RECIPIENTS OF ENERGY ASSISTANCE.—

[(I) IN GENERAL.—Subject to subclause (II), if a State agency elects to use a standard utility allowance that reflects heating or cooling costs, the standard utility allowance shall be made available to households receiving a payment, or on behalf of which a payment is made, under the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8621 et seq.) or other similar energy assistance program, if the household still incurs out-of-pocket heating or cooling expenses in excess of any assistance paid on behalf of the household to an energy provider.

[(II) SEPARATE ALLOWANCE.—A State agency may use a separate standard utility allowance for households on behalf of which a payment described in subclause (I) is made, but may not be required to do so.

[(III) STATES NOT ELECTING TO USE SEPARATE ALLOWANCE.—A State agency that does not elect to use a separate allowance but makes a single standard utility allowance available to households incurring heating or cooling expenses (other than a household described in subclause (I) or (II) of clause (ii)) may not be required to reduce the allowance due to the provision (directly or indirectly) of assistance under the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8621 et seq.).

[(IV) PRORATION OF ASSISTANCE.—For the purpose of the supplemental nutrition assistance program, assistance provided under the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8621 et seq.) shall be considered to be prorated over the entire heating or cooling season for which the assistance was provided.]

* * * * * * *

(j) Notwithstanding subsections (a) through (i), a State agency shall consider a household member who receives supplemental security income benefits under title XVI of the Social Security Act (42 U.S.C. 1382 et seq.), aid to the aged, blind, or disabled under title I, II, X, XIV, or XVI of such Act (42 U.S.C. 301 et seq.), [or who receives benefits under a State program] *or who receives cash as-*

sistance under a State program funded under part A of title IV of the Act (42 U.S.C. 601 et seq.) to have satisfied the resource limitations prescribed under subsection (g).

(k)(1) * * *

* * * * * * *

[(4) THIRD PARTY ENERGY ASSISTANCE PAYMENTS.—

[(A) ENERGY ASSISTANCE PAYMENTS.—For purposes of subsection (d)(1), a payment made under a State law (other than a law referred to in paragraph (2)(H)) to provide energy assistance to a household shall be considered money payable directly to the household.

[(B) ENERGY ASSISTANCE EXPENSES.—For purposes of subsection (e)(6), an expense paid on behalf of a household under a State law to provide energy assistance shall be considered an out-of-pocket expense incurred and paid by the household.]

(4) THIRD PARTY ENERGY ASSISTANCE PAYMENTS.—For purposes of subsection (d)(1), a payment made under a State law (other than a law referred to in paragraph (2)(G)) to provide energy assistance to a household shall be considered money payable directly to the household.

* * * * * * *

ADMINISTRATIVE COST-SHARING AND QUALITY CONTROL

SEC. 16. (a) Subject to subsection (k), the Secretary is authorized to pay to each State agency an amount equal to 50 per centum of all administrative costs involved in each State agency's operation of the supplemental nutrition assistance program *(other than a program carried out under section 6(d)(4) or section 20)*, which costs shall include, but not be limited to, the cost of (1) the certification of applicant households, (2) the acceptance, storage, protection, control, and accounting of benefits after their delivery to receiving points within the State, (3) the issuance of benefits to all eligible households, (4) informational activities relating to the supplemental nutrition assistance program, including those undertaken under section 11(e)(1)(A), but not including recruitment activities, (5) fair hearings, (6) automated data processing and information retrieval systems subject to the conditions set forth in subsection (g), (7) supplemental nutrition assistance program investigations and prosecutions, and (8) implementing and operating the immigration status verification system established under section 1137(d) of the Social Security Act (42 U.S.C. 1320b–7(d)): *Provided,* That the Secretary is authorized at the Secretary's discretion to pay any State agency administering the supplemental nutrition assistance program on all or part of an Indian reservation under section 11(d) of this Act or in a Native village within the State of Alaska identified in section 11(b) of Public Law 92–203, as amended. such amounts for administrative costs as the Secretary determines to be necessary for effective operation of the supplemental nutrition assistance program, as well as to permit each State to retain 35 percent of the value of all funds or allotments recovered or collected pursuant to sections 6(b) and 13(c) and 20 percent of the value of any other funds or allotments recovered or collected, except the value

of funds or allotments recovered or collected that arise from an error of a State agency. The officials responsible for making determinations of ineligibility under this Act shall not receive or benefit from revenues retained by the State under the provisions of this subsection.

* * * * * * *

[(d) BONUSES FOR STATES THAT DEMONSTRATE HIGH OR MOST IMPROVED PERFORMANCE.—

[(1) FISCAL YEARS 2003 AND 2004.—

[(A) GUIDANCE.—With respect to fiscal years 2003 and 2004, the Secretary shall establish, in guidance issued to State agencies not later than October 1, 2002—

[(i) performance criteria relating to—

[(I) actions taken to correct errors, reduce rates of error, and improve eligibility determinations; and

[(II) other indicators of effective administration determined by the Secretary; and

[(ii) standards for high and most improved performance to be used in awarding performance bonus payments under subparagraph (B)(ii).

[(B) PERFORMANCE BONUS PAYMENTS.—With respect to each of fiscal years 2003 and 2004, the Secretary shall—

[(i) measure the performance of each State agency with respect to the criteria established under subparagraph (A)(i); and

[(ii) subject to paragraph (3), award performance bonus payments in the following fiscal year, in a total amount of $48,000,000 for each fiscal year, to State agencies that meet standards for high or most improved performance established by the Secretary under subparagraph (A)(ii).

[(2) FISCAL YEARS 2005 AND THEREAFTER.—

[(A) REGULATIONS.—With respect to fiscal year 2005 and each fiscal year thereafter, the Secretary shall—

[(i) establish, by regulation, performance criteria relating to—

[(I) actions taken to correct errors, reduce rates of error, and improve eligibility determinations; and

[(II) other indicators of effective administration determined by the Secretary;

[(ii) establish, by regulation, standards for high and most improved performance to be used in awarding performance bonus payments under subparagraph (B)(ii); and

[(iii) before issuing proposed regulations to carry out clauses (i) and (ii), solicit ideas for performance criteria and standards for high and most improved performance from State agencies and organizations that represent State interests.

[(B) PERFORMANCE BONUS PAYMENTS.—With respect to fiscal year 2005 and each fiscal year thereafter, the Secretary shall—

[(i) measure the performance of each State agency with respect to the criteria established under subparagraph (A)(i); and

[(ii) subject to paragraph (3), award performance bonus payments in the following fiscal year, in a total amount of $48,000,000 for each fiscal year, to State agencies that meet standards for high or most improved performance established by the Secretary under subparagraph (A)(ii).

[(3) PROHIBITION ON RECEIPT OF PERFORMANCE BONUS PAYMENTS.—A State agency shall not be eligible for a performance bonus payment with respect to any fiscal year for which the State agency has a liability amount established under subsection (c)(1)(C).

[(4) PAYMENTS NOT SUBJECT TO JUDICIAL REVIEW.—A determination by the Secretary whether, and in what amount, to award a performance bonus payment under this subsection shall not be subject to administrative or judicial review.]

* * * * * * *

(h) FUNDING OF EMPLOYMENT AND TRAINING PROGRAMS.—

(1) * * *

[(2) If, in carrying out such program during such fiscal year, a State agency incurs costs that exceed the amount allocated to the State agency under paragraph (1), the Secretary shall pay such State agency an amount equal to 50 per centum of such additional costs, subject to the first limitation in paragraph (3), including the costs for case management and casework to facilitate the transition from economic dependency to self-sufficiency through work.

[(3) The Secretary shall also reimburse each State agency in an amount equal to 50 per centum of the total amount of payments made or costs incurred by the State agency in connection with transportation costs and other expenses reasonably necessary and directly related to participation in an employment and training program under section 6(d)(4), except that the amount of the reimbursement for dependent care expenses shall not exceed an amount equal to the payment made under section 6(d)(4)(I)(i)(II) but not more than the applicable local market rate, and such reimbursement shall not be made out of funds allocated under paragraph (1).]

[(4)] *(2)* Funds provided to a State agency under this subsection may be used only for operating an employment and training program under section 6(d)(4), and may not be used for carrying out other provisions of this Act.

[(5)] *(3)* The Secretary shall monitor the employment and training programs carried out by State agencies under section 6(d)(4) to measure their effectiveness in terms of the increase in the numbers of household members who obtain employment and the numbers of such members who retain such employment as a result of their participation in such employment and training programs.

* * * * * * *

RESEARCH, DEMONSTRATION, AND EVALUATIONS

SEC. 17. (a) * * *

(b)(1)(A) * * *

(B) PROJECT REQUIREMENTS.—

(i) * * *

* * * * * * *

(iv) IMPERMISSIBLE PROJECTS.—The Secretary may not conduct a project under subparagraph (A) that—

(I) * * *

* * * * * * *

(III) is inconsistent with—

(aa) * * *

* * * * * * *

(hh) subsection (a), (c), [(g), (h)(2), or (h)(3)] *or (g)* of section 16;

* * * * * * *

AUTHORIZATION FOR APPROPRIATIONS

SEC. 18. (a)(1) To carry out this Act, there are authorized to be appropriated such sums as are necessary for each of fiscal years 2008 through [2012] *2013*. Not to exceed one-fourth of 1 per centum of the previous year's appropriation is authorized in each such fiscal year to carry out the provisions of section 17 of this Act, subject to paragraph (3).

* * * * * * *

WORKFARE

SEC. 20. (a) * * *

* * * * * * *

[(g)(1) The Secretary shall pay to each operating agency 50 per centum of all administrative expenses incurred by such agency in operating a workfare program, including reimbursements to participants for work-related expenses as described in subsection (d)(3) of this section.

[(2)(A) From 50 per centum of the funds saved from employment related to a workfare program operated under this section, the Secretary shall pay to each operating agency an amount not to exceed the administrative expenses described in paragraph (1) for which no reimbursement is provided under such paragraph.

[(B) For purposes of subparagraph (A), the term "funds saved from employment related to a workfare program operated under this section" means an amount equal to three times the dollar value of the decrease in allotments issued to households, to the extent that such decrease results from wages received by members of such households for the first month of employment beginning after the date such members commence such employment if such employment commences—

[(i) while such members are participating for the first time in a workfare program operated under this section; or

[(ii) in the thirty-day period beginning on the date such first participation is terminated.

[(3) The Secretary may suspend or cancel some or all of these payments, or may withdraw approval from a political subdivision to operate a workfare program, upon a finding that the subdivision has failed to comply with the workfare requirements.]

* * * * * * *

MINNESOTA FAMILY INVESTMENT PROJECT

SEC. 22. (a) * * *

* * * * * * *

(d) FUNDING.—

(1) If an application submitted under subsection (a) complies with the requirements specified in subsection (b), then the Secretary shall—

(A) * * *

(B) subject to subsection (b)(12) from the funds appropriated under this Act provide grant awards and pay the State each calendar quarter for—

(i) * * *

(ii) the administrative costs incurred by the State to provide food assistance under the Project that are authorized under subsections (a)[, (g), (h)(2), and (h)(3)] *and (g)* of section 16 equal to the amount that otherwise would have been paid under such subsections had the Project not been implemented, as estimated under a methodology satisfactory to the Secretary after negotiations with the State: *Provided,* That payments made under subsection (g) of section 16 shall equal payments that would have been made if the Project had not been implemented.

* * * * * * *

SEC. 28. NUTRITION EDUCATION AND OBESITY PREVENTION GRANT PROGRAM.

(a) * * *

* * * * * * *

(d) FUNDING.—

(1) IN GENERAL.—Of funds made available each fiscal year under section 18(a)(1), the Secretary shall reserve for allocation to State agencies to carry out the nutrition education and obesity prevention grant program under this section, to remain available for obligation for a period of 2 fiscal [years—

[(A) for fiscal year 2011, $375,000,000; and

[(B) for fiscal year 2012 and each subsequent fiscal year, the applicable amount during the preceding fiscal year, as adjusted to reflect any increases for the 12-month period ending the preceding June 30 in the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the Department of Labor.

[(2) ALLOCATION.—

[(A) INITIAL ALLOCATION.—Of the funds set aside under paragraph (1), as determined by the Secretary—

[(i) for each of fiscal years 2011 through 2013, 100 percent shall be allocated to State agencies in direct proportion to the amount of funding that the State received for carrying out section 11(f) (as that section existed on the day before the date of enactment of this section) during fiscal year 2009, as reported to the Secretary as of February 2010; and

[(ii) subject to a reallocation under subparagraph (B)—

[(I) for fiscal year 2014—

[(aa) 90 percent shall be allocated to State agencies in accordance with clause (i); and

[(bb) 10 percent shall be allocated to State agencies based on the respective share of each State of the number of individuals participating in the supplemental nutrition assistance program during the 12-month period ending the preceding January 31;

[(II) for fiscal year 2015—

[(aa) 80 percent shall be allocated to State agencies in accordance with clause (i); and

[(bb) 20 percent shall be allocated in accordance with subclause (I)(bb);

[(III) for fiscal year 2016—

[(aa) 70 percent shall be allocated to State agencies in accordance with clause (i); and

[(bb) 30 percent shall be allocated in accordance with subclause (I)(bb);

[(IV) for fiscal year 2017—

[(aa) 60 percent shall be allocated to State agencies in accordance with clause (i); and

[(bb) 40 percent shall be allocated in accordance with subclause (I)(bb); and

[(V) for fiscal year 2018 and each fiscal year thereafter—

[(aa) 50 percent shall be allocated to State agencies in accordance with clause (i); and

[(bb) 50 percent shall be allocated in accordance with subclause (I)(bb).

[(B) REALLOCATION.—

[(i) IN GENERAL.—If the Secretary determines that a State agency will not expend all of the funds allocated to the State agency for a fiscal year under paragraph (1) or in the case of a State agency that elects not to receive the entire amount of funds allocated to the State agency for a fiscal year, the Secretary shall reallocate the unexpended funds to other States during the fiscal year or the subsequent fiscal year (as determined by the Secretary) that have approved State plans under which the State agencies may expend the reallocated funds.

[(ii) EFFECT OF ADDITIONAL FUNDS.—

[(I) FUNDS RECEIVED.—Any reallocated funds received by a State agency under clause (i) for a

fiscal year shall be considered to be part of the fiscal year 2009 base allocation of funds to the State agency for that fiscal year for purposes of determining allocation under subparagraph (A) for the subsequent fiscal year.

[(II) FUNDS SURRENDERED.—Any funds surrendered by a State agency under clause (i) shall not be considered to be part of the fiscal year 2009 base allocation of funds to a State agency for that fiscal year for purposes of determining allocation under subparagraph (A) for the subsequent fiscal year.

[(3) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

[(A) IN GENERAL.—Grants awarded under this section shall be the only source of Federal financial participation under this Act in nutrition education and obesity prevention.

[(B) EXCLUSION.—Any costs of nutrition education and obesity prevention in excess of the grants authorized under this section shall not be eligible for reimbursement under section 16(a).] *years, $375,000,000.*

* * * * * * *

LOW-INCOME HOME ENERGY ASSISTANCE ACT OF 1981

* * * * * * *

TITLE XXVI—LOW-INCOME HOME ENERGY ASSISTANCE

* * * * * * *

APPLICATIONS AND REQUIREMENTS

SEC. 2605. (a) * * *

* * * * * * *

(f)(1) * * *

(2) For purposes of paragraph (1) of this subsection [and for purposes of determining any excess shelter expense deduction under section 5(e) of the Food and Nutrition Act of 2008 (7 U.S.C. 2014(e))]—

(A) the full amount of such payments or allowances shall be deemed to be expended by such household for heating or cooling expenses, without regard to whether such payments or allowances are provided directly to, or indirectly for the benefit of, such household*, except that such payments or allowances shall not be deemed to be expended for purposes of determining any excess shelter expense deduction under section 5(e)(6) of the Food and Nutrition Act of 2008 (7 U.S.C. 2014(e)(6))*; and

* * * * * * *

MINORITY VIEWS

The House Agriculture Committee takes seriously its oversight role for both sound safety net policies for farmers and adequate nutrition programs for low-income households. However, the Budget Reconciliation Act of 2012 and the process under which it comes before our Committee in no way reflect the true gravity of this trust.

Without the benefit of a single hearing this year, the Budget Reconciliation Act of 2012 would make major alterations to the largest program within our jurisdiction, threatening the welfare of those for whom this program was created. SNAP participation has grown from 28 million participants at the time of the 2008 Farm Bill to more than 46 million participants today. This growth is not the result of any Congressional action but rather the growing need due to our ailing economy. The Congressional Budget Office estimates that SNAP demand will peak in 2013 and then fall, reacting to the nation's economic recovery.

The budget resolution the House passed in March, H. Con Res. 112, was not a serious budget document but a political exercise that resulted from a partisan division over defense cuts. It reflects none of the bipartisanship for which our committee is known and is not a legitimate deficit reduction measure.

A serious conversation about getting our nation's fiscal house in order cannot occur without putting everything on the table, including defense spending and revenue. It is simply irresponsible to attempt to balance the budget on the backs of the hardworking Americans that rely on the safety net SNAP provides.

The SNAP fraud rate is at an all-time low and is operating more efficiently than many other government programs. There may be further inefficiencies that can be addressed by this Committee, but we have not had the adequate time needed for a thorough program review.

We stand committed to having a serious conversation about our deficit reduction and are willing to consider all budget areas under this Committee's jurisdiction, however the cuts contained in the Budget Reconciliation Act of 2012 would leave millions of American families, children and seniors hungry.

COLLIN PETERSON.
BILL OWENS.
LEONARD BOSWELL.
GREGORIO KILILI CAMACHO SABLAN.
CHELLIE PINGREE.
JIM MCGOVERN.
MARCIA FUDGE.
JIM COSTA.
TERRI A. SEWELL.
DAVID SCOTT.
HENRY CUELLAR.
KURT SCHRADER.
PETER WELCH.
TIM WALZ.
JOE COURTNEY.
JOE BACA.

TITLE II—THE COMMITTEE ON ENERGY AND COMMERCE

LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, April 27, 2012.

Hon. PAUL RYAN,
Chairman, Committee on the Budget,
House of Representatives, Washington, DC.

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.

TABLE OF CONTENTS

	Page
Purpose and Summary	49
Background and Need for Legislation	49
Hearings	56
Committee Consideration	57
Committee Votes	57
Committee Oversight Findings	78
Statement of General Performance Goals and Objectives	78
New Budget Authority, Entitlement Authority, and Tax Expenditures	78
Earmark	78
Committee Cost Estimate	78
Congressional Budget Office Estimate	78
Federal Mandates Statement	88
Advisory Committee Statement	88
Constitutional Authority Statement	88
Applicability to Legislative Branch	88
Section-by-Section Analysis of the Legislation	88
Changes in Existing Law Made by the Bill, as Reported	92
Dissenting Views	108

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

PURPOSE AND SUMMARY

The purpose of these Committee Prints is to rein 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

Reining 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 Com-

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

mittee 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) 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.[3]

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.[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.[5] 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.[6] Nearly half of all medical malpractice claims do

---

[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] See note 12.

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

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

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." [7]

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.[8] 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.

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.[9] 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.[10] 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 im-

---

[7] 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.*

[8] AMA 2007–2008 Physician Practice Information survey.

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

[10] 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.

provements 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.[11] 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.[12]

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.[13] 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."[14] In his 2011 State of the Union address, President Obama again included medical liability reform as part of his agenda.[15]

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 Health Coalition on Liability and Access found that 69 percent of Americans wanted medical liability reform included in health care reform legislation.[16] 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.[17]

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

---

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

[12] 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.

[13] 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.*

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

[15] 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.

[16] 112th Congress Committee on the Judiciary Report on the "Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2011."

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

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.[18]

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.[19] 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.[20] 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.[21]

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 suffering.[22] 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 re-form[23] 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. In States with caps on non-economic damages, liability premiums are 17 percent lower than they are in States without such caps.[24]

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

---

[18] 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.*

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

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

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

[22] 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.*

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

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

liability reforms saw an average reduction of 4.3 percent in hospital costs for patients in managed care programs.[25] 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.[26]

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

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 Johnson 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.

---

[25] 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.

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

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.

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					

04/25/2012

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					

04/25/2012

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					

04/25/2012

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					

04/25/2012

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						

04/25/2012

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					

04/25/2012

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						

04/25/2012

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					

04/25/2012

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					

04/25/2012

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					

04/25/2012

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					

04/25/2012

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					

04/25/2012

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						

04/25/2012

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

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.

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:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 27, 2012.

Hon. FRED UPTON,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

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.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

Reconciliation Recommendations of the House Committee on Energy and Commerce

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 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]

---

[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.*

[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.

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).

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

[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.

legislation approved by the Committee on the Judiciary reflect that difference in the two versions of such liability reform.

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; Impact on the Private Sector: Stuart Hagen, Jimmy Jin, and Michael Levine.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

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

SUBTITLE A—REPEAL OF CERTAIN ACA FUNDING PROVISIONS

Section 201. Repealing mandatory funding to States to establish American Health Benefit Exchanges

Section 201 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 202. Repealing Prevention and Public Health Fund

Section 202 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 203. Rescinding unobligated balances for CO-OP program

Section 203 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.

SUBTITLE B—MEDICAID

Section 211. Revision of provider tax indirect guaranteed threshold

Section 211 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 212. Rebasing of State DSH allotments for fiscal year 2022

Section 212 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 213. Repeal of Medicaid and CHIP maintenance of effort requirements under PPACA

Section 213 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 214. Medicaid payment to territories

Section 214 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 215. 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.

SUBTITLE C—LIABILITY REFORM

Section 221. Findings and purpose

Section 221 states the findings and purpose of the bill.

Section 222. Encouraging speedy resolution of claims

Section 222 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 223. Compensating patient injury

Section 223 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 224. Maximizing patient recovery

Section 224 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 225. Additional health benefits

Section 225 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 226. Punitive damages

Section 226 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 unneces-

sary 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 227. Authorization of payment of future damages to claimants in health care lawsuits

Section 227 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 228. Definitions

Section 228 defines many of the terms included in the legislation.

Section 229. Effect on other laws

Section 229 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 230. State flexibility and protection of State's rights

Section 230 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 231. Applicability; effective date

Section 231 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 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 italic, 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 proportion 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 Protection 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 per-

centage 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 Reauthorization 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 (including 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.**]**

* * * * * * *

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.

[1] H. Con. Res. 112.

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 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

---

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

[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/2011/1486Collins_help_on_the_horizon_2010_biennial_survey_report_FINAL_31611.pdf*).

[8] *Id.*

is offered to self-employment or employment in a small business, resulting in job lock.

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

---

[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.

policies, enrollment and disenrollment data, data on denied claims, information on cost sharing and coverage, and more.[13]

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's 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

---

[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.

[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.

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 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 ex-

---

[18] *Id.*

[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*).

changes, and steps 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 lead-

[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.

ership. These 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

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

Partnership for Women and Families, Paralyzed Veterans of America, National Disability Rights Network, and AARP among others.

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.
- 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 pro-

[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.govisitesidefault/files/cbofiles/attachments/03–13–Coverage%20Estimates.pdf*).

vider. 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).

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%

[38] ACA, Section 4002.
[39] *Id.*
[40] Middle Class Tax Relief and Job Creation Act of 2012, Public Law No. 112–96.

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]

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

---

[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 by 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 at *http://healthyamericans.org/health-issues/wp-content/uploads/2012/04/Fund-Reconciliation-EC-April2012.pdf*).

[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).

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 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 bil-

---

[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).

[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*).

lion 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 in 10 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 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]

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]

---

[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%2020120besityBrief06.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").

[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)).

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 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

---

[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).

[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).

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.

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

[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).

[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/Publicationsassue%20Brief/2012/Apr/1591__Gardiner__innovative strategies__help__coops.pdf.

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 York, and Wisconsin. A list of the awardees is available at: *http://www.healthcare.govinews/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.

---

[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.

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 al-

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

lotments 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.

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 it 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

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

[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.

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 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, "[There 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

[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.

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.

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 cur-

[79] Centers for Medicaid, CHIP and 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*).

rent 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 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

[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).

[82] Id.

[83] Letter from Representatives Pierluisi, Christensen, Bordallo, Faleomavaega to Chairman Upton, April 20, 2012.

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.

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 mil-

[84] ASPE Issue Brief, "1.2 Million Children Gain Insurance Since Reauthorization of Children's Health Insurance Program," December 22, 2011.

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

lion 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 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;

[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.

[90] Rep. Phil Gingrey, *The HEALTH Act: A Real Reform Option* (online at: *http://gingrey.house.gov/News/DocumentSingle.aspx?DocumentD=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 HR. 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).

- 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 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

---

[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).

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 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 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 individuals do not receive just compensation; in others, damages

---

[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).

[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)).

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 to use these authorities to address patient safety in a significant fashion.[115] When fully implemented and evaluated, theses types of

---

[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).

[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/partnership041220112.html*).

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)*

The Health Act/Title III is breathtaking in its scope. Its provisions—including caps on noneconomic 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 man-

---

[116] *AACA*, Section 10607.

[117] U.S. Department of Justice, FY 2013 Performance Budget, Office of Justice Programs (Feb. 2012) (online at: *http://www.justice.gov/jmd/2013justification/pdf/fy13–ojp-justific ation.pdf*).

[118] Mello MM, Kachalia A, *Evaluation of Options for Medical Malpractice System Reform*, MedPAC, No. 10–2 (Apr. 2010).

[119] *M1CRA* 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).

ufacturers, 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 noneconomic 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.

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 pack-

---

[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.

age, 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.

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

---

[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).

[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.

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 principle. This reincarnation is stunning as well.[135]

---

[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 as 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 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

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.

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]

Record, H434 (Jan. 24, 2011)). Yet, for the 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.

[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, attor-

Continued

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 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

---

ney 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).

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]

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 physi-

[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).

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

cian 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 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

---

[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*).

[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).

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 wel1.[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 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

---

[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] NBC 10 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).

[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).

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.

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

---

[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).

[163] GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, pp. 3–4, GA0–03–561 (July 2003).

[164] GAO, *High-Risk Series: An Update*, p. 159, GA0–11–278 (Feb. 2011).

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 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

---

[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/A0N/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=*).

[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.

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]

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

---

[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 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.*

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 "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

---

[180] *Id.*
[181] *Id.*
[182] *Id.* at 12.
[183] *Wyeth* v. *Levine*, 129 S.Ct. 1187 (2009).
[184] *Id.*
[185] *Id.*
[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 HR. 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.

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.

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 pro-

---

[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 HR. 5, HEALTH Act*, 112th Cong., p. 20 (Apr. 6, 2011).

[191] House Committee on Energy and Commerce, *Markup of HR. 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).

[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 HR. 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).

file 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:

> 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.

HENRY A. WAXMAN,
Ranking Member.
FRANK PALLONE, Jr.,
Ranking Member, Subcommittee on Health.

---

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

[196] House Committee on the Judiciary, *HEALTH Act,* Dissenting Views, 112th Cong., p. 118 (Mar. 17, 2011) (H. Rept. No. 112–39, Part 1).

TITLE III—THE COMMITTEE ON FINANCIAL SERVICES

LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON FINANCIAL SERVICES,
Washington, DC, April 27, 2012.

Hon. PAUL RYAN,
Chairman, Committee on Budget,
Washington, DC.

DEAR CHAIRMAN RYAN: Pursuant to section 201 (a) of the Concurrent Resolution on the Budget for Fiscal Year 2013 (H. Con. Res. 112), I hereby transmit to the Committee on the Budget the recommendations which were approved by vote of the Committee on Financial Services on April 18, 2012, and the appropriate accompanying material including dissenting views. This submission is for the purpose of complying with the reconciliation directives included in H. Con. Res. 112, and is consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974.

If you have any questions, please do not hesitate to have your staff contact Natalie McGarry of my staff. Thank you for your attention to this matter.

Sincerely,

SPENCER BACHUS,
Chairman.

TABLE OF CONTENTS

	Page
Purpose and Summary	154
Subtitle A—Orderly Liquidation Fund	154
Subtitle B—Home Affordable Modification Program	154
Subtitle C—Bureau of Consumer Financial Protection	155
Subtitle D—Flood Insurance Reform	155
Subtitle E—Office of Financial Research	155
Background and Need for Legislation	155
Subtitle A—Orderly Liquidation Fund	155
Subtitle B—Home Affordable Modification Program	156
Subtitle C—Bureau of Consumer Financial Protection	157
Subtitle D—Flood Insurance Reform	158
Subtitle E—Office of Financial Research	159
Hearings	160
Subtitle A—Orderly Liquidation Fund	160
Subtitle B—Home Affordable Modification Program	160
Subtitle C—Bureau of Consumer Financial Protection	160
Subtitle D—Flood Insurance Reform	161
Subtitle E—Office of Financial Research	162
Committee Consideration	163
Committee Votes	163
Constitutional Authority Statement	169
Subtitle A—Orderly Liquidation Fund	169
Subtitle B—Home Affordable Modification Program	169
Subtitle C—Bureau of Consumer Financial Protection	169
Subtitle D—Flood Insurance Reform	169
Subtitle E—Office of Financial Research	169
Committee Oversight Findings	169
Performance Goals and Objectives	170
Subtitle A—Orderly Liquidation Fund	170
Subtitle B—Home Affordable Modification Program	170
Subtitle C—Bureau of Consumer Financial Protection	170
Subtitle D—Flood Insurance Reform	170
Subtitle E—Office of Financial Research	171
New Budget Authority, Entitlement Authority, and Tax Expenditures	171
Committee Cost Estimate	171
Congressional Budget Office Estimate	171
Federal Mandates Statement	182
Advisory Committee Statement	182
Subtitle A—Orderly Liquidation Fund	182
Subtitle B—Home Affordable Modification Program	182
Subtitle C—Bureau of Consumer Financial Protection	182
Subtitle D—Flood Insurance Reform	182
Subtitle E—Office of Financial Research	183
Applicability to Legislative Branch	183

Subtitle A—Orderly Liquidation Fund 183
Subtitle B—Home Affordable Modification Program 183
Subtitle C—Bureau of Consumer Financial Protection 183
Subtitle D—Flood Insurance Reform 183
Subtitle E—Office of Financial Research 183
Earmark Identification 183
Subtitle A—Orderly Liquidation Fund 183
Subtitle B—Home Affordable Modification Program 183
Subtitle C—Bureau of Consumer Financial Protection 183
Subtitle D—Flood Insurance Reform 184
Subtitle E—Office of Financial Research 184
Section-by-Section Analysis of the Legislation 184
Subtitle A—Orderly Liquidation Fund 184
Subtitle B—Home Affordable Modification Program 184
Subtitle C—Bureau of Consumer Financial Protection 185
Subtitle D—Flood Insurance Reform 185
Subtitle E—Office of Financial Research 191
Changes in Existing Law 191
Dissenting Views 358

PURPOSE AND SUMMARY

On March 29, 2012, the House passed the concurrent resolution on the budget for fiscal year 2013, H. Con. Res. 112, by a vote of 228 yeas to 191 nays. That budget resolution instructed the Committee on Financial Services to submit legislative recommendations to the Committee on the Budget that reduce the deficit by $3 billion for fiscal years 2012 and 2013, $16.7 billion for fiscal years 2012 through 2017, and $29.8 billion for fiscal years 2012 through 2022. To fulfill the instructions set forth in H. Con. Res. 112, the Committee on Financial Services recommends the following legislation, set forth in Title III, to the Budget Committee:

SUBTITLE A—ORDERLY LIQUIDATION FUND

Subtitle A would repeal Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) (P.L. 111–203). The Congressional Budget Office (CBO) estimates that Subtitle A would reduce direct spending by $3.383 billion for fiscal years 2012 and 2013, $13.585 billion for fiscal years 2012 through 2017, and $22 billion for fiscal years 2012 through 2022.

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

Subtitle B—previously introduced as H.R. 839, the HAMP Termination Act, and passed by the House—would terminate the authority of the Treasury Department to provide any new assistance to homeowners under the Home Affordable Modification Program (HAMP) authorized under Title I of the Emergency Economic Stabilization Act (12 U.S.C. 5230), while preserving any assistance already provided to HAMP participants on a permanent or trial basis. Subtitle B also provides for a study by the Treasury Department to identify best practices for making existing mortgage assistance programs available to veterans, active duty military personnel, and their relatives. The CBO estimates that Subtitle B would reduce direct spending by $617 million for fiscal years 2012

and 2013, $2.624 billion for fiscal years 2012 through 2017, and $2.838 billion for fiscal years 2012 through 2022.

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

Subtitle C would eliminate the direct funding of the Consumer Financial Protection Bureau (CFPB) by the Federal Reserve and instead fund the CFPB through Congressional appropriations. Subtitle C would authorize the appropriation of $200 million to fund the CFPB for fiscal years 2012 and 2013, and would repeal the Consumer Financial Protection Fund and the Consumer Financial Civil Penalty Fund. The CBO estimates that Subtitle C would reduce direct spending by $381 million for fiscal years 2012 and 2013, $2.435 billion for fiscal years 2012 through 2017, and $5.387 billion for fiscal years 2012 through 2022.

SUBTITLE D—FLOOD INSURANCE REFORM

Subtitle D—previously introduced as H.R. 1309, the Flood Insurance Reform Act of 2011 and passed by the House—would reauthorize the National Flood Insurance Program (NFIP) through September 30, 2016, and amend the National Flood Insurance Act to ensure the immediate and near-term fiscal and administrative health of the NFIP. Subtitle D would ensure the NFIP's continued viability by encouraging broader participation in the program, increasing financial accountability, eliminating unnecessary rate subsidies, and updating the program to meet the needs of the 21st century. The key provisions of Subtitle D include: (1) a five-year reauthorization of the NFIP; (2) a three-year delay in the mandatory purchase requirement for certain properties in newly designated Special Flood Hazard Areas (SFHAs); (3) a phase-in of full-risk, actuarial rates for areas newly designated as Special Flood Hazard; (4) a reinstatement of the Technical Mapping Advisory Council; and (5) an emphasis on greater private sector participation in providing flood insurance coverage. The CBO estimates that Subtitle D would reduce direct spending by $880 million for fiscal years 2012 through 2017, and $4.9 billion for fiscal years 2012 through 2022.

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

Subtitle E would eliminate the Office of Financial Research (OFR), an office within the Department of the Treasury which was established by the Dodd-Frank Act. The CBO estimates that Subtitle E would reduce direct spending by $270 million over the next ten years.

BACKGROUND AND NEED FOR LEGISLATION

SUBTITLE A—ORDERLY LIQUIDATION FUND

Title II of the Dodd-Frank Act establishes a so-called Orderly Liquidation Authority (OLA) that grants the Federal Deposit Insurance Corporation (FDIC) the authority to resolve large non-bank financial institutions. Title II authorizes the FDIC to act as the receiver for the failing institution. Title II further authorizes the FDIC to borrow from the Treasury an amount equal to up to 10%

of the institution's total assets in the 30 days immediately following the FDIC's appointment as receiver, and after 30 days, the FDIC can borrow up to 90% of the firm's total assets. The FDIC can then use those funds to pay off the creditors of a failed firm. Proponents of Title II have asserted that taxpayer funds would not be used to liquidate a failed firm, pointing to provisions that contemplate recouping the costs of the liquidation from large financial institutions through post hoc assessments. Despite these assertions, CBO has estimated that Title II will cost taxpayers $22 billion between 2012 and 2022. Repealing Title II thus relieves taxpayers of the burden of bailing out the creditors of large financial institutions, thereby reducing moral hazard by making it clear that creditors—rather than taxpayers—will bear the costs of failure. Repealing Title II would not only restore market discipline, according to the CBO it would also achieve savings for the purposes of deficit reduction of $3.383 billion in FY 2012–13, $13.585 billion in FY 2012–17, and $22 billion in FY 2012–22.

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

The standalone version of Subtitle B, H.R. 839, the HAMP Termination Act, was introduced by Congressman Patrick McHenry and Chairman Bachus to terminate new mortgage modification activities under the HAMP. Created under the auspices of Section 109 of the Troubled Asset Relief Program (TARP) enacted in 2008 (P.L. 110–343), HAMP is a federally-funded mortgage modification program that provides financial incentives to participating mortgage servicers to modify the mortgages of eligible homeowners.

As the signature piece of the Administration's overall Making Home Affordable initiative on foreclosure prevention, HAMP has been both costly and ineffective. According to the Treasury Department, as of March 1, 2012, the Administration has obligated $29.88 billion to HAMP, although thus far it has only disbursed $2.54 billion. Overall, the Administration has obligated $45.60 billion of TARP dollars to the Making Home Affordable initiative, which also includes the Hardest Hit Fund and the FHA Refinance program.

By any objective measure, HAMP and these other programs have failed to produce their promised results. The Administration originally projected that Making Home Affordable would help 7 to 9 million homeowners, yet foreclosures have remained elevated and the number of families assisted by the program—approximately 1.8 million—has fallen far short of projections. There were roughly 1.1 million completed foreclosures in 2010 and 830,000 more completed foreclosures in 2011. As of February 2012, more than 1.3 million mortgages in the United States were 90 days or more delinquent and around 12 percent of the loans outstanding in the market were delinquent in some way.

HAMP itself, which was initially projected to modify 3 to 4 million loans, has begun only 1.99 million cumulative trial modifications according to program performance data through February 2012. Of those trial modifications, only 782,609 (39 percent) have transitioned to active permanent modifications along with only 68,539 active trial loans. Meanwhile, nearly half of the trial modifications started (957,677) were cancelled in the trial or permanent modification stage.

Additional concerns have been raised about the benefit to participants of a mortgage modification program that gives borrowers a false sense of hope as they struggle to keep their homes. The Special Inspector General for the Troubled Asset Relief Program (SIGTARP) has testified before Congress that HAMP is a program that "benefits only a small portion of distressed homeowners, offers others little more than false hope, and in certain cases causes more harm than good." In those cases, HAMP harms those borrowers who provisionally make reduced loan payments during a trial period but do not qualify for permanent modifications. When they are rejected from the program, these borrowers are told that they owe back payments, interest, and fees; sometimes they are asked to make up these deficiencies in a lump-sum payment. For some borrowers, that reversal constitutes their last gasp, as their increased indebtedness and tarnished credit rating preclude them from qualifying for a private-sector proprietary loan modification program which might have helped them retain their home.

In addition to its high cost and poor track record, HAMP has also been plagued by poor administration and resistance to proper oversight since its inception, placing taxpayers at risk. For example, the Government Accountability Office (GAO) has cited the Treasury Department for not having "fully implemented all of our prior recommendations to increase the transparency, accountability, and consistency of the program." The Congressional Oversight Panel for TARP has noted that "despite repeated urgings from the Panel, Treasury has failed to collect and analyze data that would explain HAMP's shortcomings, and it does not even have a way to collect data for many of HAMP's add-on programs." The SIGTARP has added that HAMP "has been beset by problems from the outset and, despite frequent retooling, continues to fall dramatically short of any meaningful standard of success."

HAMP, for all its good intentions, has thus far impeded the recovery of the housing market and prolonged economic uncertainty. Enacting Subtitle B would not only end this costly, ineffective, injurious, and poorly run program, according to the CBO it would also achieve savings for the purposes of deficit reduction of $617 million in FY 2012–13, $2.624 billion in FY 2012–17, and $2.838 billion in FY 2012–22.

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

Title X of the Dodd-Frank Act created the CFPB as an independent agency housed within the Federal Reserve System, and charged it with regulating "the offering and provision of consumer financial products or services" under the federal consumer financial laws. The Dodd-Frank Act authorizes the CFPB to fund itself by drawing money from the Federal Reserve to the extent the CFPB's Director deems "necessary." The Federal Reserve does not oversee the agency or exercise any authority over it, but the Federal Reserve must transfer to the CFPB whatever funds its Director requests, up to the following fixed percentages of the Federal Reserve's 2009 operating expenses: 11 percent in fiscal year 2012, or $547.8 million; 12 percent in fiscal year 2013, or $597.6 million; and 12 percent each fiscal year thereafter, subject to annual adjustments for inflation. These funds—diverted from the Federal Re-

serve to the CFPB—would otherwise have been forwarded from the Federal Reserve to the Treasury, where they could have been used to pay for other expenditures or to reduce the debt.

Given that the CFPB's funding is not appropriated by Congress, many observers have raised concerns about the lack of transparency in the CFPB's funding and expenditures and Congress's ability to exercise oversight of the CFPB. In light of these concerns, Subtitle C would end the direct funding of the CFPB by the Federal Reserve and repealing the Consumer Financial Protection Fund and the Consumer Financial Civil Penalty Fund. Subtitle C would subject the CFPB to regular appropriations and authorize an appropriation of $200 million to fund the CFPB for fiscal years 2012 and 2013. Subtitle C would thus make the CFPB accountable to Congress and make its funding transparent. Moreover, Subtitle C would achieve savings for the purposes of deficit reduction of $381 million in FY 2012–13, $2.435 billion in FY 2012–17, and $5.387 billion in FY 2012–22, according to CBO.

SUBTITLE D—FLOOD INSURANCE REFORM

Recognizing that the private sector lacked the capacity to manage flood risk, in 1968 Congress created the NFIP to address that risk and ease the burden on taxpayers for flood losses paid out in the form of post-disaster relief following annual flooding and severe flooding following hurricanes. The NFIP is administered by the Federal Emergency Management Agency (FEMA), which is housed in the Department of Homeland Security. The NFIP manages the risk posed by floods in three ways: (i) identifying flood hazards; (ii) managing the use of land in floodplains (e.g., by establishing land use controls and setting building codes); and (iii) providing insurance protection. The NFIP plays a crucial role: without the flood insurance provided by the NFIP, homebuyers or businesses cannot close real estate transactions on properties located in areas that have been designated as Special Flood Hazard Areas (SFHAs).

Although the NFIP generated premium income of approximately $3.3 billion in 2010, those premiums cannot make up for losses that the NFIP sustained in earlier years. The 2005 hurricane season resulted in significant claims against the NFIP, and annual premium income could not cover them. To pay these claims, the NFIP borrowed from the U.S. Treasury. Before 2005, the NFIP's borrowing authority was limited by statute to $1.5 billion. To make up the shortfall that resulted from the 2005 hurricane season, Congress increased the NFIP's borrowing authority three times between September 2005 and January 2007, raising it from $1.5 billion to $20.8 billion. As of February 29, 2012, the NFIP owed $17.775 billion to the U.S. Treasury.

Notwithstanding the importance of the NFIP to those that live and do business in SFHAs, Congress has not passed a long-term NFIP reauthorization and reform bill since 2004 (P.L. 108–264). During the 110th Congress, the House and Senate each passed significant reform measures but could not agree on final legislation. Since September 2008, the NFIP has been extended on a short-term basis 16 times. During that same time period, the NFIP's authorization has lapsed three times. In 2011, after several short-term extensions and three temporary lapses, Congress extended

the NFIP through May 31, 2012. These short-term extensions and lapses have created needless uncertainty in the residential and commercial real estate sectors in communities across the country. Private insurance companies that voluntarily participate in the NFIP find it difficult to continue participating, given the uncertainty of the NFIP authorization.

Since 2006, the GAO has identified the NFIP as "high-risk" because of inadequate management and insufficient funds. To reauthorize this much-needed program while addressing the weaknesses that make it difficult for the NFIP to return to solvency, Subtitle D institutes reforms that will improve the NFIP's financial stability, reduce the burden on taxpayers, and facilitate the creation of a private market that eliminates taxpayer risk over the long-term. In addition, the CBO estimates that Subtitle D would achieve savings for the purposes of deficit reduction of $880 million in FY 2012–17 and $4.9 billion in FY 2012–22.

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

The Dodd-Frank Act established the OFR as an office within the Department of the Treasury and charged the OFR with supporting the Financial Stability Oversight Council (FSOC) by collecting information; standardizing the types and formats of data reported and collected; performing applied research and long-term research; developing tools for risk measurement and monitoring; and making the results of its activities available to financial regulatory agencies.

Congress does not appropriate the OFR's funding. Through July 2012, the OFR is funded by the Federal Reserve. Following that, the OFR will fund itself and the FSOC by levying assessments on bank holding companies with total consolidated assets of $50 billion or more and nonbank financial companies supervised by the Federal Reserve. In FY 2011, the OFR's total expenses were $14,249,000. In FY 2012, the OFR's expenses are projected to total $122,626,000, funded from both transfers from the Federal Reserve and assessments on financial institutions: $91,742,000 in transfers and $119,000,000 in assessments. In FY 2013, the OFR is expected to spend $157,745,000 and bring in $168,000,000 in assessments.

The Dodd-Frank Act empowers the OFR to demand "all data necessary" from financial companies, including banks, hedge funds, private equity firms, and brokerages. Such data would include sensitive, non-public information such as the identities of counterparties for credit default swaps, as well as information about individual loans such as interest rate and maturity. Because much of the information collected by the OFR is likely to be duplicative of information requested by other financial regulatory agencies, it will drive up compliance costs, which could further reduce the availability of credit and increase the cost of financial services for businesses and consumers. The CBO has estimated that Subtitle E would reduce direct spending by $270 million over the next ten years.

HEARINGS

SUBTITLE A—ORDERLY LIQUIDATION FUND

On June 14, 2011, the Subcommittee on Financial Institutions and Consumer Credit held a hearing titled "Does the Dodd-Frank Act End 'Too Big to Fail'?" This was a two-panel hearing, and the following witnesses testified:

Panel One

- Mr. Michael H. Krimminger, General Counsel, Federal Deposit Insurance Corporation
- Ms. Christy Romero, Acting Special Inspector General, Office of the Special Inspector General, Troubled Asset Relief Program

Panel Two

- Mr. Stephen J. Lubben, Daniel J. Moore Professor of Law, Seton Hall University School of Law
- The Honorable Michael Barr, Professor of Law, University of Michigan Law School

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

On March 2, 2011, the Subcommittee on Insurance, Housing and Community Opportunity held a hearing titled "Legislative Proposals to End Taxpayer Funding for Ineffective Foreclosure Mitigation Programs." This was a one-panel hearing, and the following witnesses testified:

- The Honorable Neil M. Barofsky, Special Inspector General for the Troubled Asset Relief Program, Office of the Special Inspector General
- The Honorable David Stevens, Assistant Secretary for Housing and Commissioner of the Federal Housing Administration, Department of Housing and Urban Development
- The Honorable Mercedes M. Mãrquez, Assistant Secretary, Community Planning and Development, Department of Housing and Urban Development
- Mr. Matthew J. Scirè, Director, Financial Markets and Community Investment, U.S. Government Accountability Office
- Ms. Katie Jones, Analyst in Housing Policy, Congressional Research Service, Library of Congress

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

The Subcommittee on Financial Institutions and Consumer Credit held a hearing on March 16, 2011, titled "Oversight of the Consumer Financial Protection Bureau." The sole witness at this hearing was:

- Ms. Elizabeth Warren, Special Advisor to the Secretary of the Treasury for the Consumer Financial Protection Bureau, Department of the Treasury

On April 6, 2011, the Subcommittee on Financial Institutions and Consumer Credit held a hearing titled "Legislative Proposals to Improve the Structure of the Consumer Financial Protection Bureau." This was a one-panel hearing, and the following witnesses testified:

• Ms. Leslie R. Andersen, President and Chief Executive Officer, Bank of Bennington on behalf of the American Bankers Association
• Ms. Lynette W. Smith, President and Chief Executive Officer, Washington Gas Light FCU on behalf of the National Association of Federal Credit Unions
• Mr. Jess Sharp, Executive Director, Center for Capital Markets Competitiveness, U.S. Chamber of Commerce
• Mr. Hilary Shelton, Director, NAACP Washington Bureau and Senior VP for Advocacy and Policy, NAACP
• Mr. Noah H. Wilcox, President and Chief Executive Officer, Grand Rapids State Bank on behalf of the Independent Community Bankers of America
• Mr. Rod Staatz, President and Chief Executive Officer, SECU of Maryland on behalf of the Credit Union National Association
• Mr. Richard Hunt, President, Consumer Bankers Association
• Prof. Adam J. Levitin, Georgetown University Law Center

On November 2, 2011, the Subcommittee on Financial Institutions and Consumer Credit held a hearing titled "The Consumer Financial Protection Bureau: The First 100 Days." The sole witness at this hearing was:

• Mr. Raj Date, Special Advisor to the Secretary of the Treasury, The Consumer Financial Protection Bureau

On February 8, 2012, the Subcommittee on Financial Institutions and Consumer Credit held a hearing titled "Legislative Proposals to Promote Accountability and Transparency at the Consumer Financial Protection Bureau." This was a one-panel hearing and the following witnesses testified:

• Mr. Michael J. Hunter, Chief Operating Officer, American Bankers Association
• Mr. Andrew J. Pincus, Partner, Mayer Brown LLP, on behalf of the U.S. Chamber of Commerce
• Mr. Chris Stinebert, President and Chief Executive Officer, American Financial Services Association
• Mr. Arthur E. Wilmarth, Jr., Professor of Law, The George Washington University

On February 15, 2012, the Subcommittee on Oversight and Investigations held a hearing titled "Budget Hearing—Consumer Financial Protection Bureau." The sole witness at this hearing was:

• The Honorable Richard Cordray, The Consumer Financial Protection Bureau

On March 29, 2012, the Committee on Financial Services held a hearing titled "The Semi-Annual Report of the Consumer Financial Protection Bureau." The sole witness at this hearing was:

• The Honorable Richard Cordray, The Consumer Financial Protection Bureau

SUBTITLE D—FLOOD INSURANCE REFORM

On March 11, 2011, the Subcommittee on Insurance, Housing and Community Opportunity held a hearing titled "Legislative Proposals to Reform the National Flood Insurance Program." This was a two-panel hearing, and the following witnesses testified:

Panel One

• Ms. Orice Williams Brown, Managing Director, Government Accountability Office

• Ms. Sally McConkey, Vice Chair, Association of State Flood Plain Managers and Manager, Coordinated Hazard Assessment and Mapping Program, Illinois State Water Survey

Panel Two

• Mr. Stephen Ellis, on behalf of the SmarterSafer Coalition, and Vice President, Taxpayers for Common Sense, Washington, D.C.

• Mr. Terry Sullivan, Chair, Committee on Flood Insurance, National Association of REALTORS® and Owner, Sullivan Realty, Spokane, Washington

• Mr. Spencer Houldin, Chair, Government Affairs Committee, Independent Insurance Agents and Brokers of America and President, Ericson Insurance Services, Washington Depot, Connecticut

• Mr. Franklin Nutter, President, Reinsurance Association of America, Washington, D.C.

• Ms. Sandra G. Parrillo, Chair, National Association of Mutual Insurance Companies and President and CEO of Providence Mutual Fire Insurance Company, Warwick, Rhode Island

• Ms. Donna Jallick, on behalf of the Property Casualty Insurers Association of America, and Vice President, Flood Operations, Harleysville Insurance, Harleysville, Pennsylvania

• Mr. Barry Rutenberg, First Vice Chairman, National Association of Home Builders, Washington, D.C.

On April 1, 2011, the Subcommittee on Insurance, Housing and Community Opportunity held a hearing titled "Legislative Proposals to Reform the National Flood Insurance Program, Part II." The sole witness at this hearing was:

• The Honorable W. Craig Fugate, Administrator, Federal Emergency Management Agency.

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

On July 14, 2011, the Subcommittee on Oversight and Investigations Credit held a hearing titled "Oversight of the Office of Financial Research and the Financial Stability Oversight Council." This was a two-panel hearing and the following witnesses testified:

Panel One

• The Honorable Richard Berner, Counselor to the Secretary of the Treasury

Panel Two

• Dr. Nassim N. Taleb, Distinguished Professor, New York University Polytechnic Institute

• Mr. Dilip Krishna, Vice President of Financial Services, Teradata Corporation

• Mr. Alan Paller, Director of Research, SANS Institute

• Dr. John Lietchy, Professor of Marketing and Statistics, Director of the Center for the Study of Global Financial Stability, Pennsylvania State University

COMMITTEE CONSIDERATION

The Committee on Financial Services met in open session on April 18, 2012, and ordered the Committee Print of budget reconciliation legislative recommendations of the Committee on Financial Services, as amended, transmitted to the Committee on the Budget by a record vote of 31 yeas and 26 nays (Record vote no. FC–76).

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. A motion by Chairman Bachus to order the Committee Print, as amended, transmitted to the Committee on the Budget was agreed to by a record vote of 31 yeas and 26 nays (Record vote no. FC–76). The names of Members voting for and against follow:

RECORD VOTE NO. FC–76

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bachus	X			Mr. Frank (MA)		X	
Mr. Hensarling	X			Ms. Waters		X	
Mr. King (NY)	X			Mrs. Maloney		X	
Mr. Royce	X			Mr. Gutierrez		X	
Mr. Lucas	X			Ms. Velázquez		X	
Mr. Paul				Mr. Watt		X	
Mr. Manzullo				Mr. Ackerman		X	
Mr. Jones				Mr. Sherman		X	
Mrs. Biggert	X			Mr. Meeks		X	
Mr. Gary G. Miller (CA)	X			Mr. Capuano		X	
Mrs. Capito	X			Mr. Hinojosa		X	
Mr. Garrett	X			Mr. Clay		X	
Mr. Neugebauer	X			Mrs. McCarthy (NY)		X	
Mr. McHenry	X			Mr. Baca		X	
Mr. Campbell	X			Mr. Lynch			
Mrs. Bachmann	X			Mr. Miller (NC)		X	
Mr. McCotter	X			Mr. David Scott (GA)		X	
Mr. McCarthy (CA)	X			Mr. Al Green (TX)		X	
Mr. Pearce	X			Mr. Cleaver		X	
Mr. Posey	X			Ms. Moore		X	
Mr. Fitzpatrick	X			Mr. Ellison		X	
Mr. Westmoreland	X			Mr. Perlmutter		X	
Mr. Luetkemeyer	X			Mr. Donnelly		X	
Mr. Huizenga	X			Mr. Carson		X	
Mr. Duffy	X			Mr. Himes		X	
Ms. Hayworth	X			Mr. Peters		X	
Mr. Renacci	X			Mr. Carney		X	
Mr. Hurt	X						
Mr. Dold	X						
Mr. Schweikert	X						
Mr. Grimm	X						
Mr. Canseco	X						
Mr. Stivers	X						
Mr. Fincher	X						

During consideration of the Committee Print by the Committee, the following amendments were considered:

1. An amendment offered by Ms. Moore, no. 1, to strike Subtitle A, was not agreed to by a record vote of 23 yeas and 29 nays (Record vote no. FC–69).

RECORD VOTE NO. FC–69

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bachus		X		Mr. Frank (MA)	X		
Mr. Hensarling		X		Ms. Waters	X		
Mr. King (NY)		X		Mrs. Maloney	X		
Mr. Royce		X		Mr. Gutierrez	X		
Mr. Lucas		X		Ms. Velázquez	X		
Mr. Paul				Mr. Watt	X		
Mr. Manzullo				Mr. Ackerman	X		
Mr. Jones				Mr. Sherman			
Mrs. Biggert		X		Mr. Meeks			
Mr. Gary G. Miller (CA)		X		Mr. Capuano	X		
Mrs. Capito		X		Mr. Hinojosa	X		
Mr. Garrett		X		Mr. Clay	X		
Mr. Neugebauer		X		Mrs. McCarthy (NY)	X		
Mr. McHenry				Mr. Baca	X		
Mr. Campbell		X		Mr. Lynch			
Mrs. Bachmann		X		Mr. Miller (NC)	X		
Mr. McCotter		X		Mr. David Scott (GA)	X		
Mr. McCarthy (CA)		X		Mr. Al Green (TX)	X		
Mr. Pearce		X		Mr. Cleaver	X		
Mr. Posey		X		Ms. Moore	X		
Mr. Fitzpatrick		X		Mr. Ellison			
Mr. Westmoreland				Mr. Perlmutter	X		
Mr. Luetkemeyer		X		Mr. Donnelly	X		
Mr. Huizenga		X		Mr. Carson	X		
Mr. Duffy		X		Mr. Himes	X		
Ms. Hayworth		X		Mr. Peters	X		
Mr. Renacci		X		Mr. Carney	X		
Mr. Hurt		X					
Mr. Dold		X					
Mr. Schweikert		X					
Mr. Grimm		X					
Mr. Canseco		X					
Mr. Stivers		X					
Mr. Fincher		X					

2. An amendment offered by Mr. Frank and Mr. Gutierrez, no. 2, to impose a $30 billion special assessment on certain financial institutions to be deposited in a Taxpayer Protection and Financial Stability Fund, was not agreed to by a record vote of 22 yeas and 33 nays (Record vote no. FC–70).

RECORD VOTE NO. FC–70

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bachus		X		Mr. Frank (MA)	X		
Mr. Hensarling		X		Ms. Waters	X		
Mr. King (NY)		X		Mrs. Maloney	X		
Mr. Royce		X		Mr. Gutierrez	X		
Mr. Lucas		X		Ms. Velázquez	X		
Mr. Paul				Mr. Watt	X		
Mr. Manzullo				Mr. Ackerman	X		
Mr. Jones				Mr. Sherman	X		
Mrs. Biggert		X		Mr. Meeks	X		
Mr. Gary G. Miller (CA)		X		Mr. Capuano	X		
Mrs. Capito		X		Mr. Hinojosa	X		
Mr. Garrett		X		Mr. Clay	X		
Mr. Neugebauer		X		Mrs. McCarthy (NY)	X		
Mr. McHenry				Mr. Baca	X		
Mr. Campbell		X		Mr. Lynch			
Mrs. Bachmann		X		Mr. Miller (NC)	X		
Mr. McCotter		X		Mr. David Scott (GA)	X		
Mr. McCarthy (CA)		X		Mr. Al Green (TX)	X		

RECORD VOTE NO. FC–70—Continued

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Pearce		X		Mr. Cleaver	X		
Mr. Posey		X		Ms. Moore	X		
Mr. Fitzpatrick		X		Mr. Ellison	X		
Mr. Westmoreland				Mr. Perlmutter		X	
Mr. Luetkemeyer		X		Mr. Donnelly		X	
Mr. Huizenga		X		Mr. Carson	X		
Mr. Duffy		X		Mr. Himes		X	
Ms. Hayworth		X		Mr. Peters	X		
Mr. Renacci		X		Mr. Carney		X	
Mr. Hurt		X					
Mr. Dold		X					
Mr. Schweikert		X					
Mr. Grimm		X					
Mr. Canseco		X					
Mr. Stivers		X					
Mr. Fincher		X					

3. An amendment offered by Mrs. Maloney, no. 3, to strike Subtitle C, was not agreed to by a record vote of 26 yeas and 29 nays (Record vote no. FC–71).

RECORD VOTE NO. FC–71

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bachus		X		Mr. Frank (MA)	X		
Mr. Hensarling		X		Ms. Waters	X		
Mr. King (NY)		X		Mrs. Maloney	X		
Mr. Royce		X		Mr. Gutierrez	X		
Mr. Lucas		X		Ms. Velázquez	X		
Mr. Paul				Mr. Watt	X		
Mr. Manzullo				Mr. Ackerman	X		
Mr. Jones				Mr. Sherman	X		
Mrs. Biggert		X		Mr. Meeks	X		
Mr. Gary G. Miller (CA)		X		Mr. Capuano	X		
Mrs. Capito		X		Mr. Hinojosa	X		
Mr. Garrett		X		Mr. Clay	X		
Mr. Neugebauer		X		Mrs. McCarthy (NY)	X		
Mr. McHenry				Mr. Baca	X		
Mr. Campbell		X		Mr. Lynch			
Mrs. Bachmann		X		Mr. Miller (NC)	X		
Mr. McCotter		X		Mr. David Scott (GA)	X		
Mr. McCarthy (CA)		X		Mr. Al Green (TX)	X		
Mr. Pearce		X		Mr. Cleaver	X		
Mr. Posey		X		Ms. Moore	X		
Mr. Fitzpatrick		X		Mr. Ellison	X		
Mr. Westmoreland				Mr. Perlmutter	X		
Mr. Luetkemeyer		X		Mr. Donnelly	X		
Mr. Huizenga		X		Mr. Carson	X		
Mr. Duffy		X		Mr. Himes	X		
Ms. Hayworth		X		Mr. Peters	X		
Mr. Renacci		X		Mr. Carney	X		
Mr. Hurt		X					
Mr. Dold		X					
Mr. Schweikert		X					
Mr. Grimm		X					
Mr. Canseco		X					
Mr. Stivers		X					
Mr. Fincher		X					

4. An amendment offered by Mr. Frank, no. 4, to fund the Federal Reserve's non-monetary policy functions through Congres-

sional appropriations, was not agreed to by a record vote of 24 yeas and 33 nays (Record vote no. FC–72).

RECORD VOTE NO. FC–72

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bachus		X		Mr. Frank (MA)	X		
Mr. Hensarling		X		Ms. Waters	X		
Mr. King (NY)		X		Mrs. Maloney	X		
Mr. Royce		X		Mr. Gutierrez	X		
Mr. Lucas		X		Ms. Velázquez	X		
Mr. Paul				Mr. Watt	X		
Mr. Manzullo				Mr. Ackerman	X		
Mr. Jones				Mr. Sherman	X		
Mrs. Biggert		X		Mr. Meeks	X		
Mr. Gary G. Miller (CA)		X		Mr. Capuano	X		
Mrs. Capito		X		Mr. Hinojosa	X		
Mr. Garrett		X		Mr. Clay	X		
Mr. Neugebauer		X		Mrs. McCarthy (NY)	X		
Mr. McHenry		X		Mr. Baca	X		
Mr. Campbell		X		Mr. Lynch			
Mrs. Bachmann		X		Mr. Miller (NC)	X		
Mr. McCotter		X		Mr. David Scott (GA)	X		
Mr. McCarthy (CA)		X		Mr. Al Green (TX)	X		
Mr. Pearce		X		Mr. Cleaver	X		
Mr. Posey		X		Ms. Moore	X		
Mr. Fitzpatrick		X		Mr. Ellison	X		
Mr. Westmoreland	X			Mr. Perlmutter	X		
Mr. Luetkemeyer		X		Mr. Donnelly		X	
Mr. Huizenga		X		Mr. Carson	X		
Mr. Duffy		X		Mr. Himes		X	
Ms. Hayworth		X		Mr. Peters		X	
Mr. Renacci		X		Mr. Carney		X	
Mr. Hurt		X					
Mr. Dold		X					
Mr. Schweikert		X					
Mr. Grimm		X					
Mr. Canseco		X					
Mr. Stivers	X						
Mr. Fincher		X					

5. Am amendment offered by Mr. Miller of N.C., no. 5, to fund the Office of the Comptroller of the Currency through Congressional appropriations, was not agreed to by a record vote of 22 yeas and 35 nays (Record Vote no. FC–73).

RECORD VOTE NO. FC–73

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bachus		X		Mr. Frank (MA)	X		
Mr. Hensarling		X		Ms. Waters	X		
Mr. King (NY)		X		Mrs. Maloney	X		
Mr. Royce		X		Mr. Gutierrez	X		
Mr. Lucas		X		Ms. Velázquez	X		
Mr. Paul				Mr. Watt		X	
Mr. Manzullo				Mr. Ackerman	X		
Mr. Jones				Mr. Sherman	X		
Mrs. Biggert		X		Mr. Meeks	X		
Mr. Gary G. Miller (CA)		X		Mr. Capuano	X		
Mrs. Capito		X		Mr. Hinojosa	X		
Mr. Garrett		X		Mr. Clay	X		
Mr. Neugebauer		X		Mrs. McCarthy (NY)	X		
Mr. McHenry		X		Mr. Baca	X		
Mr. Campbell		X		Mr. Lynch			

RECORD VOTE NO. FC–73—Continued

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mrs. Bachmann		X		Mr. Miller (NC)	X		
Mr. McCotter		X		Mr. David Scott (GA)	X		
Mr. McCarthy (CA)		X		Mr. Al Green (TX)	X		
Mr. Pearce		X		Mr. Cleaver	X		
Mr. Posey		X		Ms. Moore		X	
Mr. Fitzpatrick		X		Mr. Ellison	X		
Mr. Westmoreland	X			Mr. Perlmutter		X	
Mr. Luetkemeyer		X		Mr. Donnelly		X	
Mr. Huizenga	X			Mr. Carson	X		
Mr. Duffy		X		Mr. Himes		X	
Ms. Hayworth		X		Mr. Peters		X	
Mr. Renacci		X		Mr. Carney		X	
Mr. Hurt		X					
Mr. Dold		X					
Mr. Schweikert		X					
Mr. Grimm		X					
Mr. Canseco		X					
Mr. Stivers	X						
Mr. Fincher		X					

6. An amendment offered by Mr. Miller of N.C., no. 8, to establish a fund, paid for by certain financial institutions, to cover costs that Fannie Mae and Freddie Mac may incur in connection with mortgages they own or guarantee and which they purchased from an "underperforming" servicer, was not agreed to by a record vote of 21 yeas and 36 nays (Record vote no. FC–74).

RECORD VOTE NO. FC–74

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bachus		X		Mr. Frank (MA)	X		
Mr. Hensarling		X		Ms. Waters	X		
Mr. King (NY)		X		Mrs. Maloney	X		
Mr. Royce		X		Mr. Gutierrez	X		
Mr. Lucas		X		Ms. Velázquez	X		
Mr. Paul				Mr. Watt	X		
Mr. Manzullo				Mr. Ackerman	X		
Mr. Jones				Mr. Sherman	X		
Mrs. Biggert		X		Mr. Meeks	X		
Mr. Gary G. Miller (CA)		X		Mr. Capuano	X		
Mrs. Capito		X		Mr. Hinojosa	X		
Mr. Garrett		X		Mr. Clay	X		
Mr. Neugebauer		X		Mrs. McCarthy (NY)	X		
Mr. McHenry		X		Mr. Baca	X		
Mr. Campbell		X		Mr. Lynch			
Mrs. Bachmann		X		Mr. Miller (NC)	X		
Mr. McCotter		X		Mr. David Scott (GA)	X		
Mr. McCarthy (CA)		X		Mr. Al Green (TX)	X		
Mr. Pearce		X		Mr. Cleaver	X		
Mr. Posey		X		Ms. Moore		X	
Mr. Fitzpatrick		X		Mr. Ellison		X	
Mr. Westmoreland		X		Mr. Perlmutter		X	
Mr. Luetkemeyer		X		Mr. Donnelly		X	
Mr. Huizenga		X		Mr. Carson		X	
Mr. Duffy		X		Mr. Himes	X		
Ms. Hayworth		X		Mr. Peters	X		
Mr. Renacci		X		Mr. Carney	X		
Mr. Hurt		X					
Mr. Dold		X					
Mr. Schweikert		X					
Mr. Grimm		X					

RECORD VOTE NO. FC–74—Continued

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Canseco		X					
Mr. Stivers		X					
Mr. Fincher		X					

7. An amendment offered by Mr. Miller of N.C., no. 12, to define breaches of representations and warranties made in connection with the sale of a mortgage asset to Fannie Mae and Freddie Mac as violations of the False Claims Act, was not agreed to by a record vote of 26 yeas and 31 nays (Record vote no. FC–75).

RECORD VOTE NO. FC–75

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bachus		X		Mr. Frank (MA)	X		
Mr. Hensarling		X		Ms. Waters	X		
Mr. King (NY)		X		Mrs. Maloney	X		
Mr. Royce		X		Mr. Gutierrez	X		
Mr. Lucas		X		Ms. Velázquez	X		
Mr. Paul				Mr. Watt	X		
Mr. Manzullo				Mr. Ackerman	X		
Mr. Jones				Mr. Sherman	X		
Mrs. Biggert		X		Mr. Meeks	X		
Mr. Gary G. Miller (CA)		X		Mr. Capuano	X		
Mrs. Capito		X		Mr. Hinojosa	X		
Mr. Garrett		X		Mr. Clay	X		
Mr. Neugebauer		X		Mrs. McCarthy (NY)	X		
Mr. McHenry		X		Mr. Baca	X		
Mr. Campbell		X		Mr. Lynch			
Mrs. Bachmann		X		Mr. Miller (NC)	X		
Mr. McCotter		X		Mr. David Scott (GA)	X		
Mr. McCarthy (CA)		X		Mr. Al Green (TX)	X		
Mr. Pearce		X		Mr. Cleaver	X		
Mr. Posey		X		Ms. Moore	X		
Mr. Fitzpatrick		X		Mr. Ellison	X		
Mr. Westmoreland		X		Mr. Perlmutter	X		
Mr. Luetkemeyer		X		Mr. Donnelly	X		
Mr. Huizenga		X		Mr. Carson	X		
Mr. Duffy		X		Mr. Himes	X		
Ms. Hayworth		X		Mr. Peters	X		
Mr. Renacci		X		Mr. Carney	X		
Mr. Hurt		X					
Mr. Dold		X					
Mr. Schweikert		X					
Mr. Grimm		X					
Mr. Canseco		X					
Mr. Stivers		X					
Mr. Fincher		X					

The following amendments were also considered by the Committee:

1. An amendment offered by Mr. Perlmutter and Mrs. McCarthy, no. 6, to reauthorize the Export-Import Bank of the United States, was offered and withdrawn.

2. An amendment offered by Mr. Canseco, no. 7, to repeal Title I, Subtitle B of the Dodd-Frank Act, which established the Office of Financial Research, was agreed to by voice vote.

3. An amendment offered by Mr. Miller of N.C., no. 9, to prohibit mortgage servicers and their affiliates from owning or holding interests in mortgage loans secured by the same property that is sub-

ject to the mortgage loan serviced by the servicer, was ruled nongermane.

4. An amendment offered by Mr. Perlmutter, no. 10, to legalize, license, and regulate Internet gambling, was offered and withdrawn.

5. An amendment offered by Mr. Miller of N.C., no. 11, to authorize the Federal Housing Finance Authority to acquire certain second mortgages by right of eminent domain, was offered and withdrawn.

CONSTITUTIONAL AUTHORITY STATEMENT

SUBTITLE A—ORDERLY LIQUIDATION FUND

Congress has the power to enact this legislation pursuant to the following: Clause 3 of Section 8 of Article I of the Constitution, under which Congress has the power to regulate commerce among the states.

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

Congress has the power to enact this legislation pursuant to the following: Clause 3 of Section 8 of Article I of the Constitution, under which Congress has the power to regulate commerce among the states.

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

Congress has the power to enact this legislation pursuant to the following: Clause 3 of Section 8 of Article I of the Constitution, under which Congress has the power to regulate commerce among the states.

SUBTITLE D—FLOOD INSURANCE REFORM

Congress has the power to enact this legislation pursuant to the following: Clause 3 of Section 8 of Article I of the Constitution, under which Congress has the power to regulate commerce among the states; and Clause 1 of Section 8 of Article I of the Constitution, under which Congress has the power relating to the general welfare of the United States.

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

Congress has the power to enact this legislation pursuant to the following: Clause 3 of Section 8 of Article I of the Constitution, under which Congress has the power to regulate commerce among the states.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee has held hearings and made findings that are reflected in this report.

PERFORMANCE GOALS AND OBJECTIVES

SUBTITLE A—ORDERLY LIQUIDATION FUND

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee establishes the following performance related goals and objectives for this legislation:

The objective of this Subtitle is to repeal the Title II of the Dodd-Frank Act, which would reduce direct spending by $22 billion, according to CBO.

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee establishes the following performance related goals and objectives for this legislation:

The objective of this Subtitle is to terminate the authority of the Treasury Department to provide new assistance to homeowners under HAMP under Title I of the Emergency Economic Stabilization Act (12 U.S.C. 5230), while preserving any assistance already provided to HAMP participants on a permanent or trial basis. Enactment of these provisions would reduce direct spending by $2.838 billion over ten years, according to CBO.

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee establishes the following performance related goals and objectives for this legislation:

The objective of this Subtitle is to eliminate direct funding of the CFPB by the Federal Reserve and instead recommend that the CFPB be subjected to the annual Congressional appropriations process. The provisions of this Subtitle would also authorize $200 million to be appropriated to fund the CFPB for fiscal years 2012 and 2013, and would repeal the Consumer Financial Protection Fund and the Consumer Financial Civil Penalty Fund. Enactment of these provisions would reduce direct spending by $5.387 billion over ten years, according to CBO.

SUBTITLE D—FLOOD INSURANCE REFORM

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee establishes the following performance related goals and objectives for this legislation:

The objective of this Subtitle is to reauthorize the NFIP through September 30, 2016, and amend the National Flood Insurance Act to ensure the immediate and near-term fiscal and administrative health of the NFIP. The provisions of this Subtitle also ensure the NFIP's continued viability by encouraging broader participation in the program, increasing financial accountability, eliminating unnecessary rate subsidies, and updating the program to meet the needs of the 21st century. The key provisions of Subtitle D include: (1) a five-year reauthorization of the NFIP; (2) a three-year delay in the mandatory purchase requirement for certain properties in newly designated Special Flood Hazard Areas (SFHAs); (3) a phase-in of full-risk, actuarial rates for areas newly designated as Special Flood Hazard; (4) a reinstatement of the Technical Map-

ping Advisory Council; and (5) an emphasis on greater private sector participation in providing flood insurance coverage. Enactment of these provisions would reduce direct spending by $4.9 billion over ten years, according to CBO.

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

Pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee establishes the following performance related goals and objectives for this legislation:

The objective of this Subtitle is to eliminate the OFR, an office within the Department of the Treasury established by the Dodd-Frank Act. According to CBO, eliminating the OFR would reduce direct spending by approximately $270 million over the next ten years.

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 adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

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:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 24, 2012.

Hon. SPENCER BACHUS,
Chairman, Committee on Financial Services,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the Reconciliation Recommendations of the House Committee on Financial Services.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Daniel Hoople.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

Reconciliation recommendations of the House Committee on Financial Services

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 Financial Services was instructed to recommend changes to current law that would reduce the deficit by $29.8 billion for fiscal years 2012 through 2022.

CBO estimates that the reconciliation recommendations approved by the Committee on Financial Services on April 18, 2012, would reduce direct spending by $40.9 billion and revenues by $10.6 billion over the 2012–2022 period, assuming enactment on or near October 1, 2012. Taken together, CBO estimates that enacting the recommendations would reduce budget deficits by $30.4 billion over the 2012–2022 period, assuming enactment on or near October 1, 2012.

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 Financial Services Committee's recommendations would result in greater budgetary savings than those estimated assuming an October 1 enactment date. Under the alternative assumption of a July 1 enactment date, CBO estimates that the Financial Services proposals would reduce deficits by $4.4 billion over the 2012–2013 period and $31.1 billion over the 2012–2022 period.

The committee's recommendations would make the following changes:

- Subtitle A would repeal the authority provided to the Federal Deposit Insurance Corporation (FDIC) in the Dodd-Frank Wall Street Reform and Consumer Protection Act (Public Law 111–203) to liquidate large, systemically important financial companies in default or in danger of default.
- Subtitle B would terminate the authority of the Secretary of the Treasury to provide new assistance under the Home Affordable Modification Program (HAMP).
- Subtitle C would terminate transfers of funds from the Federal Reserve for expenses of the Bureau of Consumer Financial Protection (CFPB) and authorize appropriations for the CFPB for fiscal years 2012 and 2013.
- Subtitle D would reauthorize the National Flood Insurance Program (NFIP) of the Federal Emergency Management Agency (FEMA) through 2016 and amend the program to increase premiums charged to certain policyholders.
- Subtitle E would eliminate the Office of Financial Research (OFR), established in the Dodd-Frank Wall Street Reform and Consumer Protection Act.

In addition to the changes in direct spending and revenues, CBO estimates that implementing the committee's recommendations would cost $766 million over the 2012–2017 period, assuming appropriation of the necessary amounts. That estimate includes funding for the CFPB, the Financial Stability Oversight Council, and

flood mapping and mitigation efforts under the National Flood Insurance Program (NFIP).

The legislation would impose intergovernmental and private-sector mandates, as defined in the Unfunded Mandates Reform Act (UMRA), on public and private mortgage lenders. Because the mandates would require only small changes in existing industry practice, CBO expects the cost to comply with the mandates would be small relative to the annual thresholds established in UMRA for intergovernmental and private-sector mandates ($73 million and $146 million in 2012, respectively, adjusted annually for inflation).

Estimated cost to the Federal Government: The estimated impact on direct spending and revenues of the recommendations of the House Committee on Financial Services is shown in the following tables. Table 1 summarizes those effects assuming that the committee recommendations are enacted around October 1, 2012, and Table 2 displays the budgetary impact assuming those recommendations are enacted by July 1, 2012. (Potential effects on discretionary spending are not shown in Tables 1 and 2, but those effects are mentioned in a footnote in each table.) The spending effects of this legislation fall within budget functions 370 (commerce and housing credit) and 450 (community and regional development).

TABLE 1. EFFECTS ON DIRECT SPENDING AND REVENUES FOR RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON FINANCIAL SERVICES, AS APPROVED BY THE COMMITTEE ON APRIL 18, 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[a]													
Orderly Liquidation Authority:													
Estimated Budget Authority 0	0	−2,350	−3,365	−3,725	−3,360	−2,745	−2,985	−3,180	−3,370	−3,536	−3,704	−15,545	−32,320
Estimated Outlays	0	−2,350	−3,365	−3,725	−3,360	−2,745	−2,985	−3,180	−3,370	−3,536	−3,704	−15,545	−32,320
Home Affordable Modification Program:													
Estimated Budget Authority	0	−414	−573	−428	−351	−297	−202	−6	0	0	0	−2,063	−2,271
Estimated Outlays	0	−414	−573	−428	−351	−297	−202	−6	0	0	0	−2,063	−2,271
Bureau of Consumer Financial Protection:													
Estimated Budget Authority	0	−448	−495	−509	−524	−539	−557	−575	−593	−611	−631	−2,515	−5,482
Estimated Outlays	0	−381	−488	−507	−522	−537	−554	−572	−590	−608	−628	−2,435	−5,387
National Flood Insurance Program:													
Estimated Budget Authority	0	0	−60	−150	210	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	−60	−150	210	0	0	0	0	0	0	0	0
Office of Financial Research:													
Estimated Budget Authority	0	−71	−93	−95	−97	−99	−101	−103	−105	−107	−108	−455	−979
Estimated Outlays	0	−62	−93	−95	−97	−99	−101	−103	−105	−107	−108	−446	−970
Total Changes:													
Estimated Budget Authority	0	−3,283	−4,586	−4,907	−4,122	−3,680	−3,845	−3,864	−4,068	−4,254	−4,443	−20,578	−41,052
Estimated Outlays	0	−3,207	−4,579	−4,905	−4,120	−3,678	−3,842	−3,861	−4,065	−4,251	−4,440	−20,489	−40,948
CHANGES IN REVENUES ASSUMING ENACTMENT AROUND OCTOBER 1, 2012													
Orderly Liquidation Authority	0	0	−180	−405	−645	−905	−1,135	−1,355	−1,570	−1,770	−1,905	−2,135	−9,870
Office of Financial Research	0	−67	−68	−69	−70	−71	−72	−73	−74	−75	−76	−345	−715
Total Changes	0	−67	−248	−474	−715	−976	−1,207	−1,428	−1,644	−1,845	−1,981	−2,480	−10,585
NET DEFICIT REDUCTION (−) ASSUMING ENACTMENT OF DIRECT SPENDING AND REVENUE CHANGES AROUND OCTOBER 1, 2012													
Net Effect on Deficit	0	−3,140	−4,331	−4,431	−3,405	−2,702	−2,635	−2,433	−2,421	−2,406	−2,459	−18,009	−30,363
Memorandum:													
Change in Net Income to the National Flood Insurance Program:[b]													
Estimated Budget Authority	0	0	60	150	265	405	580	775	830	890	945	880	4,900

Estimated Outlays	0	0	60	150	265	405	580	775	830	890	945	880	4,900

Note: Estimates are relative to CBO's March 2012 baseline; components may not sum to totals because of rounding.

[a] In addition, CBO estimates that implementing the Financial Services Committee's recommendations would cost $766 million over the 2012–2017 period, assuming appropriation of the necessary amounts. That estimate includes funding for the Bureau of Consumer Financial Protection, the Financial Stability Oversight Council, and for mapping and mitigation efforts under the National Flood Insurance Program.

[b] The proposed language would raise premiums for certain subsidized flood insurance policies, increasing net income to the National Flood Insurance Program by $4.9 billion. However, because many policies would continue to be subsidized and the program would continue to face significant interest costs for borrowing over the past decade, CBO expects that additional receipts collected under this legislation would be spent to cover future program shortfalls, resulting in no net effect on the budget over the 2012–2022 period.

TABLE 2. EFFECTS ON DIRECT SPENDING AND REVENUES FROM RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON FINANCIAL SERVICES, AS APPROVED BY THE COMMITTEE ON APRIL 18, 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 [a]													
Orderly Liquidation Authority:													
Estimated Budget Authority	−585	−2,838	−3,046	−3,550	−3,270	−2,756	−2,990	−3,185	−3,375	−3,540	−3,705	−16,045	−32,840
Estimated Outlays	−585	−2,838	−3,046	−3,550	−3,270	−2,756	−2,990	−3,185	−3,375	−3,540	−3,705	−16,045	−32,840
Home Affordable Modification Program:													
Estimated Budget Authority	0	−617	−687	−522	−427	−371	−209	−6	0	0	0	−2,624	−2,839
Estimated Outlays	0	−617	−687	−522	−427	−371	−209	−6	0	0	0	−2,624	−2,839
Bureau of Consumer Financial Protection:													
Estimated Budget Authority	0	−448	−495	−509	−524	−539	−557	−575	−593	−611	−631	−2,515	−5,482
Estimated Outlays	0	−381	−488	−507	−522	−537	−554	−572	−590	−608	−628	−2,435	−5,387
National Flood Insurance Program:													
Estimated Budget Authority	0	0	−60	−150	210	0	0	0	0	0	0	0	0
Estimated Outlays	0	0	−60	−150	210	0	0	0	0	0	0	0	0
Office of Financial Research:													
Estimated Budget Authority	0	−91	−93	−95	−97	−99	−101	−103	−105	−107	−108	−475	−999
Estimated Outlays	0	−74	−93	−95	−97	−99	−101	−103	−105	−107	−108	−458	−982
Total Changes:													
Estimated Budget Authority	−585	−3,994	−4,381	−4,826	−4,108	−3,765	−3,857	−3,869	−4,073	−4,258	−4,444	−21,659	−42,160
Estimated Outlays	−585	−3,910	−4,374	−4,824	−4,106	−3,763	−3,854	−3,866	−4,070	−4,255	−4,441	−21,562	−42,048
CHANGES IN REVENUES ASSUMING ENACTMENT BY JULY 1, 2012													
Orderly Liquidation Authority	0	−35	−230	−455	−690	−940	−1,175	−1,390	−1,600	−1,785	−1,920	−2,350	−10,220
Office of Financial Research	−15	−67	−68	−69	−70	−71	−72	−73	−74	−75	−76	−360	−730

TABLE 2. EFFECTS ON DIRECT SPENDING AND REVENUES FROM RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON FINANCIAL SERVICES, AS APPROVED BY THE COMMITTEE ON APRIL 18, 2012, ASSUMING ENACTMENT BY JULY 1, 2012, AS DIRECTED BY THE CHAIRMAN OF THE HOUSE COMMITTEE ON THE BUDGET—Continued

	By fiscal year, in millions of dollars—												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012–2017	2012–2022
Total Changes	−15	−102	−298	−524	−760	−1,011	−1,247	−1,463	−1,674	−1,860	−1,996	−2,710	−10,950
NET DEFICIT REDUCTIONS (−) ASSUMING ENACTMENT OF DIRECT SPENDING AND REVENUE CHANGES BY JULY 1, 2012													
Net Effect on Deficit	−570	−3,808	−4,076	−4,300	−3,346	−2,752	−2,607	−2,403	−2,396	−2,395	−2,445	−18,852	−31,098
Memorandum:													
Change in Net Income to the National Flood Insurance Program [b]													
Estimated Budget Authority	0	0	60	150	265	405	580	775	830	890	945	880	4,900
Estimated Outlays	0	0	60	150	265	405	580	775	830	890	945	880	4,900

Note: Components may not sum to totals because of rounding.

[a] In addition, CBO estimates that implementing the Financial Services Committee's recommendations would cost $766 million over the 2012–2017 period, assuming appropriation of the necessary amounts. That estimate includes funding for the Bureau of Consumer Financial Protection, the Financial Stability Oversight Council, and for mapping and mitigation efforts under the National Flood Insurance Program.

[b] The proposed language would raise premiums for certain subsidized flood insurance policies, increasing net income to the National Flood Insurance Program by $4.9 billion. However, because many policies would continue to be subsidized and the program would continue to face significant interest costs for borrowing over the past decade, CBO expects that additional receipts collected under this legislation would be spent to cover future program shortfalls, resulting in no net effect on the budget over the 2012–2022 period.

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

Changes in direct spending and revenues

Five provisions in the committee's recommendations would reduce direct spending by $40.9 billion over the 2012–2022 period, assuming enactment around October 1, 2012, and by $42.0 billion over that period, assuming enactment by July 1, 2012.

Orderly Liquidation Authority. Subtitle A would repeal the authority of the FDIC to liquidate large, systemically important financial companies (excluding insured depository institutions, which can be resolved using other authorities of the agency) that are in default or in danger of default.

Under current law, if a financial company is determined to be in default or in danger of default and if its liquidation under applicable federal and state bankruptcy laws would have a significant impact on the nation's financial stability, the FDIC may be appointed as receiver of the failing company. As receiver, the FDIC would liquidate the company in an orderly manner with the goal of minimizing both losses to the receivership and disruption to the financial system. Any losses incurred by the receivership, including administrative costs, would be recouped through proceeds from asset sales and assessments on large bank holding companies and other nonbank financial companies supervised by the Federal Reserve. All of these transactions would be recorded in the federal budget on a cash basis through the Orderly Liquidation Fund (OLF).

CBO's most recent baseline estimates for the cash flows of the OLF project net outlays of more than $30 billion to resolve failing companies and revenues from assessments of nearly $15 billion over the 2012–2022 period to begin the recovery of those costs; under current law, the remainder of the costs would be recovered after 2022. Those baseline projections reflect expected values of the estimated net costs of liquidating one or more financial companies and the subsequent assessments collected to begin to recoup those costs over that period. CBO expects that the probability that the federal government would have to liquidate a financial institution in any given year is relatively small;[1] however, the potential cash flows if the orderly liquidation authority is used would probably be large. As such, actual outlays and revenues will probably vary significantly from the above estimates (in fact, in many years, it is likely that no spending or revenues will be recorded in the budget).

Because CBO assumes some small probability of a large financial event in every year of the projection period and because the majority of spending for an orderly liquidation would precede the recoupment of expenses, a snapshot of projected cash flows in any given 10-year period will reflect net increases in the federal deficit

[1] CBO does not alter the probabilities used to calculate the expected values based on the current or expected future status of the financial system. Recognizing that certain economic and financial events are inherently unpredictable, those probabilities reflect CBO's best judgment on the basis of historical experience and do not vary from year to year.

under current law. For that reason, the proposed repeal of the orderly liquidation authority would result in decreases in the deficit, on a cash basis, over the same period. (As noted above, the recoupment of expenses will ultimately equal the expenses, but not within the 10-year period.)

In addition, any assessments levied under current law to offset costs of the OLF will become additional business expenses for the large financial companies required to pay them. Those additional expenses would result in decreases in taxable income elsewhere in the economy, which would produce a loss of government revenue from payroll and income taxes (estimated to vary between 24 percent and 30 percent of the additional expenses during the 2013–2022 period[2]). By eliminating the orderly liquidation authority (and thus, any assessments that would be collected), expected taxable incomes of large financial companies would increase, resulting in additional revenues from payroll and income taxes. (CBO's estimates do not incorporate any effects of the elimination of the orderly liquidation authority on the probability of a financial crisis or economic slump—both because the agency is unable to assess those effects, and because standard estimating conventions for legislation hold aggregate economic conditions unchanged.)

Assuming enactment around October 1, 2012, CBO estimates that eliminating the FDIC's orderly liquidation authority would result in a net decrease in the federal deficit of $22.5 billion over the 2012–2022 period (or $22.6 billion if enacted by July 1, 2012).

Home Affordable Modification Program. Subtitle B of the committee's recommendations would terminate the Department of Treasury's Home Affordable Modification Program (HAMP) that aims to help homeowners facing the possibility of foreclosure by subsidizing loan modifications as well as other foreclosure alternatives.

HAMP funds are used to cover costs incurred to modify mortgages that are not owned or guaranteed by the government-sponsored enterprises (GSEs) Fannie Mae or Freddie Mac. Generally, the program provides incentive payments to mortgage servicers, investors, and eligible homeowners to either reduce a homeowner's mortgage payment to 31 percent of their monthly income or to sell their house outside of foreclosure. Through February 29, 2012, approximately 974,000 mortgages have been modified through HAMP. Servicers and borrowers currently have until December 31, 2013, to modify mortgages through the program.

CBO estimates that the committee's recommendation would prevent the Treasury from making payments for approximately 150,000 new modifications of non-GSE mortgages assuming an October 1, 2012, effective date. (The cost of modifications entered into prior to enactment would continue to be paid by the Treasury.) Based on data provided by the Office of the Special Inspector General for the Troubled Asset Relief Program, CBO estimates that such modifications cost about $15,000 on average. As a result, CBO estimates that the provisions would reduce direct spending by $2.3

[2] Percentages used to estimate income and payroll tax offsets can be found at: Joint Committee on Taxation, *The Income and Payroll Tax Offset to Changes in Excise Tax Revenues for 2012–2022* (JCX–23–12), March 6, 2012.

billion over the 2012–2022 period, assuming an October 1, 2012, effective date (or $2.8 billion assuming enactment by July 1, 2012).

National Flood Insurance Program. Subtitle D would authorize the NFIP to enter into and renew flood insurance policies through fiscal year 2016. The committee's recommendations also would make a number of changes that would affect the financial status of the program, including: increasing premiums for some subsidized policyholders, offering temporary discounted premiums for properties that are newly mapped into a flood plain, and requiring the capitalization of a reserve fund for use during higher-than-average loss years.

The changes made by the bill would improve the financial condition of the NFIP and reduce its need to borrow from the Treasury—a source of direct spending—by a total of $210 million in 2014 and 2015, CBO estimates. Because the NFIP would continue to operate with insurance premiums that are not sufficient, in the aggregate, to cover all expected costs after the committee's recommendations were enacted, CBO estimates that reduced borrowing in 2014 and 2015 would be offset by increased borrowing in 2016 (when we expect the program would exhaust its remaining borrowing authority under this proposal), resulting in no net effect on direct spending over the next 10 years.

Section 507(b) of H. Con. Res. 112 requires that CBO estimate the change in net income to the NFIP if the committee's recommendations were enacted. CBO estimates that the proposed changes in subtitle D would increase net income to the NFIP by $4.9 billion over the 2012–2022 period (as shown in the memorandum to tables 1 and 2), mostly because of increases in premiums for subsidized policyholders (some of which would be retained by private insurers which sell the insurance policies). Increased premiums to the program would not result in a net reduction in CBO's estimate of the deficit, however, because we expect that this additional income would be used to fulfill obligations to policyholders that would otherwise be delayed, resulting in no net impact on direct spending over the five- and ten-year projection periods.

Bureau of Consumer Financial Protection. The Dodd-Frank Wall Street Reform and Consumer Financial Protection Act established the Bureau of Consumer Financial Protection (CFPB) to enforce certain federal laws. The annual operating costs of the CFPB, an autonomous agency within the Federal Reserve, are paid through transfers from the earnings of the Federal Reserve and are recorded as expenditures in the federal budget. Subtitle C would change that funding mechanism by terminating the transfers from the Federal Reserve and authorizing the appropriation of $200 million for each of fiscal years 2012 and 2013 for the agency's operations. CBO estimates that the CFPB will spend $310 million in fiscal year 2012, and that outlays will average about $545 million per year over the 2013–2022 period.

CBO estimates that enacting this change to the method of funding the agency would reduce direct spending by $5.4 billion over the 2012–2022 period, assuming enactment at any point between July 1, 2012, and October 1, 2012.

Office of Financial Research. Subtitle E would eliminate the Office of Financial Research (OFR), which was established to support the Financial Stability Oversight Council (FSOC) by collecting information on financial markets and providing independent research on financial stability issues.

Under current law, the OFR is authorized to collect fees to offset its expenses, which also include the operating costs of the FSOC and certain costs incurred by the FDIC to implement the orderly liquidation authority. Those fees are recorded in the budget as revenues. Subtitle E would terminate the authority to collect those fees as well as spending for all of the activities associated with the OFR. Based on information from the OFR, CBO estimates that spending by the OFR will average about $100 million per year over the 2013–2022 period, and that fee collections will average about $72 million per year over the same period, net of effects on payroll and income taxes.

Thus, enacting this provision would reduce budget deficits by $255 million over the 2012–2022 period if enacted around October 1, 2012 (or $252 million if enacted by July 1, 2012), CBO estimates.

Spending subject to appropriation

CBO estimates that implementing the committee recommendations would have a discretionary cost of $766 million over the 2013–2017 period, assuming appropriation of the necessary amounts, to fund activities of the CFPB and the FSOC, as well as mapping and mitigation efforts under the NFIP.

Bureau of Consumer Financial Protection. Subtitle C would change the method for funding the CFPB. Under current law, the bureau's operating costs are covered by amounts transferred from the earnings of the Federal Reserve; the recommendation would terminate those transfers and authorize the appropriation of $200 million each year for 2012 and 2013.

Based on information from the CFPB as well as historical spending patterns, CBO estimates that $325 million, an amount similar to what CBO estimates the agency will spend in 2012, would be sufficient for the CFPB to execute its statutory oversight and enforcement activities in 2013. CBO believes that the agency could not continue its mission with an appropriation of only $200 million in 2013, because the committee recommendations would not diminish the agency's responsibilities. Therefore, CBO estimates that implementing subtitle C would cost $325 million over the 2013–2017 period, assuming appropriation of the necessary amounts for 2013 and assuming enactment anytime between July 1, 2012, and October 1, 2012.

Financial Stability Oversight Council. Under current law, the activities of the FSOC are funded through the Office of Financial Research, which, as noted earlier, would be eliminated under subtitle E. Based on information from the OFR, CBO estimates that continuing the activities of the FSOC would cost about $10 million per year. Therefore, implementing subtitle E would cost $49 million over the 2013–2017 period, assuming appropriation of the necessary amounts and assuming enactment anytime between July 1, 2012, and October 1, 2012.

Flood Mapping and Mitigation Programs. The committee recommendations would direct FEMA to implement new standards for flood insurance rate maps. The agency would have 10 years to incorporate the new standards, subject to the availability of appropriated funds. Based on the costs of FEMA's current map modernization program and the estimated costs of new updates, CBO estimates that implementing this provision would cost $254 million over the next five years.

Subtitle D also would authorize the appropriation of $40 million a year above amounts already authorized in current law for grants to mitigate future flood damages. Such amounts would come from the National Flood Insurance Fund, but would be subject to future appropriation actions. Based on historical expenditure patterns of FEMA's flood mitigation programs, CBO estimates that implementing this provision would cost $138 million over the next five years.

Intergovernmental and private-sector impact: The legislation would impose intergovernmental and private-sector mandates, as defined in UMRA, on public and private mortgage lenders. Because the mandates would require only small changes in existing industry practice, CBO expects that the cost to comply with the mandates would be small relative to the annual thresholds established in UMRA for intergovernmental and private-sector mandates ($73 million and $146 million in 2012, respectively, adjusted annually for inflation).

Flood insurance

Current law prohibits lenders from making loans for real estate in areas at high risk for flood damage unless the property is covered by flood insurance. This bill would require lenders to accept flood insurance from a private company if the policy fulfills all federal requirements for flood insurance. Under current law, lenders also are required to purchase flood insurance on behalf of the homeowner if, at any time during the life of a loan, they determine that a homeowner does not have a current policy in place. The bill would require lenders to terminate those policies within 30 days of being notified that the homeowner has purchased another policy. Lenders also would have to refund any premium payments and fees made by the homeowner for the time when both policies were in effect. Based on information from industry sources and on current industry practice, CBO estimates that the cost to public and private mortgage lenders of complying with those mandates would be small.

Disclosure requirements

Current law requires mortgage lenders that make federally related mortgages (as defined in 12 U.S.C. 2602) to provide a good-faith estimate of the amount or range of charges the borrower is likely to incur for specific settlement services. The bill would require those lenders to include specific information about the availability of flood insurance in each good-faith estimate. The mandate would require small changes in existing disclosure requirements. Consequently, CBO estimates that the cost of the mandate to public and private mortgage lenders would be small.

Other impacts

State, local, and tribal governments would benefit if funds authorized to be appropriated for mitigation and outreach activities related to flood hazards were made available. Any costs to those governments, including matching funds, would be incurred voluntarily.

Previous CBO estimates: On March 11, 2011, CBO transmitted a cost estimate for H.R. 839, the HAMP Termination Act of 2011, as ordered reported by the House Committee on Financial Services on March 9, 2011. Differences in the estimated costs of subtitle B and H.R. 839 reflect differences in effective dates and administrative changes that have been made to the HAMP programs.

On June 8, 2011, CBO transmitted a cost estimate for H.R. 1309, the Flood Insurance Reform Modernization Act, as ordered reported by the House Committee on Financial Services on May 13, 2011. Differences in the estimated costs of subtitle D and H.R. 1309 reflect differences in the effective dates as well as the requirement that the NFIP establish a reserve fund, which was included in the recommendation, but not in the committee-reported version of H.R. 1309.

Estimate prepared by: Federal Costs: Orderly Liquidation Authority and the NFIP: Daniel Hoople; Bureau of Consumer Financial Protection and Office of Financial Research: Susan Willie; Home Affordable Modification Program: Chad Chirico.

Impact on State, local, and tribal governments: Elizabeth Cove Delisle and Melissa Merrell.

Impact on the private sector: Vi Nguyen and Paige Piper/Bach.

Estimate approved by: Theresa Gullo, Deputy Assistant Director for Budget Analysis.

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

SUBTITLE A—ORDERLY LIQUIDATION FUND

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

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

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

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

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

SUBTITLE D—FLOOD INSURANCE REFORM

Section 346 of Subtitle D creates a new Technical Mapping Advisory Council within the meaning of section 5(b) of the Federal Advisory Committee Act.

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

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

APPLICABILITY TO LEGISLATIVE BRANCH

SUBTITLE A—ORDERLY LIQUIDATION FUND

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

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

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

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

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

SUBTITLE D—FLOOD INSURANCE REFORM

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

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

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

EARMARK IDENTIFICATION

SUBTITLE A—ORDERLY LIQUIDATION FUND

Subtitle A does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI.

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

Subtitle B does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI.

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

Subtitle C does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI.

SUBTITLE D—FLOOD INSURANCE REFORM

Subtitle D does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI.

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

Subtitle E does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

SUBTITLE A—ORDERLY LIQUIDATION FUND

Section 311. Repeal of Liquidation Authority

Section 311 repeals Title II of the Dodd-Frank Act, and makes conforming amendments to the Dodd-Frank Act and the Federal Deposit Insurance Act.

SUBTITLE B—HOME AFFORDABLE MODIFICATION PROGRAM

Section 321. Short title

This section establishes the short title of the Subtitle, the "The HAMP Termination Act of 2012."

Section 322. Congressional findings

This section sets forth several Congressional findings regarding HAMP, including the purpose of the program, the number of active permanent mortgage modifications made under the program, the harms sustained by homeowners as a result of HAMP modification cancellations, the cost of the program, and the savings that will be achieved by terminating the program.

Section 323. Termination of authority

This section amends Section 120 of the Emergency Economic Stabilization Act of 2008 to terminate the authority of the Treasury Department to provide new assistance to homeowners under the HAMP. It also preserves the Treasury Department's authority to continue to provide assistance to homeowners who have already been extended an offer to participate in HAMP on a permanent or trial basis.

Further, this section directs the Treasury Secretary to conduct a study to determine the extent to which "covered homeowners" use HAMP. "Covered homeowners" are defined as individuals who are active duty members of the U.S. armed forces and their spouses or parents, veterans of the U.S. armed forces, and individuals eligible to receive a Gold Star lapel button under 10 U.S.C. 1126 as the widow, parent, or next of kin of a fallen member of the U.S. armed forces. The Treasury Secretary is then required to report to Congress on the study and to identify any best practices that could be applied to existing mortgage assistance programs available to covered homeowners within 90 days of enactment of this Subtitle.

Finally, this section requires the Treasury Secretary to publish in a prominent location on the Treasury Department's website, in

a noticeable font, a statement that HAMP has been terminated and inviting borrowers who are having trouble paying their mortgages and who need help in communicating with their lenders or servicers to contact their Member of Congress for assistance in reaching the lender or servicer for the purpose of negotiating or acquiring a loan modification.

Section 324. Sense of Congress

This section establishes the sense of Congress that banks should be encouraged to work with homeowners to provide loan modifications to those that are eligible, as well as to work and to assist homeowners and prospective homeowners with foreclosure prevention programs and information on loan modifications.

SUBTITLE C—BUREAU OF CONSUMER FINANCIAL PROTECTION

Section 331. Bringing the Bureau of Consumer Financial Protection into the regular appropriations process

Section 331 amends Section 1017 of the Dodd-Frank Act by terminating the CFPB's authority to determine its own budget and draw that amount from the Federal Reserve System. This section authorizes $200 million in appropriations to fund the CFPB for fiscal years 2012 and 2013. This section also eliminates the Consumer Financial Protection Fund and the Consumer Financial Civil Penalty Fund.

SUBTITLE D—FLOOD INSURANCE REFORM

Section 341. Short title and Table of Contents

This section establishes the short title of the Subtitle, the "Flood Insurance Reform Act of 2012."

Section 342. Extensions

This section reauthorizes the NFIP and its financing through September 30, 2016.

Section 343. Mandatory purchase

Temporary Mandatory Purchase Suspensions—Under the NFIP, federally regulated lenders are obligated to require flood insurance on any mortgage issued or guaranteed by the federal government in a Special Flood Hazard Area in a community that participates in the NFIP. This section allows the mandatory purchase requirement to be suspended on a community-by-community basis for one year at the request of a local governing authority if FEMA finds at least one of the following conditions apply to the community: (1) it has never been mapped as a high-risk area; (2) it is taking specific steps to rebuild or repair a dam or levee that has been decertified and is making adequate progress in securing financial commitments and completing that work; or (3) it has filed a formal appeal of the accuracy of a dam or levee decertification or flood risk map revision. This suspension could be extended for a maximum of two additional one-year periods (for a total of three years) for all qualifying communities at FEMA's discretion. For certain qualifying communities determined by FEMA to be making more than adequate progress in the construction of their flood protection sys-

tems, FEMA may, at its discretion, further extend the suspension of the mandatory purchase requirement for existing mortgages for a maximum of two additional one-year periods (for a total of five years).

Termination of Force-Placed Insurance—Mortgage lenders and servicers must terminate any force-placed insurance and refund any premiums paid for coverage overlap periods once property owners have obtained their required flood insurance.

Equal Treatment of Private Flood Insurance—To encourage greater private sector participation, this section requires lenders to accept non-NFIP backed flood insurance coverage provided by a private entity if that coverage meets the same requirements as NFIP-backed flood insurance.

Section 344. Reforms of coverage terms

Minimum Deductibles—Minimum deductibles are set at $1,000 for properties with full-risk rates and at $2,000 for properties with discounted rates.

Maximum Coverage Limits—Limits would be indexed for inflation, starting in 2012.

Optional Coverage for Additional Living Expenses/Business Interruption (ALE/BI)—FEMA would be authorized to offer optional coverage for additional living expenses ($5,000 maximum) and coverage for the interruption of business operations ($20,000 maximum) if FEMA: (1) charges full-risk rates for such coverage; (2) finds that a competitive private market for such coverage does not exist; and (3) certifies that the NFIP can offer such coverage without borrowing additional funds from the Treasury.

Installment Payments—Policyholders would be allowed to pay their premiums for one-year policies in installments.

Flood in Progress Protections—New policyholders would not have their coverage limited by a FEMA-determined flood-in-progress exclusion if they have not sustained any actual damage or loss to their property within the initial 30-day waiting period required under a standard flood insurance policy before flood coverage can go into effect.

Section 345. Reforms of premium rates

Annual Limit on Premium Rate Increases—The annual cap on premium rate increases would be increased from 10 percent to 20 percent.

Five Year Phase-in of Full-Risk Rates for Newly-Mapped Areas—For primary residence properties mapped into a mandatory purchase area, initial rates would be set at 20 percent of full-risk rates and increase by 20 percent each year for four years thereafter.

Full-Risk Rates for Certain Subsidized Properties—Full actuarial rates would be phased-in for roughly 350,000 properties currently receiving NFIP subsidies including: commercial properties, second and vacation homes, homes sold to new owners, homes substantially damaged or improved, Severe Repetitive Loss Properties (SRLPs) with multiple flood claims, and property owners who allowed their policies to lapse by choice.

Use of State and Local Funding Considerations in Setting Flood Rates—FEMA would be required to update its standards for evaluating eligibility for special flood insurance rates by considering several factors, including state and local funding of flood control projects and other flood control reconstruction and improvement projects.

Section 346. Technical Mapping Advisory Council

This section establishes a new Technical Mapping Advisory Council made up of federal, state, and local experts, with an adequate number of representatives from states at a high-risk for flooding, to review flood hazard risk mapping standards and propose new mapping standards to FEMA. The Council has 12 months to develop and submit to FEMA and Congress its proposed new mapping standards, during which time FEMA is prohibited from making effective any new or updated flood insurance rate maps based on its current mapping standards.

Section 347. FEMA incorporation of New Mapping Protocols

This section requires FEMA to update its flood maps according to the Technical Mapping Advisory Council's recommendations within six months of receiving those recommendations, or report to Congress why it rejected them.

Section 348. Treatment of levees

This section prohibits FEMA from issuing or updating flood insurance maps that do not factor in the actual protection afforded by existing levees regardless of their FEMA accreditation status (i.e., FEMA's maps must award partial credit to existing dams and levees).

Section 349. Privatization initiatives

This section requires FEMA and the GAO to report on various privatization initiatives, including options to begin privatizing the NFIP over time; determining the capacity of private insurers, reinsurers, and financial markets to underwrite NFIP flood risk; and assessing new ways to strengthen the NFIP's ability to pay claims without having to borrow from the Treasury.

Section 350. FEMA annual report on insurance program

This section requires FEMA to report annually to Congress on the status of the NFIP with detailed information about the financial status of the program.

Section 351. Mitigation assistance

This section amends the current planning assistance grants program to authorize $90 million in financial assistance for FEMA to (1) make assistance grants available to states and communities for flood mitigation activities, particularly activities that reduce flood damage to severe repetitive loss structures; and (2) make direct grants available to property owners for flood mitigation activities. To become eligible for mitigation assistance, states must develop a new multi-hazard mitigation plan that examines the reduction of flood losses, including the demolition and rebuilding of properties,

and requires states and communities to use mitigation assistance in a manner that is consistent with activities outlined in their mitigation plan. In awarding grants, FEMA may approve only mitigation activities that it determines are technically feasible, cost-effective and represent savings to the NFIP, with a priority given to mitigation activities that will result in savings for the NFIP.

Section 352. Notification to homeowners regarding mandatory purchase requirement applicability and rate phase-ins

This section establishes an annual notification process to inform individuals who reside in an area having special flood hazards that they are subject to the mandatory purchase requirement and provide estimates of what other homeowners in similar areas pay for their flood insurance.

Section 353. Notification of Congress regarding the establishment of flood map changes

This section requires FEMA to notify Members of the House and Senate whose districts or states are affected when it changes or updates floodplain areas or flood risk zones.

Section 354. Notification and appeals process for map changes based on flood elevations

This section requires FEMA, when establishing new flood maps based on elevation, to provide written notification by first class mail of the proposed change and the appeals process to each effected property owner with, copies of the new maps to the chief executive officer of each community affected, and to publish notice of the proposed change and the appeals process in the Federal Register and a prominent local newspaper.

Section 355. Notification to tenants of the availability of contents insurance

This section requires FEMA to develop a notice to landlords to inform tenants if they live in an area having special flood hazards and details about NFIP insurance for the contents of their apartment.

Section 356. Notification to policy holders regarding direct management of policy by FEMA

This section requires FEMA to annually notify all holders of policies transferred to the NFIP Direct program of their options to purchase flood insurance directly from another WYO insurance company.

Section 357—Notice of the availability of flood insurance and escrow in RESPA good faith estimate

This section amends the Real Estate Settlement Procedures Act (RESPA) to disclose as part of RESPA's good faith estimate that flood insurance is generally available from the NFIP for all homes, and that the escrowing of flood insurance payments is required for many loans and may be an option available under other loans.

Section 358—Reimbursement for costs incurred by homeowners and communities obtaining letters of map amendment or revision

This section allows homeowners or communities to be reimbursed for certain costs associated with a successful challenge to a bona fide mapping error made by FEMA resulting in a Letter of Map Amendment (LOMA) or Letter of Map Revision (LOMR), not including legal fees.

Section 359—Enhanced communication to communities with non-updated flood maps

This section requires FEMA, when establishing new flood maps, to communicate with communities whose flood insurance rate maps that have not been updated in 20 or more years to help resolve outstanding flooding issues, provide technical assistance, and disseminate information to reduce the prevalence of outdated maps in flood-prone areas.

Section 360—Notification to residents newly included in flood hazard areas

This section requires FEMA to provide to each property owner newly mapped into a special flood hazard area with a copy of the revised or updated flood insurance map that affects that owner's property, as well as the appeals process to challenge that mapping determination.

Section 361—Treatment of swimming pool enclosures outside of hurricane season

This section allows certain properties with swimming pools that are enclosed with non-supporting breakaway walls outside of hurricane season (November 20 through June 1) to be eligible for participation in the NFIP.

Section 362—Information regarding multiple perils claims

This section allows NFIP policyholders who also have non-NFIP wind or other homeowners insurance coverage and sustain damage to property covered under both policies to request the damage estimate, proofs of loss, and any expert or engineering reports used to determine the cause of the damage from FEMA and their NFIP-participating WYO insurance company.

Section 363—FEMA authority to reject the transfer of policies to NFIP direct

This section authorizes FEMA to refuse to accept the future transfer of any flood insurance policies from a WYO company to its NFIP Direct policy servicing program.

Section 364—Media notification of proposed map changes and extended appeals process

This section requires FEMA to notify local television and radio stations of proposed changes to flood maps. This section also requires FEMA to grant property owners a 90-day extension of the existing appeals process period if their community certifies to FEMA that there are affected property owners who were unaware of the expiration of the appeals process period and that the commu-

nity will use that 90-day period to inform affected property owners about the availability of the appeals process.

Section 365—Establishment of a Reserve Fund for the NFIP

This section establishes a National Flood Insurance Reserve Fund within the Treasury Department where the NFIP would be required to maintain a reserve ratio balance of at least 1 percent of the sum of the total potential loss exposure of all outstanding flood insurance policies in force the prior fiscal year. FEMA is authorized to establish and adjust the amount of aggregate annual insurance premiums it collects to maintain or achieve that reserve ratio. Starting in 2012, FEMA would be required to transfer to the Fund at least 7.5 percent of the amount needed to achieve its 1 percent reserve ratio balance each year until the full 1 percent reserve ratio is achieved. FEMA would also be required to submit a report to Congress for any year in which it cannot achieve a 1 percent reserve ratio.

Section 366—CDBG eligibility for flood insurance outreach activities and community building code administration grants

This section allows communities to use Community Development Block Grant (CDBG) funds for local building code enforcement, as long as local matching funds are provided. It also allows CDBG funds to be used by local governments for flood risk outreach and education activities.

Section 367—Technical corrections

This section makes a technical correction to the underlying National Flood Insurance Act of 1968 and the Flood Disaster Protection Act of 1973 to update references in those statutes to the head of FEMA as its "Administrator" rather than its "Director."

Section 368—Requiring competition for NFIP policies

To address the rapid increase in the number of policies administered under FEMA's NFIP Direct policy servicing program, FEMA would be required to report to Congress within 90 days on the procedures and policies it can implement to limit the size of NFIP Direct to no more than 10 percent of all flood insurance policies, and then implement those size reduction procedures and policies—without preventing agents handling policies transitioned out of the NFIP Direct from continuing to sell or service those policies—within one year of issuing that report.

Section 369—Studies of voluntary community-based flood insurance options

This section directs FEMA and GAO to conduct a study to assess options, methods, and strategies for offering voluntary community-based flood insurance policies, and to report their findings to Congress within 18 months of enactment of this subtitle.

Section 370—Report on inclusion of building codes in floodplain management criteria

This section directs FEMA to study the impact, effectiveness, and feasibility of including widely used and nationally recognized build-

ing codes as part of its floodplain management criteria, and report its findings to Congress within 6 months of enactment of this subtitle.

Section 371—Study on graduated risk

This section requires the National Academy of Sciences to study methods for understanding graduated risk for properties and residential and commercial structures behind levees and report its findings to Congress within one year of enactment of this subtitle.

Section 372—Report on flood-in-progress determination

This section directs FEMA to review its processes and procedures for issuing a flood-in-progress determination and providing public notification of that determination, and report the results of that review to Congress within 6 months of enactment of this subtitle.

Section 373—Study on Repaying flood insurance debt

This section requires FEMA to report to Congress within 6 months of enactment of this subtitle on its plan to repay all outstanding sums previously borrowed from the Treasury, with interest, over the next 10 years.

Section 374—No cause of action

This section specifies that no cause of action against the federal government exists for failure to comply with any notification requirement under this Act.

Section 375—State and local requests for the Corps of Engineers to evaluate Corps-constructed levees

This section permits state and local governments to request the Army Corps of Engineers to evaluate their locally-operated levee systems, provided that the levee was constructed by the Corps and that the requesting state or local government agrees to fully reimburse the Corps for all costs associated with the evaluation.

SUBTITLE E—OFFICE OF FINANCIAL RESEARCH

Section 381. Repeal of the Office of Financial Research

Section 381 repeals Title I, Subtitle B of the Dodd-Frank Act, which establishes the OFR as an office within the Department of the Treasury.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

DODD-FRANK WALL STREET REFORM AND CONSUMER PROTECTION ACT

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) * * *

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

* * * * * * *

TITLE I—FINANCIAL STABILITY

* * * * * * *

SUBTITLE A—FINANCIAL STABILITY OVERSIGHT COUNCIL

* * * * * * *

[Sec. 118. Council funding.]

* * * * * * *

[SUBTITLE B—OFFICE OF FINANCIAL RESEARCH

[Sec. 151. Definitions.
[Sec. 152. Office of Financial Research established.
[Sec. 153. Purpose and duties of the Office.
[Sec. 154. Organizational structure; responsibilities of primary programmatic units.
[Sec. 155. Funding.
[Sec. 156. Transition oversight.]

* * * * * * *

[TITLE II—ORDERLY LIQUIDATION AUTHORITY

[Sec. 201. Definitions.
[Sec. 202. Judicial review.
[Sec. 203. Systemic risk determination.
[Sec. 204. Orderly liquidation of covered financial companies.
[Sec. 205. Orderly liquidation of covered brokers and dealers.
[Sec. 206. Mandatory terms and conditions for all orderly liquidation actions.
[Sec. 207. Directors not liable for acquiescing in appointment of receiver.
[Sec. 208. Dismissal and exclusion of other actions.
[Sec. 209. Rulemaking; non-conflicting law.
[Sec. 210. Powers and duties of the Corporation.
[Sec. 211. Miscellaneous provisions.
[Sec. 212. Prohibition of circumvention and prevention of conflicts of interest.
[Sec. 213. Ban on certain activities by senior executives and directors.
[Sec. 214. Prohibition on taxpayer funding.
[Sec. 215. Study on secured creditor haircuts.
[Sec. 216. Study on bankruptcy process for financial and nonbank financial institutions
[Sec. 217. Study on international coordination relating to bankruptcy process for nonbank financial institutions]

* * * * * * *

TITLE I—FINANCIAL STABILITY

* * * * * * *

SEC. 102. DEFINITIONS.

(a) IN GENERAL.—For purposes of this title, unless the context otherwise requires, the following definitions shall apply:

(1) * * *

* * * * * * *

[(5) OFFICE OF FINANCIAL RESEARCH.—The term "Office of Financial Research" means the office established under section 152.]

* * * * * * *

Subtitle A—Financial Stability Oversight Council

SEC. 111. FINANCIAL STABILITY OVERSIGHT COUNCIL ESTABLISHED.

(a) * * *

(b) MEMBERSHIP.—The Council shall consist of the following members:

(1) * * *

(2) NONVOTING MEMBERS.—The nonvoting members, who shall serve in an advisory capacity as a nonvoting member of the Council, shall be—

[(A) the Director of the Office of Financial Research;]

[(B)] *(A)* the Director of the Federal Insurance Office;

[(C)] *(B)* a State insurance commissioner, to be designated by a selection process determined by the State insurance commissioners;

[(D)] *(C)* a State banking supervisor, to be designated by a selection process determined by the State banking supervisors; and

[(E)] *(D)* a State securities commissioner (or an officer performing like functions), to be designated by a selection process determined by such State securities commissioners.

* * * * * * *

(c) TERMS; VACANCY.—

(1) TERMS.—The independent member of the Council shall serve for a term of 6 years, and each nonvoting member described in [subparagraphs (C), (D), and (E)] *subparagraphs (B), (C), and (D)* of subsection (b)(2) shall serve for a term of 2 years.

* * * * * * *

SEC. 112. COUNCIL AUTHORITY.

(a) PURPOSES AND DUTIES OF THE COUNCIL.—

(1) * * *

(2) DUTIES.—The Council shall, in accordance with this title—

(A) collect information from member agencies, other Federal and State financial regulatory agencies, the Federal Insurance Office and, if necessary to assess risks to the United States financial system, [direct the Office of Financial Research to] collect information from bank holding companies and nonbank financial companies;

[(B) provide direction to, and request data and analyses from, the Office of Financial Research to support the work of the Council;]

[(C)] *(B)* monitor the financial services marketplace in order to identify potential threats to the financial stability of the United States;

[(D)] *(C)* to monitor domestic and international financial regulatory proposals and developments, including insurance and accounting issues, and to advise Congress and

make recommendations in such areas that will enhance the integrity, efficiency, competitiveness, and stability of the U.S. financial markets;

[(E)] *(D)* facilitate information sharing and coordination among the member agencies and other Federal and State agencies regarding domestic financial services policy development, rulemaking, examinations, reporting requirements, and enforcement actions;

[(F)] *(E)* recommend to the member agencies general supervisory priorities and principles reflecting the outcome of discussions among the member agencies;

[(G)] *(F)* identify gaps in regulation that could pose risks to the financial stability of the United States;

[(H)] *(G)* require supervision by the Board of Governors for nonbank financial companies that may pose risks to the financial stability of the United States in the event of their material financial distress or failure, or because of their activities pursuant to section 113;

[(I)] *(H)* make recommendations to the Board of Governors concerning the establishment of heightened prudential standards for risk-based capital, leverage, liquidity, contingent capital, resolution plans and credit exposure reports, concentration limits, enhanced public disclosures, and overall risk management for nonbank financial companies and large, interconnected bank holding companies supervised by the Board of Governors;

[(J)] *(I)* identify systemically important financial market utilities and payment, clearing, and settlement activities (as that term is defined in title VIII);

[(K)] *(J)* make recommendations to primary financial regulatory agencies to apply new or heightened standards and safeguards for financial activities or practices that could create or increase risks of significant liquidity, credit, or other problems spreading among bank holding companies, nonbank financial companies, and United States financial markets;

[(L)] *(K)* review and, as appropriate, may submit comments to the Commission and any standard-setting body with respect to an existing or proposed accounting principle, standard, or procedure;

[(M)] *(L)* provide a forum for—

(i) * * *

* * * * * * *

[(N)] *(M)* annually report to and testify before Congress on—

(i) * * *

* * * * * * *

(d) AUTHORITY TO OBTAIN INFORMATION.—

(1) IN GENERAL.—The Council may receive, and may request the submission of, any data or information from [the Office of Financial Research, member agencies, and] *member agencies and* the Federal Insurance Office, as necessary—

(A) * * *

* * * * * * *

(2) SUBMISSIONS BY THE OFFICE AND MEMBER AGENCIES.—Notwithstanding any other provision of law, [the Office of Financial Research, any member agency, and] *any member agency and* the Federal Insurance Office, are authorized to submit information to the Council.

(3) FINANCIAL DATA COLLECTION.—

(A) IN GENERAL.—The Council [, acting through the Office of Financial Research,] may require the submission of periodic and other reports from any nonbank financial company or bank holding company for the purpose of assessing the extent to which a financial activity or financial market in which the nonbank financial company or bank holding company participates, or the nonbank financial company or bank holding company itself, poses a threat to the financial stability of the United States.

(B) MITIGATION OF REPORT BURDEN.—Before requiring the submission of reports from any nonbank financial company or bank holding company that is regulated by a member agency or any primary financial regulatory agency, the Council[, acting through the Office of Financial Research,] shall coordinate with such agencies and shall, whenever possible, rely on information available from [the Office of Financial Research or] such agencies.

(C) MITIGATION IN CASE OF FOREIGN FINANCIAL COMPANIES.—Before requiring the submission of reports from a company that is a foreign nonbank financial company or foreign-based bank holding company, the Council shall[, acting through the Office of Financial Research,] to the extent appropriate, consult with the appropriate foreign regulator of such company and, whenever possible, rely on information already being collected by such foreign regulator, with English translation.

* * * * * * *

(5) CONFIDENTIALITY.—

(A) IN GENERAL.—The Council[, the Office of Financial Research,] and the other member agencies shall maintain the confidentiality of any data, information, and reports submitted under this title.

* * * * * * *

SEC. 116. REPORTS.

(a) IN GENERAL.—Subject to subsection (b), the Council[, acting through the Office of Financial Research,] may require a bank holding company with total consolidated assets of $50,000,000,000 or greater or a nonbank financial company supervised by the Board of Governors, and any subsidiary thereof, to submit certified reports to keep the Council informed as to—

(1) * * *

* * * * * * *

(b) USE OF EXISTING REPORTS.—

(1) IN GENERAL.—For purposes of compliance with subsection (a), the Council[, acting through the Office of Financial Research,] shall, to the fullest extent possible, use—

(A) * * *

* * * * * * *

[SEC. 118. COUNCIL FUNDING.

[Any expenses of the Council shall be treated as expenses of, and paid by, the Office of Financial Research.]

* * * * * * *

[Subtitle B—Office of Financial Research

[SEC. 151. DEFINITIONS.

[For purposes of this subtitle—

[(1) the terms "Office" and "Director" mean the Office of Financial Research established under this subtitle and the Director thereof, respectively;

[(2) the term "financial company" has the same meaning as in title II, and includes an insured depository institution and an insurance company;

[(3) the term "Data Center" means the data center established under section 154;

[(4) the term "Research and Analysis Center" means the research and analysis center established under section 154;

[(5) the term "financial transaction data" means the structure and legal description of a financial contract, with sufficient detail to describe the rights and obligations between counterparties and make possible an independent valuation;

[(6) the term "position data"—

[(A) means data on financial assets or liabilities held on the balance sheet of a financial company, where positions are created or changed by the execution of a financial transaction; and

[(B) includes information that identifies counterparties, the valuation by the financial company of the position, and information that makes possible an independent valuation of the position;

[(7) the term "financial contract" means a legally binding agreement between 2 or more counterparties, describing rights and obligations relating to the future delivery of items of intrinsic or extrinsic value among the counterparties; and

[(8) the term "financial instrument" means a financial contract in which the terms and conditions are publicly available, and the roles of one or more of the counterparties are assignable without the consent of any of the other counterparties (including common stock of a publicly traded company, government bonds, or exchange traded futures and options contracts).

[SEC. 152. OFFICE OF FINANCIAL RESEARCH ESTABLISHED.

[(a) ESTABLISHMENT.—There is established within the Department of the Treasury the Office of Financial Research.

[(b) DIRECTOR.—

[(1) IN GENERAL.—The Office shall be headed by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate.

[(2) TERM OF SERVICE.—The Director shall serve for a term of 6 years, except that, in the event that a successor is not nominated and confirmed by the end of the term of service of a Director, the Director may continue to serve until such time as the next Director is appointed and confirmed.

[(3) EXECUTIVE LEVEL.—The Director shall be compensated at Level III of the Executive Schedule.

[(4) PROHIBITION ON DUAL SERVICE.—The individual serving in the position of Director may not, during such service, also serve as the head of any financial regulatory agency.

[(5) RESPONSIBILITIES, DUTIES, AND AUTHORITY.—The Director shall have sole discretion in the manner in which the Director fulfills the responsibilities and duties and exercises the authorities described in this subtitle.

[(c) BUDGET.—The Director, in consultation with the Chairperson, shall establish the annual budget of the Office.

[(d) OFFICE PERSONNEL.—

[(1) IN GENERAL.—The Director, in consultation with the Chairperson, may fix the number of, and appoint and direct, all employees of the Office.

[(2) COMPENSATION.—The Director, in consultation with the Chairperson, shall fix, adjust, and administer the pay for all employees of the Office, without regard to chapter 51 or subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates.

[(3) COMPARABILITY.—Section 1206(a) of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (12 U.S.C. 1833b(a)) is amended—

[(A) by striking "Finance Board," and inserting "Finance Board, the Office of Financial Research, and the Bureau of Consumer Financial Protection"; and

[(B) by striking "and the Office of Thrift Supervision,".

[(4) SENIOR EXECUTIVES.—Section 3132(a)(1)(D) of title 5, United States Code, is amended by striking "and the National Credit Union Administration;" and inserting "the National Credit Union Administration, the Bureau of Consumer Financial Protection, and the Office of Financial Research;".

[(e) ASSISTANCE FROM FEDERAL AGENCIES.—Any department or agency of the United States may provide to the Office and any special advisory, technical, or professional committees appointed by the Office, such services, funds, facilities, staff, and other support services as the Office may determine advisable. Any Federal Government employee may be detailed to the Office without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

[(f) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for Level V of the Executive Schedule under section 5316 of such title.

[(g) POST-EMPLOYMENT PROHIBITIONS.—The Secretary, with the concurrence of the Director of the Office of Government Ethics, shall issue regulations prohibiting the Director and any employee of the Office who has had access to the transaction or position data maintained by the Data Center or other business confidential information about financial entities required to report to the Office from being employed by or providing advice or consulting services to a financial company, for a period of 1 year after last having had access in the course of official duties to such transaction or position data or business confidential information, regardless of whether that entity is required to report to the Office. For employees whose access to business confidential information was limited, the regulations may provide, on a case-by-case basis, for a shorter period of post-employment prohibition, provided that the shorter period does not compromise business confidential information.

[(h) TECHNICAL AND PROFESSIONAL ADVISORY COMMITTEES.—The Office, in consultation with the Chairperson, may appoint such special advisory, technical, or professional committees as may be useful in carrying out the functions of the Office, and the members of such committees may be staff of the Office, or other persons, or both.

[(i) FELLOWSHIP PROGRAM.—The Office, in consultation with the Chairperson, may establish and maintain an academic and professional fellowship program, under which qualified academics and professionals shall be invited to spend not longer than 2 years at the Office, to perform research and to provide advanced training for Office personnel.

[(j) EXECUTIVE SCHEDULE COMPENSATION.—Section 5314 of title 5, United States Code, is amended by adding at the end the following new item:Director of the Office of Financial Research.".

[SEC. 153. PURPOSE AND DUTIES OF THE OFFICE.

[(a) PURPOSE AND DUTIES.—The purpose of the Office is to support the Council in fulfilling the purposes and duties of the Council, as set forth in subtitle A, and to support member agencies, by—

[(1) collecting data on behalf of the Council, and providing such data to the Council and member agencies;

[(2) standardizing the types and formats of data reported and collected;

[(3) performing applied research and essential long-term research;

[(4) developing tools for risk measurement and monitoring;

[(5) performing other related services;

[(6) making the results of the activities of the Office available to financial regulatory agencies; and

[(7) assisting such member agencies in determining the types and formats of data authorized by this Act to be collected by such member agencies.

[(b) ADMINISTRATIVE AUTHORITY.—The Office may—

[(1) share data and information, including software developed by the Office, with the Council, member agencies, and the Bureau of Economic Analysis, which shared data, information, and software—

[(A) shall be maintained with at least the same level of security as is used by the Office; and

[(B) may not be shared with any individual or entity without the permission of the Council;

[(2) sponsor and conduct research projects; and

[(3) assist, on a reimbursable basis, with financial analyses undertaken at the request of other Federal agencies that are not member agencies.

[(c) RULEMAKING AUTHORITY.—

[(1) SCOPE.—The Office, in consultation with the Chairperson, shall issue rules, regulations, and orders only to the extent necessary to carry out the purposes and duties described in paragraphs (1), (2), and (7) of subsection (a).

[(2) STANDARDIZATION.—Member agencies, in consultation with the Office, shall implement regulations promulgated by the Office under paragraph (1) to standardize the types and formats of data reported and collected on behalf of the Council, as described in subsection (a)(2). If a member agency fails to implement such regulations prior to the expiration of the 3-year period following the date of publication of final regulations, the Office, in consultation with the Chairperson, may implement such regulations with respect to the financial entities under the jurisdiction of the member agency. This paragraph shall not supersede or interfere with the independent authority of a member agency under other law to collect data, in such format and manner as the member agency requires.

[(d) TESTIMONY.—

[(1) IN GENERAL.—The Director of the Office shall report to and testify before the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives annually on the activities of the Office, including the work of the Data Center and the Research and Analysis Center, and the assessment of the Office of significant financial market developments and potential emerging threats to the financial stability of the United States.

[(2) NO PRIOR REVIEW.—No officer or agency of the United States shall have any authority to require the Director to submit the testimony required under paragraph (1) or other congressional testimony to any officer or agency of the United States for approval, comment, or review prior to the submission of such testimony. Any such testimony to Congress shall include a statement that the views expressed therein are those of the Director and do not necessarily represent the views of the President.

[(e) ADDITIONAL REPORTS.—The Director may provide additional reports to Congress concerning the financial stability of the United States. The Director shall notify the Council of any such additional reports provided to Congress.

[(f) SUBPOENA.—

[(1) IN GENERAL.—The Director may require from a financial company, by subpoena, the production of the data requested under subsection (a)(1) and section 154(b)(1), but only upon a written finding by the Director that—

[(A) such data is required to carry out the functions described under this subtitle; and

[(B) the Office has coordinated with the relevant primary financial regulatory agency, as required under section 154(b)(1)(B)(ii).

[(2) FORMAT.—Subpoenas under paragraph (1) shall bear the signature of the Director, and shall be served by any person or class of persons designated by the Director for that purpose.

[(3) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena, the subpoena shall be enforceable by order of any appropriate district court of the United States. Any failure to obey the order of the court may be punished by the court as a contempt of court.

[SEC. 154. ORGANIZATIONAL STRUCTURE; RESPONSIBILITIES OF PRIMARY PROGRAMMATIC UNITS.

[(a) IN GENERAL.—There are established within the Office, to carry out the programmatic responsibilities of the Office—

[(1) the Data Center; and

[(2) the Research and Analysis Center.

[(b) DATA CENTER.—

[(1) GENERAL DUTIES.—

[(A) DATA COLLECTION.—The Data Center, on behalf of the Council, shall collect, validate, and maintain all data necessary to carry out the duties of the Data Center, as described in this subtitle. The data assembled shall be obtained from member agencies, commercial data providers, publicly available data sources, and financial entities under subparagraph (B).

[(B) AUTHORITY.—

[(i) IN GENERAL.—The Office may, as determined by the Council or by the Director in consultation with the Council, require the submission of periodic and other reports from any financial company for the purpose of assessing the extent to which a financial activity or financial market in which the financial company participates, or the financial company itself, poses a threat to the financial stability of the United States.

[(ii) MITIGATION OF REPORT BURDEN.—Before requiring the submission of a report from any financial company that is regulated by a member agency, any primary financial regulatory agency, a foreign supervisory authority, or the Office shall coordinate with such agencies or authority, and shall, whenever possible, rely on information available from such agencies or authority.

[(iii) COLLECTION OF FINANCIAL TRANSACTION AND POSITION DATA.—The Office shall collect, on a schedule determined by the Director, in consultation with the Council, financial transaction data and position data from financial companies.

[(C) RULEMAKING.—The Office shall promulgate regulations pursuant to subsections (a)(1), (a)(2), (a)(7), and (c)(1) of section 153 regarding the type and scope of the data to be collected by the Data Center under this paragraph.

[(2) RESPONSIBILITIES.—

[(A) PUBLICATION.—The Data Center shall prepare and publish, in a manner that is easily accessible to the public—

[(i) a financial company reference database;

[(ii) a financial instrument reference database; and

[(iii) formats and standards for Office data, including standards for reporting financial transaction and position data to the Office.

[(B) CONFIDENTIALITY.—The Data Center shall not publish any confidential data under subparagraph (A).

[(3) INFORMATION SECURITY.—The Director shall ensure that data collected and maintained by the Data Center are kept secure and protected against unauthorized disclosure.

[(4) CATALOG OF FINANCIAL ENTITIES AND INSTRUMENTS.—The Data Center shall maintain a catalog of the financial entities and instruments reported to the Office.

[(5) AVAILABILITY TO THE COUNCIL AND MEMBER AGENCIES.—The Data Center shall make data collected and maintained by the Data Center available to the Council and member agencies, as necessary to support their regulatory responsibilities.

[(6) OTHER AUTHORITY.—The Office shall, after consultation with the member agencies, provide certain data to financial industry participants and to the general public to increase market transparency and facilitate research on the financial system, to the extent that intellectual property rights are not violated, business confidential information is properly protected, and the sharing of such information poses no significant threats to the financial system of the United States.

[(c) RESEARCH AND ANALYSIS CENTER.—

[(1) GENERAL DUTIES.—The Research and Analysis Center, on behalf of the Council, shall develop and maintain independent analytical capabilities and computing resources—

[(A) to develop and maintain metrics and reporting systems for risks to the financial stability of the United States;

[(B) to monitor, investigate, and report on changes in systemwide risk levels and patterns to the Council and Congress;

[(C) to conduct, coordinate, and sponsor research to support and improve regulation of financial entities and markets;

[(D) to evaluate and report on stress tests or other stability-related evaluations of financial entities overseen by the member agencies;

[(E) to maintain expertise in such areas as may be necessary to support specific requests for advice and assistance from financial regulators;

[(F) to investigate disruptions and failures in the financial markets, report findings, and make recommendations to the Council based on those findings;

[(G) to conduct studies and provide advice on the impact of policies related to systemic risk; and

[(H) to promote best practices for financial risk management.

[(d) REPORTING RESPONSIBILITIES.—

[(1) REQUIRED REPORTS.—Not later than 2 years after the date of enactment of this Act, and not later than 120 days after the end of each fiscal year thereafter, the Office shall prepare and submit a report to Congress.

[(2) CONTENT.—Each report required by this subsection shall assess the state of the United States financial system, including—

[(A) an analysis of any threats to the financial stability of the United States;

[(B) the status of the efforts of the Office in meeting the mission of the Office; and

[(C) key findings from the research and analysis of the financial system by the Office.

[SEC. 155. FUNDING.

[(a) FINANCIAL RESEARCH FUND.—

[(1) FUND ESTABLISHED.—There is established in the Treasury of the United States a separate fund to be known as the "Financial Research Fund".

[(2) FUND RECEIPTS.—All amounts provided to the Office under subsection (c), and all assessments that the Office receives under subsection (d) shall be deposited into the Financial Research Fund.

[(3) INVESTMENTS AUTHORIZED.—

[(A) AMOUNTS IN FUND MAY BE INVESTED.—The Director may request the Secretary to invest the portion of the Financial Research Fund that is not, in the judgment of the Director, required to meet the needs of the Office.

[(B) ELIGIBLE INVESTMENTS.—Investments shall be made by the Secretary in obligations of the United States or obligations that are guaranteed as to principal and interest by the United States, with maturities suitable to the needs of the Financial Research Fund, as determined by the Director.

[(4) INTEREST AND PROCEEDS CREDITED.—The interest on, and the proceeds from the sale or redemption of, any obligations held in the Financial Research Fund shall be credited to and form a part of the Financial Research Fund.

[(b) USE OF FUNDS.—

[(1) IN GENERAL.—Funds obtained by, transferred to, or credited to the Financial Research Fund shall be immediately available to the Office, and shall remain available until expended, to pay the expenses of the Office in carrying out the duties and responsibilities of the Office.

[(2) FEES, ASSESSMENTS, AND OTHER FUNDS NOT GOVERNMENT FUNDS.—Funds obtained by, transferred to, or credited to the Financial Research Fund shall not be construed to be Government funds or appropriated moneys.

[(3) AMOUNTS NOT SUBJECT TO APPORTIONMENT.—Notwithstanding any other provision of law, amounts in the Financial Research Fund shall not be subject to apportionment for purposes of chapter 15 of title 31, United States Code, or under any other authority, or for any other purpose.

[(c) INTERIM FUNDING.—During the 2-year period following the date of enactment of this Act, the Board of Governors shall provide to the Office an amount sufficient to cover the expenses of the Office.

[(d) PERMANENT SELF-FUNDING.—Beginning 2 years after the date of enactment of this Act, the Secretary shall establish, by regulation, and with the approval of the Council, an assessment schedule, including the assessment base and rates, applicable to bank holding companies with total consolidated assets of 50,000,000,000 or greater and nonbank financial companies supervised by the Board of Governors, that takes into account differences among such companies, based on the considerations for establishing the prudential standards under section 115, to collect assessments equal to the total expenses of the Office.

[SEC. 156. TRANSITION OVERSIGHT.

[(a) PURPOSE.—The purpose of this section is to ensure that the Office—

[(1) has an orderly and organized startup;

[(2) attracts and retains a qualified workforce; and

[(3) establishes comprehensive employee training and benefits programs.

[(b) REPORTING REQUIREMENT.—

[(1) IN GENERAL.—The Office shall submit an annual report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives that includes the plans described in paragraph (2).

[(2) PLANS.—The plans described in this paragraph are as follows:

[(A) TRAINING AND WORKFORCE DEVELOPMENT PLAN.—The Office shall submit a training and workforce development plan that includes, to the extent practicable—

[(i) identification of skill and technical expertise needs and actions taken to meet those requirements;

[(ii) steps taken to foster innovation and creativity;

[(iii) leadership development and succession planning; and

[(iv) effective use of technology by employees.

[(B) WORKPLACE FLEXIBILITY PLAN.—The Office shall submit a workforce flexibility plan that includes, to the extent practicable—

[(i) telework;

[(ii) flexible work schedules;

[(iii) phased retirement;

[(iv) reemployed annuitants;

[(v) part-time work;

[(vi) job sharing;

[(vii) parental leave benefits and childcare assistance;

[(viii) domestic partner benefits;

[(ix) other workplace flexibilities; or

[(x) any combination of the items described in clauses (i) through (ix).

[(C) RECRUITMENT AND RETENTION PLAN.—The Office shall submit a recruitment and retention plan that includes, to the extent practicable, provisions relating to—

[(i) the steps necessary to target highly qualified applicant pools with diverse backgrounds;

[(ii) streamlined employment application processes;

[(iii) the provision of timely notification of the status of employment applications to applicants; and

[(iv) the collection of information to measure indicators of hiring effectiveness.

[(c) EXPIRATION.—The reporting requirement under subsection (b) shall terminate 5 years after the date of enactment of this Act.

[(d) RULE OF CONSTRUCTION.—Nothing in this section may be construed to affect—

[(1) a collective bargaining agreement, as that term is defined in section 7103(a)(8) of title 5, United States Code, that is in effect on the date of enactment of this Act; or

[(2) the rights of employees under chapter 71 of title 5, United States Code.]

Subtitle C—Additional Board of Governors Authority for Certain Nonbank Financial Companies and Bank Holding Companies

* * * * * * *

SEC. 165. ENHANCED SUPERVISION AND PRUDENTIAL STANDARDS FOR NONBANK FINANCIAL COMPANIES SUPERVISED BY THE BOARD OF GOVERNORS AND CERTAIN BANK HOLDING COMPANIES.

(a) * * *

* * * * * * *

(d) RESOLUTION PLAN AND CREDIT EXPOSURE REPORTS.—

(1) * * *

* * * * * * *

(6) NO LIMITING EFFECT.—A resolution plan submitted in accordance with this subsection shall not be binding on a bankruptcy court[, a receiver appointed under title II,] or any other authority that is authorized or required to resolve the nonbank financial company supervised by the Board, any bank holding company, or any subsidiary or affiliate of the foregoing.

* * * * * * *

[TITLE II—ORDERLY LIQUIDATION AUTHORITY

[SEC. 201. DEFINITIONS.

[(a) IN GENERAL.—In this title, the following definitions shall apply:

[(1) ADMINISTRATIVE EXPENSES OF THE RECEIVER.—The term "administrative expenses of the receiver" includes—

[(A) the actual, necessary costs and expenses incurred by the Corporation as receiver for a covered financial company in liquidating a covered financial company; and

[(B) any obligations that the Corporation as receiver for a covered financial company determines are necessary and appropriate to facilitate the smooth and orderly liquidation of the covered financial company.

[(2) BANKRUPTCY CODE.—The term "Bankruptcy Code" means title 11, United States Code.

[(3) BRIDGE FINANCIAL COMPANY.—The term "bridge financial company" means a new financial company organized by the Corporation in accordance with section 210(h) for the purpose of resolving a covered financial company.

[(4) CLAIM.—The term "claim" means any right to payment, whether or not such right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, legal, equitable, secured, or unsecured.

[(5) COMPANY.—The term "company" has the same meaning as in section 2(b) of the Bank Holding Company Act of 1956 (12 U.S.C. 1841(b)), except that such term includes any company described in paragraph (11), the majority of the securities of which are owned by the United States or any State.

[(6) COURT.—The term "Court" means the United States District Court for the District of Columbia, unless the context otherwise requires.

[(7) COVERED BROKER OR DEALER.—The term "covered broker or dealer" means a covered financial company that is a broker or dealer that—

[(A) is registered with the Commission under section 15(b) of the Securities Exchange Act of 1934 (15 U.S.C. 78o(b)); and

[(B) is a member of SIPC.

[(8) COVERED FINANCIAL COMPANY.—The term "covered financial company"—

[(A) means a financial company for which a determination has been made under section 203(b); and

[(B) does not include an insured depository institution.

[(9) COVERED SUBSIDIARY.—The term "covered subsidiary" means a subsidiary of a covered financial company, other than—

[(A) an insured depository institution;

[(B) an insurance company; or

[(C) a covered broker or dealer.

[(10) DEFINITIONS RELATING TO COVERED BROKERS AND DEALERS.—The terms "customer", "customer name securities", "customer property", and "net equity" in the context of a covered broker or dealer, have the same meanings as in section 16 of the Securities Investor Protection Act of 1970 (15 U.S.C. 78lll).

[(11) FINANCIAL COMPANY.—The term "financial company" means any company that—

[(A) is incorporated or organized under any provision of Federal law or the laws of any State;

[(B) is—

[(i) a bank holding company, as defined in section 2(a) of the Bank Holding Company Act of 1956 (12 U.S.C. 1841(a));

[(ii) a nonbank financial company supervised by the Board of Governors;

[(iii) any company that is predominantly engaged in activities that the Board of Governors has determined are financial in nature or incidental thereto for purposes of section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)) other than a company described in clause (i) or (ii); or

[(iv) any subsidiary of any company described in any of clauses (i) through (iii) that is predominantly engaged in activities that the Board of Governors has determined are financial in nature or incidental thereto for purposes of section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)) (other than a subsidiary that is an insured depository institution or an insurance company); and

[(C) is not a Farm Credit System institution chartered under and subject to the provisions of the Farm Credit Act of 1971, as amended (12 U.S.C. 2001 et seq.), a governmental entity, or a regulated entity, as defined under section 1303(20) of the Federal Housing Enterprises Financial Safety and Soundness Act of 1992 (12 U.S.C. 4502(20)).

[(12) FUND.—The term "Fund" means the Orderly Liquidation Fund established under section 210(n).

[(13) INSURANCE COMPANY.—The term "insurance company" means any entity that is—

[(A) engaged in the business of insurance;

[(B) subject to regulation by a State insurance regulator; and

[(C) covered by a State law that is designed to specifically deal with the rehabilitation, liquidation, or insolvency of an insurance company.

[(14) NONBANK FINANCIAL COMPANY.—The term "nonbank financial company" has the same meaning as in section 102(a)(4)(C).

[(15) NONBANK FINANCIAL COMPANY SUPERVISED BY THE BOARD OF GOVERNORS.—The term "nonbank financial company supervised by the Board of Governors" has the same meaning as in section 102(a)(4)(D).

[(16) SIPC.—The term "SIPC" means the Securities Investor Protection Corporation.

[(b) DEFINITIONAL CRITERIA.—For purpose of the definition of the term "financial company" under subsection (a)(11), no company shall be deemed to be predominantly engaged in activities that the Board of Governors has determined are financial in nature or incidental thereto for purposes of section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)), if the consolidated revenues of such company from such activities constitute less than 85 percent of the total consolidated revenues of such company, as the Corporation, in consultation with the Secretary, shall establish by regulation. In determining whether a company is a financial com-

pany under this title, the consolidated revenues derived from the ownership or control of a depository institution shall be included.

[SEC. 202. JUDICIAL REVIEW.

[(a) COMMENCEMENT OF ORDERLY LIQUIDATION.—

[(1) PETITION TO DISTRICT COURT.—

[(A) DISTRICT COURT REVIEW.—

[(i) PETITION TO DISTRICT COURT.—Subsequent to a determination by the Secretary under section 203 that a financial company satisfies the criteria in section 203(b), the Secretary shall notify the Corporation and the covered financial company. If the board of directors (or body performing similar functions) of the covered financial company acquiesces or consents to the appointment of the Corporation as receiver, the Secretary shall appoint the Corporation as receiver. If the board of directors (or body performing similar functions) of the covered financial company does not acquiesce or consent to the appointment of the Corporation as receiver, the Secretary shall petition the United States District Court for the District of Columbia for an order authorizing the Secretary to appoint the Corporation as receiver.

[(ii) FORM AND CONTENT OF ORDER.—The Secretary shall present all relevant findings and the recommendation made pursuant to section 203(a) to the Court. The petition shall be filed under seal.

[(iii) DETERMINATION.—On a strictly confidential basis, and without any prior public disclosure, the Court, after notice to the covered financial company and a hearing in which the covered financial company may oppose the petition, shall determine whether the determination of the Secretary that the covered financial company is in default or in danger of default and satisfies the definition of a financial company under section 201(a)(11) is arbitrary and capricious.

[(iv) ISSUANCE OF ORDER.—If the Court determines that the determination of the Secretary that the covered financial company is in default or in danger of default and satisfies the definition of a financial company under section 201(a)(11)—

[(I) is not arbitrary and capricious, the Court shall issue an order immediately authorizing the Secretary to appoint the Corporation as receiver of the covered financial company; or

[(II) is arbitrary and capricious, the Court shall immediately provide to the Secretary a written statement of each reason supporting its determination, and afford the Secretary an immediate opportunity to amend and refile the petition under clause (i).

[(v) PETITION GRANTED BY OPERATION OF LAW.—If the Court does not make a determination within 24 hours of receipt of the petition—

[(I) the petition shall be granted by operation of law;

[(II) the Secretary shall appoint the Corporation as receiver; and

[(III) liquidation under this title shall automatically and without further notice or action be commenced and the Corporation may immediately take all actions authorized under this title.

[(B) EFFECT OF DETERMINATION.—The determination of the Court under subparagraph (A) shall be final, and shall be subject to appeal only in accordance with paragraph (2). The decision shall not be subject to any stay or injunction pending appeal. Upon conclusion of its proceedings under subparagraph (A), the Court shall provide immediately for the record a written statement of each reason supporting the decision of the Court, and shall provide copies thereof to the Secretary and the covered financial company.

[(C) CRIMINAL PENALTIES.—A person who recklessly discloses a determination of the Secretary under section 203(b) or a petition of the Secretary under subparagraph (A), or the pendency of court proceedings as provided for under subparagraph (A), shall be fined not more than 250,000, or imprisoned for not more than 5 years, or both.

[(2) APPEAL OF DECISIONS OF THE DISTRICT COURT.—

[(A) APPEAL TO COURT OF APPEALS.—

[(i) IN GENERAL.—Subject to clause (ii), the United States Court of Appeals for the District of Columbia Circuit shall have jurisdiction of an appeal of a final decision of the Court filed by the Secretary or a covered financial company, through its board of directors, notwithstanding section 210(a)(1)(A)(i), not later than 30 days after the date on which the decision of the Court is rendered or deemed rendered under this subsection.

[(ii) CONDITION OF JURISDICTION.—The Court of Appeals shall have jurisdiction of an appeal by a covered financial company only if the covered financial company did not acquiesce or consent to the appointment of a receiver by the Secretary under paragraph (1)(A).

[(iii) EXPEDITION.—The Court of Appeals shall consider any appeal under this subparagraph on an expedited basis.

[(iv) SCOPE OF REVIEW.—For an appeal taken under this subparagraph, review shall be limited to whether the determination of the Secretary that a covered financial company is in default or in danger of default and satisfies the definition of a financial company under section 201(a)(11) is arbitrary and capricious.

[(B) APPEAL TO THE SUPREME COURT.—

[(i) IN GENERAL.—A petition for a writ of certiorari to review a decision of the Court of Appeals under subparagraph (A) may be filed by the Secretary or the covered financial company, through its board of directors, notwithstanding section 210(a)(1)(A)(i), with the

Supreme Court of the United States, not later than 30 days after the date of the final decision of the Court of Appeals, and the Supreme Court shall have discretionary jurisdiction to review such decision.

[(ii) WRITTEN STATEMENT.—In the event of a petition under clause (i), the Court of Appeals shall immediately provide for the record a written statement of each reason for its decision.

[(iii) EXPEDITION.—The Supreme Court shall consider any petition under this subparagraph on an expedited basis.

[(iv) SCOPE OF REVIEW.—Review by the Supreme Court under this subparagraph shall be limited to whether the determination of the Secretary that the covered financial company is in default or in danger of default and satisfies the definition of a financial company under section 201(a)(11) is arbitrary and capricious.

[(b) ESTABLISHMENT AND TRANSMITTAL OF RULES AND PROCEDURES.—

[(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Court shall establish such rules and procedures as may be necessary to ensure the orderly conduct of proceedings, including rules and procedures to ensure that the 24-hour deadline is met and that the Secretary shall have an ongoing opportunity to amend and refile petitions under subsection (a)(1).

[(2) PUBLICATION OF RULES.—The rules and procedures established under paragraph (1), and any modifications of such rules and procedures, shall be recorded and shall be transmitted to—

[(A) the Committee on the Judiciary of the Senate;

[(B) the Committee on Banking, Housing, and Urban Affairs of the Senate;

[(C) the Committee on the Judiciary of the House of Representatives; and

[(D) the Committee on Financial Services of the House of Representatives.

[(c) PROVISIONS APPLICABLE TO FINANCIAL COMPANIES.—

[(1) BANKRUPTCY CODE.—Except as provided in this subsection, the provisions of the Bankruptcy Code and rules issued thereunder or otherwise applicable insolvency law, and not the provisions of this title, shall apply to financial companies that are not covered financial companies for which the Corporation has been appointed as receiver.

[(2) THIS TITLE.—The provisions of this title shall exclusively apply to and govern all matters relating to covered financial companies for which the Corporation is appointed as receiver, and no provisions of the Bankruptcy Code or the rules issued thereunder shall apply in such cases, except as expressly provided in this title.

[(d) TIME LIMIT ON RECEIVERSHIP AUTHORITY.—

[(1) BASELINE PERIOD.—Any appointment of the Corporation as receiver under this section shall terminate at the end of the

3-year period beginning on the date on which such appointment is made.

[(2) EXTENSION OF TIME LIMIT.—The time limit established in paragraph (1) may be extended by the Corporation for up to 1 additional year, if the Chairperson of the Corporation determines and certifies in writing to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives that continuation of the receivership is necessary—

[(A) to—

[(i) maximize the net present value return from the sale or other disposition of the assets of the covered financial company; or

[(ii) minimize the amount of loss realized upon the sale or other disposition of the assets of the covered financial company; and

[(B) to protect the stability of the financial system of the United States.

[(3) SECOND EXTENSION OF TIME LIMIT.—

[(A) IN GENERAL.—The time limit under this subsection, as extended under paragraph (2), may be extended for up to 1 additional year, if the Chairperson of the Corporation, with the concurrence of the Secretary, submits the certifications described in paragraph (2).

[(B) ADDITIONAL REPORT REQUIRED.—Not later than 30 days after the date of commencement of the extension under subparagraph (A), the Corporation shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives describing the need for the extension and the specific plan of the Corporation to conclude the receivership before the end of the second extension.

[(4) ONGOING LITIGATION.—The time limit under this subsection, as extended under paragraph (3), may be further extended solely for the purpose of completing ongoing litigation in which the Corporation as receiver is a party, provided that the appointment of the Corporation as receiver shall terminate not later than 90 days after the date of completion of such litigation, if—

[(A) the Council determines that the Corporation used its best efforts to conclude the receivership in accordance with its plan before the end of the time limit described in paragraph (3);

[(B) the Council determines that the completion of longer-term responsibilities in the form of ongoing litigation justifies the need for an extension; and

[(C) the Corporation submits a report approved by the Council not later than 30 days after the date of the determinations by the Council under subparagraphs (A) and (B) to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives, describing—

[(i) the ongoing litigation justifying the need for an extension; and

[(ii) the specific plan of the Corporation to complete the litigation and conclude the receivership.

[(5) REGULATIONS.—The Corporation may issue regulations governing the termination of receiverships under this title.

[(6) NO LIABILITY.—The Corporation and the Deposit Insurance Fund shall not be liable for unresolved claims arising from the receivership after the termination of the receivership.

[(e) STUDY OF BANKRUPTCY AND ORDERLY LIQUIDATION PROCESS FOR FINANCIAL COMPANIES.—

[(1) STUDY.—

[(A) IN GENERAL.—The Administrative Office of the United States Courts and the Comptroller General of the United States shall each monitor the activities of the Court, and each such Office shall conduct separate studies regarding the bankruptcy and orderly liquidation process for financial companies under the Bankruptcy Code.

[(B) ISSUES TO BE STUDIED.—In conducting the study under subparagraph (A), the Administrative Office of the United States Courts and the Comptroller General of the United States each shall evaluate—

[(i) the effectiveness of chapter 7 or chapter 11 of the Bankruptcy Code in facilitating the orderly liquidation or reorganization of financial companies;

[(ii) ways to maximize the efficiency and effectiveness of the Court; and

[(iii) ways to make the orderly liquidation process under the Bankruptcy Code for financial companies more effective.

[(2) REPORTS.—Not later than 1 year after the date of enactment of this Act, in each successive year until the third year, and every fifth year after that date of enactment, the Administrative Office of the United States Courts and the Comptroller General of the United States shall submit to the Committee on Banking, Housing, and Urban Affairs and the Committee on the Judiciary of the Senate and the Committee on Financial Services and the Committee on the Judiciary of the House of Representatives separate reports summarizing the results of the studies conducted under paragraph (1).

[(f) STUDY OF INTERNATIONAL COORDINATION RELATING TO BANKRUPTCY PROCESS FOR FINANCIAL COMPANIES.—

[(1) STUDY.—

[(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study regarding international coordination relating to the orderly liquidation of financial companies under the Bankruptcy Code.

[(B) ISSUES TO BE STUDIED.—In conducting the study under subparagraph (A), the Comptroller General of the United States shall evaluate, with respect to the bankruptcy process for financial companies—

[(i) the extent to which international coordination currently exists;

[(ii) current mechanisms and structures for facilitating international cooperation;

[(iii) barriers to effective international coordination; and

[(iv) ways to increase and make more effective international coordination.

[(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Banking, Housing, and Urban Affairs and the Committee on the Judiciary of the Senate and the Committee on Financial Services and the Committee on the Judiciary of the House of Representatives and the Secretary a report summarizing the results of the study conducted under paragraph (1).

[(g) STUDY OF PROMPT CORRECTIVE ACTION IMPLEMENTATION BY THE APPROPRIATE FEDERAL AGENCIES.—

[(1) STUDY.—The Comptroller General of the United States shall conduct a study regarding the implementation of prompt corrective action by the appropriate Federal banking agencies.

[(2) ISSUES TO BE STUDIED.—In conducting the study under paragraph (1), the Comptroller General shall evaluate—

[(A) the effectiveness of implementation of prompt corrective action by the appropriate Federal banking agencies and the resolution of insured depository institutions by the Corporation; and

[(B) ways to make prompt corrective action a more effective tool to resolve the insured depository institutions at the least possible long-term cost to the Deposit Insurance Fund.

[(3) REPORT TO COUNCIL.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit a report to the Council on the results of the study conducted under this subsection.

[(4) COUNCIL REPORT OF ACTION.—Not later than 6 months after the date of receipt of the report from the Comptroller General under paragraph (3), the Council shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives on actions taken in response to the report, including any recommendations made to the Federal primary financial regulatory agencies under section 120.

[SEC. 203. SYSTEMIC RISK DETERMINATION.

[(a) WRITTEN RECOMMENDATION AND DETERMINATION.—

[(1) VOTE REQUIRED.—

[(A) IN GENERAL.—On their own initiative, or at the request of the Secretary, the Corporation and the Board of Governors shall consider whether to make a written recommendation described in paragraph (2) with respect to whether the Secretary should appoint the Corporation as receiver for a financial company. Such recommendation shall be made upon a vote of not fewer than ⅔ of the members of the Board of Governors then serving and ⅔ of the members of the board of directors of the Corporation then serving.

[(B) CASES INVOLVING BROKERS OR DEALERS.—In the case of a broker or dealer, or in which the largest United States subsidiary (as measured by total assets as of the end of the previous calendar quarter) of a financial company is a broker or dealer, the Commission and the Board of Governors, at the request of the Secretary, or on their own initiative, shall consider whether to make the written recommendation described in paragraph (2) with respect to the financial company. Subject to the requirements in paragraph (2), such recommendation shall be made upon a vote of not fewer than ⅔ of the members of the Board of Governors then serving and ⅔ of the members of the Commission then serving, and in consultation with the Corporation.

[(C) CASES INVOLVING INSURANCE COMPANIES.—In the case of an insurance company, or in which the largest United States subsidiary (as measured by total assets as of the end of the previous calendar quarter) of a financial company is an insurance company, the Director of the Federal Insurance Office and the Board of Governors, at the request of the Secretary or on their own initiative, shall consider whether to make the written recommendation described in paragraph (2) with respect to the financial company. Subject to the requirements in paragraph (2), such recommendation shall be made upon a vote of not fewer than ⅔ of the Board of Governors then serving and the affirmative approval of the Director of the Federal Insurance Office, and in consultation with the Corporation.

[(2) RECOMMENDATION REQUIRED.—Any written recommendation pursuant to paragraph (1) shall contain—

[(A) an evaluation of whether the financial company is in default or in danger of default;

[(B) a description of the effect that the default of the financial company would have on financial stability in the United States;

[(C) a description of the effect that the default of the financial company would have on economic conditions or financial stability for low income, minority, or underserved communities;

[(D) a recommendation regarding the nature and the extent of actions to be taken under this title regarding the financial company;

[(E) an evaluation of the likelihood of a private sector alternative to prevent the default of the financial company;

[(F) an evaluation of why a case under the Bankruptcy Code is not appropriate for the financial company;

[(G) an evaluation of the effects on creditors, counterparties, and shareholders of the financial company and other market participants; and

[(H) an evaluation of whether the company satisfies the definition of a financial company under section 201.

[(b) DETERMINATION BY THE SECRETARY.—Notwithstanding any other provision of Federal or State law, the Secretary shall take action in accordance with section 202(a)(1)(A), if, upon the written

recommendation under subsection (a), the Secretary (in consultation with the President) determines that—

[(1) the financial company is in default or in danger of default;

[(2) the failure of the financial company and its resolution under otherwise applicable Federal or State law would have serious adverse effects on financial stability in the United States;

[(3) no viable private sector alternative is available to prevent the default of the financial company;

[(4) any effect on the claims or interests of creditors, counterparties, and shareholders of the financial company and other market participants as a result of actions to be taken under this title is appropriate, given the impact that any action taken under this title would have on financial stability in the United States;

[(5) any action under section 204 would avoid or mitigate such adverse effects, taking into consideration the effectiveness of the action in mitigating potential adverse effects on the financial system, the cost to the general fund of the Treasury, and the potential to increase excessive risk taking on the part of creditors, counterparties, and shareholders in the financial company;

[(6) a Federal regulatory agency has ordered the financial company to convert all of its convertible debt instruments that are subject to the regulatory order; and

[(7) the company satisfies the definition of a financial company under section 201.

[(c) DOCUMENTATION AND REVIEW.—

[(1) IN GENERAL.—The Secretary shall—

[(A) document any determination under subsection (b);

[(B) retain the documentation for review under paragraph (2); and

[(C) notify the covered financial company and the Corporation of such determination.

[(2) REPORT TO CONGRESS.—Not later than 24 hours after the date of appointment of the Corporation as receiver for a covered financial company, the Secretary shall provide written notice of the recommendations and determinations reached in accordance with subsections (a) and (b) to the Majority Leader and the Minority Leader of the Senate and the Speaker and the Minority Leader of the House of Representatives, the Committee on Banking, Housing, and Urban Affairs of the Senate, and the Committee on Financial Services of the House of Representatives, which shall consist of a summary of the basis for the determination, including, to the extent available at the time of the determination—

[(A) the size and financial condition of the covered financial company;

[(B) the sources of capital and credit support that were available to the covered financial company;

[(C) the operations of the covered financial company that could have had a significant impact on financial stability, markets, or both;

[(D) identification of the banks and financial companies which may be able to provide the services offered by the covered financial company;

[(E) any potential international ramifications of resolution of the covered financial company under other applicable insolvency law;

[(F) an estimate of the potential effect of the resolution of the covered financial company under other applicable insolvency law on the financial stability of the United States;

[(G) the potential effect of the appointment of a receiver by the Secretary on consumers;

[(H) the potential effect of the appointment of a receiver by the Secretary on the financial system, financial markets, and banks and other financial companies; and

[(I) whether resolution of the covered financial company under other applicable insolvency law would cause banks or other financial companies to experience severe liquidity distress.

[(3) REPORTS TO CONGRESS AND THE PUBLIC.—

[(A) IN GENERAL.—Not later than 60 days after the date of appointment of the Corporation as receiver for a covered financial company, the Corporation shall file a report with the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives—

[(i) setting forth information on the financial condition of the covered financial company as of the date of the appointment, including a description of its assets and liabilities;

[(ii) describing the plan of, and actions taken by, the Corporation to wind down the covered financial company;

[(iii) explaining each instance in which the Corporation waived any applicable requirements of part 366 of title 12, Code of Federal Regulations (or any successor thereto) with respect to conflicts of interest by any person in the private sector who was retained to provide services to the Corporation in connection with such receivership;

[(iv) describing the reasons for the provision of any funding to the receivership out of the Fund;

[(v) setting forth the expected costs of the orderly liquidation of the covered financial company;

[(vi) setting forth the identity of any claimant that is treated in a manner different from other similarly situated claimants under subsection (b)(4), (d)(4), or (h)(5)(E), the amount of any additional payment to such claimant under subsection (d)(4), and the reason for any such action; and

[(vii) which report the Corporation shall publish on an online website maintained by the Corporation, subject to maintaining appropriate confidentiality.

[(B) AMENDMENTS.—The Corporation shall, on a timely basis, not less frequently than quarterly, amend or revise

and resubmit the reports prepared under this paragraph, as necessary.

[(C) CONGRESSIONAL TESTIMONY.—The Corporation and the primary financial regulatory agency, if any, of the financial company for which the Corporation was appointed receiver under this title shall appear before Congress, if requested, not later than 30 days after the date on which the Corporation first files the reports required under subparagraph (A).

[(4) DEFAULT OR IN DANGER OF DEFAULT.—For purposes of this title, a financial company shall be considered to be in default or in danger of default if, as determined in accordance with subsection (b)—

[(A) a case has been, or likely will promptly be, commenced with respect to the financial company under the Bankruptcy Code;

[(B) the financial company has incurred, or is likely to incur, losses that will deplete all or substantially all of its capital, and there is no reasonable prospect for the company to avoid such depletion;

[(C) the assets of the financial company are, or are likely to be, less than its obligations to creditors and others; or

[(D) the financial company is, or is likely to be, unable to pay its obligations (other than those subject to a bona fide dispute) in the normal course of business.

[(5) GAO REVIEW.—The Comptroller General of the United States shall review and report to Congress on any determination under subsection (b), that results in the appointment of the Corporation as receiver, including—

[(A) the basis for the determination;

[(B) the purpose for which any action was taken pursuant thereto;

[(C) the likely effect of the determination and such action on the incentives and conduct of financial companies and their creditors, counterparties, and shareholders; and

[(D) the likely disruptive effect of the determination and such action on the reasonable expectations of creditors, counterparties, and shareholders, taking into account the impact any action under this title would have on financial stability in the United States, including whether the rights of such parties will be disrupted.

[(d) CORPORATION POLICIES AND PROCEDURES.—As soon as is practicable after the date of enactment of this Act, the Corporation shall establish policies and procedures that are acceptable to the Secretary governing the use of funds available to the Corporation to carry out this title, including the terms and conditions for the provision and use of funds under sections 204(d), 210(h)(2)(G)(iv), and 210(h)(9).

[(e) TREATMENT OF INSURANCE COMPANIES AND INSURANCE COMPANY SUBSIDIARIES.—

[(1) IN GENERAL.—Notwithstanding subsection (b), if an insurance company is a covered financial company or a subsidiary or affiliate of a covered financial company, the liquida-

tion or rehabilitation of such insurance company, and any subsidiary or affiliate of such company that is not excepted under paragraph (2), shall be conducted as provided under applicable State law.

[(2) EXCEPTION FOR SUBSIDIARIES AND AFFILIATES.—The requirement of paragraph (1) shall not apply with respect to any subsidiary or affiliate of an insurance company that is not itself an insurance company.

[(3) BACKUP AUTHORITY.—Notwithstanding paragraph (1), with respect to a covered financial company described in paragraph (1), if, after the end of the 60-day period beginning on the date on which a determination is made under section 202(a) with respect to such company, the appropriate regulatory agency has not filed the appropriate judicial action in the appropriate State court to place such company into orderly liquidation under the laws and requirements of the State, the Corporation shall have the authority to stand in the place of the appropriate regulatory agency and file the appropriate judicial action in the appropriate State court to place such company into orderly liquidation under the laws and requirements of the State.

[SEC. 204. ORDERLY LIQUIDATION OF COVERED FINANCIAL COMPANIES.

[(a) PURPOSE OF ORDERLY LIQUIDATION AUTHORITY.—It is the purpose of this title to provide the necessary authority to liquidate failing financial companies that pose a significant risk to the financial stability of the United States in a manner that mitigates such risk and minimizes moral hazard. The authority provided in this title shall be exercised in the manner that best fulfills such purpose, so that—

[(1) creditors and shareholders will bear the losses of the financial company;

[(2) management responsible for the condition of the financial company will not be retained; and

[(3) the Corporation and other appropriate agencies will take all steps necessary and appropriate to assure that all parties, including management, directors, and third parties, having responsibility for the condition of the financial company bear losses consistent with their responsibility, including actions for damages, restitution, and recoupment of compensation and other gains not compatible with such responsibility.

[(b) CORPORATION AS RECEIVER.—Upon the appointment of the Corporation under section 202, the Corporation shall act as the receiver for the covered financial company, with all of the rights and obligations set forth in this title.

[(c) CONSULTATION.—The Corporation, as receiver—

[(1) shall consult with the primary financial regulatory agency or agencies of the covered financial company and its covered subsidiaries for purposes of ensuring an orderly liquidation of the covered financial company;

[(2) may consult with, or under subsection (a)(1)(B)(v) or (a)(1)(L) of section 210, acquire the services of, any outside experts, as appropriate to inform and aid the Corporation in the orderly liquidation process;

[(3) shall consult with the primary financial regulatory agency or agencies of any subsidiaries of the covered financial company that are not covered subsidiaries, and coordinate with such regulators regarding the treatment of such solvent subsidiaries and the separate resolution of any such insolvent subsidiaries under other governmental authority, as appropriate; and

[(4) shall consult with the Commission and the Securities Investor Protection Corporation in the case of any covered financial company for which the Corporation has been appointed as receiver that is a broker or dealer registered with the Commission under section 15(b) of the Securities Exchange Act of 1934 (15 U.S.C. 78o(b)) and is a member of the Securities Investor Protection Corporation, for the purpose of determining whether to transfer to a bridge financial company organized by the Corporation as receiver, without consent of any customer, customer accounts of the covered financial company.

[(d) FUNDING FOR ORDERLY LIQUIDATION.—Upon its appointment as receiver for a covered financial company, and thereafter as the Corporation may, in its discretion, determine to be necessary or appropriate, the Corporation may make available to the receivership, subject to the conditions set forth in section 206 and subject to the plan described in section 210(n)(9), funds for the orderly liquidation of the covered financial company. All funds provided by the Corporation under this subsection shall have a priority of claims under subparagraph (A) or (B) of section 210(b)(1), as applicable, including funds used for—

[(1) making loans to, or purchasing any debt obligation of, the covered financial company or any covered subsidiary;

[(2) purchasing or guaranteeing against loss the assets of the covered financial company or any covered subsidiary, directly or through an entity established by the Corporation for such purpose;

[(3) assuming or guaranteeing the obligations of the covered financial company or any covered subsidiary to 1 or more third parties;

[(4) taking a lien on any or all assets of the covered financial company or any covered subsidiary, including a first priority lien on all unencumbered assets of the covered financial company or any covered subsidiary to secure repayment of any transactions conducted under this subsection;

[(5) selling or transferring all, or any part, of such acquired assets, liabilities, or obligations of the covered financial company or any covered subsidiary; and

[(6) making payments pursuant to subsections (b)(4), (d)(4), and (h)(5)(E) of section 210.

[SEC. 205. ORDERLY LIQUIDATION OF COVERED BROKERS AND DEALERS.

[(a) APPOINTMENT OF SIPC AS TRUSTEE.—

[(1) APPOINTMENT.—Upon the appointment of the Corporation as receiver for any covered broker or dealer, the Corporation shall appoint, without any need for court approval, the Securities Investor Protection Corporation to act as trustee for

the liquidation under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.) of the covered broker or dealer.

[(2) ACTIONS BY SIPC.—

[(A) FILING.—Upon appointment of SIPC under paragraph (1), SIPC shall promptly file with any Federal district court of competent jurisdiction specified in section 21 or 27 of the Securities Exchange Act of 1934 (15 U.S.C. 78u, 78aa), an application for a protective decree under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.) as to the covered broker or dealer. The Federal district court shall accept and approve the filing, including outside of normal business hours, and shall immediately issue the protective decree as to the covered broker or dealer.

[(B) ADMINISTRATION BY SIPC.—Following entry of the protective decree, and except as otherwise provided in this section, the determination of claims and the liquidation of assets retained in the receivership of the covered broker or dealer and not transferred to the bridge financial company shall be administered under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.) by SIPC, as trustee for the covered broker or dealer.

[(C) DEFINITION OF FILING DATE.—For purposes of the liquidation proceeding, the term "filing date" means the date on which the Corporation is appointed as receiver of the covered broker or dealer.

[(D) DETERMINATION OF CLAIMS.—As trustee for the covered broker or dealer, SIPC shall determine and satisfy, consistent with this title and with the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.), all claims against the covered broker or dealer arising on or before the filing date.

[(b) POWERS AND DUTIES OF SIPC.—

[(1) IN GENERAL.—Except as provided in this section, upon its appointment as trustee for the liquidation of a covered broker or dealer, SIPC shall have all of the powers and duties provided by the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.), including, without limitation, all rights of action against third parties, and shall conduct such liquidation in accordance with the terms of the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.), except that SIPC shall have no powers or duties with respect to assets and liabilities transferred by the Corporation from the covered broker or dealer to any bridge financial company established in accordance with this title.

[(2) LIMITATION OF POWERS.—The exercise by SIPC of powers and functions as trustee under subsection (a) shall not impair or impede the exercise of the powers and duties of the Corporation with regard to—

[(A) any action, except as otherwise provided in this title—

[(i) to make funds available under section 204(d);

[(ii) to organize, establish, operate, or terminate any bridge financial company;

[(iii) to transfer assets and liabilities;

[(iv) to enforce or repudiate contracts; or

[(v) to take any other action relating to such bridge financial company under section 210; or

[(B) determining claims under subsection (e).

[(3) PROTECTIVE DECREE.—SIPC and the Corporation, in consultation with the Commission, shall jointly determine the terms of the protective decree to be filed by SIPC with any court of competent jurisdiction under section 21 or 27 of the Securities Exchange Act of 1934 (15 U.S.C. 78u, 78aa), as required by subsection (a).

[(4) QUALIFIED FINANCIAL CONTRACTS.—Notwithstanding any provision of the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.) to the contrary (including section 5(b)(2)(C) of that Act (15 U.S.C. 78eee(b)(2)(C))), the rights and obligations of any party to a qualified financial contract (as that term is defined in section 210(c)(8)) to which a covered broker or dealer for which the Corporation has been appointed receiver is a party shall be governed exclusively by section 210, including the limitations and restrictions contained in section 210(c)(10)(B).

[(c) LIMITATION ON COURT ACTION.—Except as otherwise provided in this title, no court may take any action, including any action pursuant to the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.) or the Bankruptcy Code, to restrain or affect the exercise of powers or functions of the Corporation as receiver for a covered broker or dealer and any claims against the Corporation as such receiver shall be determined in accordance with subsection (e) and such claims shall be limited to money damages.

[(d) ACTIONS BY CORPORATION AS RECEIVER.—

[(1) IN GENERAL.—Notwithstanding any other provision of this title, no action taken by the Corporation as receiver with respect to a covered broker or dealer shall—

[(A) adversely affect the rights of a customer to customer property or customer name securities;

[(B) diminish the amount or timely payment of net equity claims of customers; or

[(C) otherwise impair the recoveries provided to a customer under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.).

[(2) NET PROCEEDS.—The net proceeds from any transfer, sale, or disposition of assets of the covered broker or dealer, or proceeds thereof by the Corporation as receiver for the covered broker or dealer shall be for the benefit of the estate of the covered broker or dealer, as provided in this title.

[(e) CLAIMS AGAINST THE CORPORATION AS RECEIVER.—Any claim against the Corporation as receiver for a covered broker or dealer for assets transferred to a bridge financial company established with respect to such covered broker or dealer—

[(1) shall be determined in accordance with section 210(a)(2); and

[(2) may be reviewed by the appropriate district or territorial court of the United States in accordance with section 210(a)(5).

[(f) SATISFACTION OF CUSTOMER CLAIMS.—

[(1) OBLIGATIONS TO CUSTOMERS.—Notwithstanding any other provision of this title, all obligations of a covered broker or dealer or of any bridge financial company established with respect to such covered broker or dealer to a customer relating to, or net equity claims based upon, customer property or customer name securities shall be promptly discharged by SIPC, the Corporation, or the bridge financial company, as applicable, by the delivery of securities or the making of payments to or for the account of such customer, in a manner and in an amount at least as beneficial to the customer as would have been the case had the actual proceeds realized from the liquidation of the covered broker or dealer under this title been distributed in a proceeding under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.) without the appointment of the Corporation as receiver and without any transfer of assets or liabilities to a bridge financial company, and with a filing date as of the date on which the Corporation is appointed as receiver.

[(2) SATISFACTION OF CLAIMS BY SIPC.—SIPC, as trustee for a covered broker or dealer, shall satisfy customer claims in the manner and amount provided under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.), as if the appointment of the Corporation as receiver had not occurred, and with a filing date as of the date on which the Corporation is appointed as receiver. The Corporation shall satisfy customer claims, to the extent that a customer would have received more securities or cash with respect to the allocation of customer property had the covered financial company been subject to a proceeding under the Securities Investor Protection Act (15 U.S.C. 78aaa et seq.) without the appointment of the Corporation as receiver, and with a filing date as of the date on which the Corporation is appointed as receiver.

[(g) PRIORITIES.—

[(1) CUSTOMER PROPERTY.—As trustee for a covered broker or dealer, SIPC shall allocate customer property and deliver customer name securities in accordance with section 8(c) of the Securities Investor Protection Act of 1970 (15 U.S.C. 78fff-2(c)).

[(2) OTHER CLAIMS.—All claims other than those described in paragraph (1) (including any unpaid claim by a customer for the allowed net equity claim of such customer from customer property) shall be paid in accordance with the priorities in section 210(b).

[(h) RULEMAKING.—The Commission and the Corporation, after consultation with SIPC, shall jointly issue rules to implement this section.

[SEC. 206. MANDATORY TERMS AND CONDITIONS FOR ALL ORDERLY LIQUIDATION ACTIONS.

[In taking action under this title, the Corporation shall—

[(1) determine that such action is necessary for purposes of the financial stability of the United States, and not for the purpose of preserving the covered financial company;

[(2) ensure that the shareholders of a covered financial company do not receive payment until after all other claims and the Fund are fully paid;

[(3) ensure that unsecured creditors bear losses in accordance with the priority of claim provisions in section 210;

[(4) ensure that management responsible for the failed condition of the covered financial company is removed (if such management has not already been removed at the time at which the Corporation is appointed receiver);

[(5) ensure that the members of the board of directors (or body performing similar functions) responsible for the failed condition of the covered financial company are removed, if such members have not already been removed at the time the Corporation is appointed as receiver; and

[(6) not take an equity interest in or become a shareholder of any covered financial company or any covered subsidiary.

[SEC. 207. DIRECTORS NOT LIABLE FOR ACQUIESCING IN APPOINTMENT OF RECEIVER.

[The members of the board of directors (or body performing similar functions) of a covered financial company shall not be liable to the shareholders or creditors thereof for acquiescing in or consenting in good faith to the appointment of the Corporation as receiver for the covered financial company under section 203.

[SEC. 208. DISMISSAL AND EXCLUSION OF OTHER ACTIONS.

[(a) IN GENERAL.—Effective as of the date of the appointment of the Corporation as receiver for the covered financial company under section 202 or the appointment of SIPC as trustee for a covered broker or dealer under section 205, as applicable, any case or proceeding commenced with respect to the covered financial company under the Bankruptcy Code or the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.) shall be dismissed, upon notice to the bankruptcy court (with respect to a case commenced under the Bankruptcy Code), and upon notice to SIPC (with respect to a covered broker or dealer) and no such case or proceeding may be commenced with respect to a covered financial company at any time while the orderly liquidation is pending.

[(b) REVESTING OF ASSETS.—Effective as of the date of appointment of the Corporation as receiver, the assets of a covered financial company shall, to the extent they have vested in any entity other than the covered financial company as a result of any case or proceeding commenced with respect to the covered financial company under the Bankruptcy Code, the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.), or any similar provision of State liquidation or insolvency law applicable to the covered financial company, revest in the covered financial company.

[(c) LIMITATION.—Notwithstanding subsections (a) and (b), any order entered or other relief granted by a bankruptcy court prior to the date of appointment of the Corporation as receiver shall continue with the same validity as if an orderly liquidation had not been commenced.

[SEC. 209. RULEMAKING; NON-CONFLICTING LAW.

[The Corporation shall, in consultation with the Council, prescribe such rules or regulations as the Corporation considers nec-

essary or appropriate to implement this title, including rules and regulations with respect to the rights, interests, and priorities of creditors, counterparties, security entitlement holders, or other persons with respect to any covered financial company or any assets or other property of or held by such covered financial company, and address the potential for conflicts of interest between or among individual receiverships established under this title or under the Federal Deposit Insurance Act. To the extent possible, the Corporation shall seek to harmonize applicable rules and regulations promulgated under this section with the insolvency laws that would otherwise apply to a covered financial company.

[SEC. 210. POWERS AND DUTIES OF THE CORPORATION.

[(a) POWERS AND AUTHORITIES.—

[(1) GENERAL POWERS.—

[(A) SUCCESSOR TO COVERED FINANCIAL COMPANY.—The Corporation shall, upon appointment as receiver for a covered financial company under this title, succeed to—

[(i) all rights, titles, powers, and privileges of the covered financial company and its assets, and of any stockholder, member, officer, or director of such company; and

[(ii) title to the books, records, and assets of any previous receiver or other legal custodian of such covered financial company.

[(B) OPERATION OF THE COVERED FINANCIAL COMPANY DURING THE PERIOD OF ORDERLY LIQUIDATION.—The Corporation, as receiver for a covered financial company, may—

[(i) take over the assets of and operate the covered financial company with all of the powers of the members or shareholders, the directors, and the officers of the covered financial company, and conduct all business of the covered financial company;

[(ii) collect all obligations and money owed to the covered financial company;

[(iii) perform all functions of the covered financial company, in the name of the covered financial company;

[(iv) manage the assets and property of the covered financial company, consistent with maximization of the value of the assets in the context of the orderly liquidation; and

[(v) provide by contract for assistance in fulfilling any function, activity, action, or duty of the Corporation as receiver.

[(C) FUNCTIONS OF COVERED FINANCIAL COMPANY OFFICERS, DIRECTORS, AND SHAREHOLDERS.—The Corporation may provide for the exercise of any function by any member or stockholder, director, or officer of any covered financial company for which the Corporation has been appointed as receiver under this title.

[(D) ADDITIONAL POWERS AS RECEIVER.—The Corporation shall, as receiver for a covered financial company, and subject to all legally enforceable and perfected security in-

terests and all legally enforceable security entitlements in respect of assets held by the covered financial company, liquidate, and wind-up the affairs of a covered financial company, including taking steps to realize upon the assets of the covered financial company, in such manner as the Corporation deems appropriate, including through the sale of assets, the transfer of assets to a bridge financial company established under subsection (h), or the exercise of any other rights or privileges granted to the receiver under this section.

[(E) ADDITIONAL POWERS WITH RESPECT TO FAILING SUBSIDIARIES OF A COVERED FINANCIAL COMPANY.—

[(i) IN GENERAL.—In any case in which a receiver is appointed for a covered financial company under section 202, the Corporation may appoint itself as receiver of any covered subsidiary of the covered financial company that is organized under Federal law or the laws of any State, if the Corporation and the Secretary jointly determine that—

[(I) the covered subsidiary is in default or in danger of default;

[(II) such action would avoid or mitigate serious adverse effects on the financial stability or economic conditions of the United States; and

[(III) such action would facilitate the orderly liquidation of the covered financial company.

[(ii) TREATMENT AS COVERED FINANCIAL COMPANY.—If the Corporation is appointed as receiver of a covered subsidiary of a covered financial company under clause (i), the covered subsidiary shall thereafter be considered a covered financial company under this title, and the Corporation shall thereafter have all the powers and rights with respect to that covered subsidiary as it has with respect to a covered financial company under this title.

[(F) ORGANIZATION OF BRIDGE COMPANIES.—The Corporation, as receiver for a covered financial company, may organize a bridge financial company under subsection (h).

[(G) MERGER; TRANSFER OF ASSETS AND LIABILITIES.—

[(i) IN GENERAL.—Subject to clauses (ii) and (iii), the Corporation, as receiver for a covered financial company, may—

[(I) merge the covered financial company with another company; or

[(II) transfer any asset or liability of the covered financial company (including any assets and liabilities held by the covered financial company for security entitlement holders, any customer property, or any assets and liabilities associated with any trust or custody business) without obtaining any approval, assignment, or consent with respect to such transfer.

[(ii) FEDERAL AGENCY APPROVAL; ANTITRUST REVIEW.—With respect to a transaction described in

clause (i)(I) that requires approval by a Federal agency—

[(I) the transaction may not be consummated before the 5th calendar day after the date of approval by the Federal agency responsible for such approval;

[(II) if, in connection with any such approval, a report on competitive factors is required, the Federal agency responsible for such approval shall promptly notify the Attorney General of the United States of the proposed transaction, and the Attorney General shall provide the required report not later than 10 days after the date of the request; and

[(III) if notification under section 7A of the Clayton Act is required with respect to such transaction, then the required waiting period shall end on the 15th day after the date on which the Attorney General and the Federal Trade Commission receive such notification, unless the waiting period is terminated earlier under subsection (b)(2) of such section 7A, or is extended pursuant to subsection (e)(2) of such section 7A.

[(iii) SETOFF.—Subject to the other provisions of this title, any transferee of assets from a receiver, including a bridge financial company, shall be subject to such claims or rights as would prevail over the rights of such transferee in such assets under applicable noninsolvency law.

[(H) PAYMENT OF VALID OBLIGATIONS.—The Corporation, as receiver for a covered financial company, shall, to the extent that funds are available, pay all valid obligations of the covered financial company that are due and payable at the time of the appointment of the Corporation as receiver, in accordance with the prescriptions and limitations of this title.

[(I) APPLICABLE NONINSOLVENCY LAW.—Except as may otherwise be provided in this title, the applicable noninsolvency law shall be determined by the noninsolvency choice of law rules otherwise applicable to the claims, rights, titles, persons, or entities at issue.

[(J) SUBPOENA AUTHORITY.—

[(i) IN GENERAL.—The Corporation, as receiver for a covered financial company, may, for purposes of carrying out any power, authority, or duty with respect to the covered financial company (including determining any claim against the covered financial company and determining and realizing upon any asset of any person in the course of collecting money due the covered financial company), exercise any power established under section 8(n) of the Federal Deposit Insurance Act, as if the Corporation were the appropriate Federal banking agency for the covered financial com-

pany, and the covered financial company were an insured depository institution.

[(ii) RULE OF CONSTRUCTION.—This subparagraph may not be construed as limiting any rights that the Corporation, in any capacity, might otherwise have to exercise any powers described in clause (i) or under any other provision of law.

[(K) INCIDENTAL POWERS.—The Corporation, as receiver for a covered financial company, may exercise all powers and authorities specifically granted to receivers under this title, and such incidental powers as shall be necessary to carry out such powers under this title.

[(L) UTILIZATION OF PRIVATE SECTOR.—In carrying out its responsibilities in the management and disposition of assets from the covered financial company, the Corporation, as receiver for a covered financial company, may utilize the services of private persons, including real estate and loan portfolio asset management, property management, auction marketing, legal, and brokerage services, if such services are available in the private sector, and the Corporation determines that utilization of such services is practicable, efficient, and cost effective.

[(M) SHAREHOLDERS AND CREDITORS OF COVERED FINANCIAL COMPANY.—Notwithstanding any other provision of law, the Corporation, as receiver for a covered financial company, shall succeed by operation of law to the rights, titles, powers, and privileges described in subparagraph (A), and shall terminate all rights and claims that the stockholders and creditors of the covered financial company may have against the assets of the covered financial company or the Corporation arising out of their status as stockholders or creditors, except for their right to payment, resolution, or other satisfaction of their claims, as permitted under this section. The Corporation shall ensure that shareholders and unsecured creditors bear losses, consistent with the priority of claims provisions under this section.

[(N) COORDINATION WITH FOREIGN FINANCIAL AUTHORITIES.—The Corporation, as receiver for a covered financial company, shall coordinate, to the maximum extent possible, with the appropriate foreign financial authorities regarding the orderly liquidation of any covered financial company that has assets or operations in a country other than the United States.

[(O) RESTRICTION ON TRANSFERS.—

[(i) SELECTION OF ACCOUNTS FOR TRANSFER.—If the Corporation establishes one or more bridge financial companies with respect to a covered broker or dealer, the Corporation shall transfer to one of such bridge financial companies, all customer accounts of the covered broker or dealer, and all associated customer name securities and customer property, unless the Corporation, after consulting with the Commission and SIPC, determines that—

[(I) the customer accounts, customer name securities, and customer property are likely to be promptly transferred to another broker or dealer that is registered with the Commission under section 15(b) of the Securities Exchange Act of 1934 (15 U.S.C. 73o(b)) and is a member of SIPC; or

[(II) the transfer of the accounts to a bridge financial company would materially interfere with the ability of the Corporation to avoid or mitigate serious adverse effects on financial stability or economic conditions in the United States.

[(ii) TRANSFER OF PROPERTY.—SIPC, as trustee for the liquidation of the covered broker or dealer, and the Commission shall provide any and all reasonable assistance necessary to complete such transfers by the Corporation.

[(iii) CUSTOMER CONSENT AND COURT APPROVAL NOT REQUIRED.—Neither customer consent nor court approval shall be required to transfer any customer accounts or associated customer name securities or customer property to a bridge financial company in accordance with this section.

[(iv) NOTIFICATION OF SIPC AND SHARING OF INFORMATION.—The Corporation shall identify to SIPC the customer accounts and associated customer name securities and customer property transferred to the bridge financial company. The Corporation and SIPC shall cooperate in the sharing of any information necessary for each entity to discharge its obligations under this title and under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.) including by providing access to the books and records of the covered financial company and any bridge financial company established in accordance with this title.

[(2) DETERMINATION OF CLAIMS.—

[(A) IN GENERAL.—The Corporation, as receiver for a covered financial company, shall report on claims, as set forth in section 203(c)(3). Subject to paragraph (4) of this subsection, the Corporation, as receiver for a covered financial company, shall determine claims in accordance with the requirements of this subsection and regulations prescribed under section 209.

[(B) NOTICE REQUIREMENTS.—The Corporation, as receiver for a covered financial company, in any case involving the liquidation or winding up of the affairs of a covered financial company, shall—

[(i) promptly publish a notice to the creditors of the covered financial company to present their claims, together with proof, to the receiver by a date specified in the notice, which shall be not earlier than 90 days after the date of publication of such notice; and

[(ii) republish such notice 1 month and 2 months, respectively, after the date of publication under clause (i).

[(C) MAILING REQUIRED.—The Corporation as receiver shall mail a notice similar to the notice published under clause (i) or (ii) of subparagraph (B), at the time of such publication, to any creditor shown on the books and records of the covered financial company—

[(i) at the last address of the creditor appearing in such books;

[(ii) in any claim filed by the claimant; or

[(iii) upon discovery of the name and address of a claimant not appearing on the books and records of the covered financial company, not later than 30 days after the date of the discovery of such name and address.

[(3) PROCEDURES FOR RESOLUTION OF CLAIMS.—

[(A) DECISION PERIOD.—

[(i) IN GENERAL.—Prior to the 180th day after the date on which a claim against a covered financial company is filed with the Corporation as receiver, or such later date as may be agreed as provided in clause (ii), the Corporation shall notify the claimant whether it allows or disallows the claim, in accordance with subparagraphs (B), (C), and (D).

[(ii) EXTENSION OF TIME.—By written agreement executed not later than 180 days after the date on which a claim against a covered financial company is filed with the Corporation, the period described in clause (i) may be extended by written agreement between the claimant and the Corporation. Failure to notify the claimant of any disallowance within the time period set forth in clause (i), as it may be extended by agreement under this clause, shall be deemed to be a disallowance of such claim, and the claimant may file or continue an action in court, as provided in paragraph (4).

[(iii) MAILING OF NOTICE SUFFICIENT.—The requirements of clause (i) shall be deemed to be satisfied if the notice of any decision with respect to any claim is mailed to the last address of the claimant which appears—

[(I) on the books, records, or both of the covered financial company;

[(II) in the claim filed by the claimant; or

[(III) in documents submitted in proof of the claim.

[(iv) CONTENTS OF NOTICE OF DISALLOWANCE.—If the Corporation as receiver disallows any claim filed under clause (i), the notice to the claimant shall contain—

[(I) a statement of each reason for the disallowance; and

[(II) the procedures required to file or continue an action in court, as provided in paragraph (4).

[(B) ALLOWANCE OF PROVEN CLAIM.—The receiver shall allow any claim received by the receiver on or before the

date specified in the notice under paragraph (2)(B)(i), which is proved to the satisfaction of the receiver.

[(C) DISALLOWANCE OF CLAIMS FILED AFTER END OF FILING PERIOD.—

[(i) IN GENERAL.—Except as provided in clause (ii), claims filed after the date specified in the notice published under paragraph (2)(B)(i) shall be disallowed, and such disallowance shall be final.

[(ii) CERTAIN EXCEPTIONS.—Clause (i) shall not apply with respect to any claim filed by a claimant after the date specified in the notice published under paragraph (2)(B)(i), and such claim may be considered by the receiver under subparagraph (B), if—

[(I) the claimant did not receive notice of the appointment of the receiver in time to file such claim before such date; and

[(II) such claim is filed in time to permit payment of such claim.

[(D) AUTHORITY TO DISALLOW CLAIMS.—

[(i) IN GENERAL.—The Corporation may disallow any portion of any claim by a creditor or claim of a security, preference, setoff, or priority which is not proved to the satisfaction of the Corporation.

[(ii) PAYMENTS TO UNDERSECURED CREDITORS.—In the case of a claim against a covered financial company that is secured by any property or other asset of such covered financial company, the receiver—

[(I) may treat the portion of such claim which exceeds an amount equal to the fair market value of such property or other asset as an unsecured claim; and

[(II) may not make any payment with respect to such unsecured portion of the claim, other than in connection with the disposition of all claims of unsecured creditors of the covered financial company.

[(iii) EXCEPTIONS.—No provision of this paragraph shall apply with respect to—

[(I) any extension of credit from any Federal reserve bank, or the Corporation, to any covered financial company; or

[(II) subject to clause (ii), any legally enforceable and perfected security interest in the assets of the covered financial company securing any such extension of credit.

[(E) LEGAL EFFECT OF FILING.—

[(i) STATUTE OF LIMITATIONS TOLLED.—For purposes of any applicable statute of limitations, the filing of a claim with the receiver shall constitute a commencement of an action.

[(ii) NO PREJUDICE TO OTHER ACTIONS.—Subject to paragraph (8), the filing of a claim with the receiver shall not prejudice any right of the claimant to continue any action which was filed before the date of ap-

pointment of the receiver for the covered financial company.

[(4) JUDICIAL DETERMINATION OF CLAIMS.—

[(A) IN GENERAL.—Subject to subparagraph (B), a claimant may file suit on a claim (or continue an action commenced before the date of appointment of the Corporation as receiver) in the district or territorial court of the United States for the district within which the principal place of business of the covered financial company is located (and such court shall have jurisdiction to hear such claim).

[(B) TIMING.—A claim under subparagraph (A) may be filed before the end of the 60-day period beginning on the earlier of—

[(i) the end of the period described in paragraph (3)(A)(i) (or, if extended by agreement of the Corporation and the claimant, the period described in paragraph (3)(A)(ii)) with respect to any claim against a covered financial company for which the Corporation is receiver; or

[(ii) the date of any notice of disallowance of such claim pursuant to paragraph (3)(A)(i).

[(C) STATUTE OF LIMITATIONS.—If any claimant fails to file suit on such claim (or to continue an action on such claim commenced before the date of appointment of the Corporation as receiver) prior to the end of the 60-day period described in subparagraph (B), the claim shall be deemed to be disallowed (other than any portion of such claim which was allowed by the receiver) as of the end of such period, such disallowance shall be final, and the claimant shall have no further rights or remedies with respect to such claim.

[(5) EXPEDITED DETERMINATION OF CLAIMS.—

[(A) PROCEDURE REQUIRED.—The Corporation shall establish a procedure for expedited relief outside of the claims process established under paragraph (3), for any claimant that alleges—

[(i) having a legally valid and enforceable or perfected security interest in property of a covered financial company or control of any legally valid and enforceable security entitlement in respect of any asset held by the covered financial company for which the Corporation has been appointed receiver; and

[(ii) that irreparable injury will occur if the claims procedure established under paragraph (3) is followed.

[(B) DETERMINATION PERIOD.—Prior to the end of the 90-day period beginning on the date on which a claim is filed in accordance with the procedures established pursuant to subparagraph (A), the Corporation shall—

[(i) determine—

[(I) whether to allow or disallow such claim, or any portion thereof; or

[(II) whether such claim should be determined pursuant to the procedures established pursuant to paragraph (3);

[(ii) notify the claimant of the determination; and

[(iii) if the claim is disallowed, provide a statement of each reason for the disallowance and the procedure for obtaining a judicial determination.

[(C) PERIOD FOR FILING OR RENEWING SUIT.—Any claimant who files a request for expedited relief shall be permitted to file suit (or continue a suit filed before the date of appointment of the Corporation as receiver seeking a determination of the rights of the claimant with respect to such security interest (or such security entitlement) after the earlier of—

[(i) the end of the 90-day period beginning on the date of the filing of a request for expedited relief; or

[(ii) the date on which the Corporation denies the claim or a portion thereof.

[(D) STATUTE OF LIMITATIONS.—If an action described in subparagraph (C) is not filed, or the motion to renew a previously filed suit is not made, before the end of the 30-day period beginning on the date on which such action or motion may be filed in accordance with subparagraph (C), the claim shall be deemed to be disallowed as of the end of such period (other than any portion of such claim which was allowed by the receiver), such disallowance shall be final, and the claimant shall have no further rights or remedies with respect to such claim.

[(E) LEGAL EFFECT OF FILING.—

[(i) STATUTE OF LIMITATIONS TOLLED.—For purposes of any applicable statute of limitations, the filing of a claim with the receiver shall constitute a commencement of an action.

[(ii) NO PREJUDICE TO OTHER ACTIONS.—Subject to paragraph (8), the filing of a claim with the receiver shall not prejudice any right of the claimant to continue any action which was filed before the appointment of the Corporation as receiver for the covered financial company.

[(6) AGREEMENTS AGAINST INTEREST OF THE RECEIVER.—No agreement that tends to diminish or defeat the interest of the Corporation as receiver in any asset acquired by the receiver under this section shall be valid against the receiver, unless such agreement—

[(A) is in writing;

[(B) was executed by an authorized officer or representative of the covered financial company, or confirmed in the ordinary course of business by the covered financial company; and

[(C) has been, since the time of its execution, an official record of the company or the party claiming under the agreement provides documentation, acceptable to the receiver, of such agreement and its authorized execution or confirmation by the covered financial company.

[(7) PAYMENT OF CLAIMS.—

[(A) IN GENERAL.—Subject to subparagraph (B), the Corporation as receiver may, in its discretion and to the ex-

tent that funds are available, pay creditor claims, in such manner and amounts as are authorized under this section, which are—

[(i) allowed by the receiver;

[(ii) approved by the receiver pursuant to a final determination pursuant to paragraph (3) or (5), as applicable; or

[(iii) determined by the final judgment of a court of competent jurisdiction.

[(B) LIMITATION.—A creditor shall, in no event, receive less than the amount that the creditor is entitled to receive under paragraphs (2) and (3) of subsection (d), as applicable.

[(C) PAYMENT OF DIVIDENDS ON CLAIMS.—The Corporation as receiver may, in its sole discretion, and to the extent otherwise permitted by this section, pay dividends on proven claims at any time, and no liability shall attach to the Corporation as receiver, by reason of any such payment or for failure to pay dividends to a claimant whose claim is not proved at the time of any such payment.

[(D) RULEMAKING BY THE CORPORATION.—The Corporation may prescribe such rules, including definitions of terms, as the Corporation deems appropriate to establish an interest rate for or to make payments of post-insolvency interest to creditors holding proven claims against the receivership estate of a covered financial company, except that no such interest shall be paid until the Corporation as receiver has satisfied the principal amount of all creditor claims.

[(8) SUSPENSION OF LEGAL ACTIONS.—

[(A) IN GENERAL.—After the appointment of the Corporation as receiver for a covered financial company, the Corporation may request a stay in any judicial action or proceeding in which such covered financial company is or becomes a party, for a period of not to exceed 90 days.

[(B) GRANT OF STAY BY ALL COURTS REQUIRED.—Upon receipt of a request by the Corporation pursuant to subparagraph (A), the court shall grant such stay as to all parties.

[(9) ADDITIONAL RIGHTS AND DUTIES.—

[(A) PRIOR FINAL ADJUDICATION.—The Corporation shall abide by any final, non-appealable judgment of any court of competent jurisdiction that was rendered before the appointment of the Corporation as receiver.

[(B) RIGHTS AND REMEDIES OF RECEIVER.—In the event of any appealable judgment, the Corporation as receiver shall—

[(i) have all the rights and remedies available to the covered financial company (before the date of appointment of the Corporation as receiver under section 202) and the Corporation, including removal to Federal court and all appellate rights; and

[(ii) not be required to post any bond in order to pursue such remedies.

[(C) NO ATTACHMENT OR EXECUTION.—No attachment or execution may be issued by any court upon assets in the possession of the Corporation as receiver for a covered financial company.

[(D) LIMITATION ON JUDICIAL REVIEW.—Except as otherwise provided in this title, no court shall have jurisdiction over—

[(i) any claim or action for payment from, or any action seeking a determination of rights with respect to, the assets of any covered financial company for which the Corporation has been appointed receiver, including any assets which the Corporation may acquire from itself as such receiver; or

[(ii) any claim relating to any act or omission of such covered financial company or the Corporation as receiver.

[(E) DISPOSITION OF ASSETS.—In exercising any right, power, privilege, or authority as receiver in connection with any covered financial company for which the Corporation is acting as receiver under this section, the Corporation shall, to the greatest extent practicable, conduct its operations in a manner that—

[(i) maximizes the net present value return from the sale or disposition of such assets;

[(ii) minimizes the amount of any loss realized in the resolution of cases;

[(iii) mitigates the potential for serious adverse effects to the financial system;

[(iv) ensures timely and adequate competition and fair and consistent treatment of offerors; and

[(v) prohibits discrimination on the basis of race, sex, or ethnic group in the solicitation and consideration of offers.

[(10) STATUTE OF LIMITATIONS FOR ACTIONS BROUGHT BY RECEIVER.—

[(A) IN GENERAL.—Notwithstanding any provision of any contract, the applicable statute of limitations with regard to any action brought by the Corporation as receiver for a covered financial company shall be—

[(i) in the case of any contract claim, the longer of—

[(I) the 6-year period beginning on the date on which the claim accrues; or

[(II) the period applicable under State law; and

[(ii) in the case of any tort claim, the longer of—

[(I) the 3-year period beginning on the date on which the claim accrues; or

[(II) the period applicable under State law.

[(B) DATE ON WHICH A CLAIM ACCRUES.—For purposes of subparagraph (A), the date on which the statute of limitations begins to run on any claim described in subparagraph (A) shall be the later of—

[(i) the date of the appointment of the Corporation as receiver under this title; or

[(ii) the date on which the cause of action accrues.

[(C) REVIVAL OF EXPIRED STATE CAUSES OF ACTION.—

[(i) IN GENERAL.—In the case of any tort claim described in clause (ii) for which the applicable statute of limitations under State law has expired not more than 5 years before the date of appointment of the Corporation as receiver for a covered financial company, the Corporation may bring an action as receiver on such claim without regard to the expiration of the statute of limitations.

[(ii) CLAIMS DESCRIBED.—A tort claim referred to in clause (i) is a claim arising from fraud, intentional misconduct resulting in unjust enrichment, or intentional misconduct resulting in substantial loss to the covered financial company.

[(11) AVOIDABLE TRANSFERS.—

[(A) FRAUDULENT TRANSFERS.—The Corporation, as receiver for any covered financial company, may avoid a transfer of any interest of the covered financial company in property, or any obligation incurred by the covered financial company, that was made or incurred at or within 2 years before the date on which the Corporation was appointed receiver, if—

[(i) the covered financial company voluntarily or involuntarily—

[(I) made such transfer or incurred such obligation with actual intent to hinder, delay, or defraud any entity to which the covered financial company was or became, on or after the date on which such transfer was made or such obligation was incurred, indebted; or

[(II) received less than a reasonably equivalent value in exchange for such transferor obligation; and

[(ii) the covered financial company voluntarily or involuntarily—

[(I) was insolvent on the date that such transfer was made or such obligation was incurred, or became insolvent as a result of such transfer or obligation;

[(II) was engaged in business or a transaction, or was about to engage in business or a transaction, for which any property remaining with the covered financial company was an unreasonably small capital;

[(III) intended to incur, or believed that the covered financial company would incur, debts that would be beyond the ability of the covered financial company to pay as such debts matured; or

[(IV) made such transfer to or for the benefit of an insider, or incurred such obligation to or for the benefit of an insider, under an employment contract and not in the ordinary course of business.

[(B) PREFERENTIAL TRANSFERS.—The Corporation as receiver for any covered financial company may avoid a transfer of an interest of the covered financial company in property—

[(i) to or for the benefit of a creditor;

[(ii) for or on account of an antecedent debt that was owed by the covered financial company before the transfer was made;

[(iii) that was made while the covered financial company was insolvent;

[(iv) that was made—

[(I) 90 days or less before the date on which the Corporation was appointed receiver; or

[(II) more than 90 days, but less than 1 year before the date on which the Corporation was appointed receiver, if such creditor at the time of the transfer was an insider; and

[(v) that enables the creditor to receive more than the creditor would receive if—

[(I) the covered financial company had been liquidated under chapter 7 of the Bankruptcy Code;

[(II) the transfer had not been made; and

[(III) the creditor received payment of such debt to the extent provided by the provisions of chapter 7 of the Bankruptcy Code.

[(C) POST-RECEIVERSHIP TRANSACTIONS.—The Corporation as receiver for any covered financial company may avoid a transfer of property of the receivership that occurred after the Corporation was appointed receiver that was not authorized under this title by the Corporation as receiver.

[(D) RIGHT OF RECOVERY.—To the extent that a transfer is avoided under subparagraph (A), (B), or (C), the Corporation may recover, for the benefit of the covered financial company, the property transferred or, if a court so orders, the value of such property (at the time of such transfer) from—

[(i) the initial transferee of such transfer or the person for whose benefit such transfer was made; or

[(ii) any immediate or mediate transferee of any such initial transferee.

[(E) RIGHTS OF TRANSFEREE OR OBLIGEE.—The Corporation may not recover under subparagraph (D)(ii) from—

[(i) any transferee that takes for value, including in satisfaction of or to secure a present or antecedent debt, in good faith, and without knowledge of the voidability of the transfer avoided; or

[(ii) any immediate or mediate good faith transferee of such transferee.

[(F) DEFENSES.—Subject to the other provisions of this title—

[(i) a transferee or obligee from which the Corporation seeks to recover a transfer or to avoid an obligation under subparagraph (A), (B), (C), or (D) shall

have the same defenses available to a transferee or obligee from which a trustee seeks to recover a transfer or avoid an obligation under sections 547, 548, and 549 of the Bankruptcy Code; and

[(ii) the authority of the Corporation to recover a transfer or avoid an obligation shall be subject to subsections (b) and (c) of section 546, section 547(c), and section 548(c) of the Bankruptcy Code.

[(G) RIGHTS UNDER THIS SECTION.—The rights of the Corporation as receiver under this section shall be superior to any rights of a trustee or any other party (other than a Federal agency) under the Bankruptcy Code.

[(H) RULES OF CONSTRUCTION; DEFINITIONS.—For purposes of—

[(i) subparagraphs (A) and (B)—

[(I) the term "insider" has the same meaning as in section 101(31) of the Bankruptcy Code;

[(II) a transfer is made when such transfer is so perfected that a bona fide purchaser from the covered financial company against whom applicable law permits such transfer to be perfected cannot acquire an interest in the property transferred that is superior to the interest in such property of the transferee, but if such transfer is not so perfected before the date on which the Corporation is appointed as receiver for the covered financial company, such transfer is made immediately before the date of such appointment; and

[(III) the term "value" means property, or satisfaction or securing of a present or antecedent debt of the covered financial company, but does not include an unperformed promise to furnish support to the covered financial company; and

[(ii) subparagraph (B)—

[(I) the covered financial company is presumed to have been insolvent on and during the 90-day period immediately preceding the date of appointment of the Corporation as receiver; and

[(II) the term "insolvent" has the same meaning as in section 101(32) of the Bankruptcy Code.

[(12) SETOFF.—

[(A) GENERALLY.—Except as otherwise provided in this title, any right of a creditor to offset a mutual debt owed by the creditor to any covered financial company that arose before the Corporation was appointed as receiver for the covered financial company against a claim of such creditor may be asserted if enforceable under applicable noninsolvency law, except to the extent that—

[(i) the claim of the creditor against the covered financial company is disallowed;

[(ii) the claim was transferred, by an entity other than the covered financial company, to the creditor—

[(I) after the Corporation was appointed as receiver of the covered financial company; or

[(II)(aa) after the 90-day period preceding the date on which the Corporation was appointed as receiver for the covered financial company; and

[(bb) while the covered financial company was insolvent (except for a setoff in connection with a qualified financial contract); or

[(iii) the debt owed to the covered financial company was incurred by the covered financial company—

[(I) after the 90-day period preceding the date on which the Corporation was appointed as receiver for the covered financial company;

[(II) while the covered financial company was insolvent; and

[(III) for the purpose of obtaining a right of setoff against the covered financial company (except for a setoff in connection with a qualified financial contract).

[(B) INSUFFICIENCY.—

[(i) IN GENERAL.—Except with respect to a setoff in connection with a qualified financial contract, if a creditor offsets a mutual debt owed to the covered financial company against a claim of the covered financial company on or within the 90-day period preceding the date on which the Corporation is appointed as receiver for the covered financial company, the Corporation may recover from the creditor the amount so offset, to the extent that any insufficiency on the date of such setoff is less than the insufficiency on the later of—

[(I) the date that is 90 days before the date on which the Corporation is appointed as receiver for the covered financial company; or

[(II) the first day on which there is an insufficiency during the 90-day period preceding the date on which the Corporation is appointed as receiver for the covered financial company.

[(ii) DEFINITION OF INSUFFICIENCY.—In this subparagraph, the term "insufficiency" means the amount, if any, by which a claim against the covered financial company exceeds a mutual debt owed to the covered financial company by the holder of such claim.

[(C) INSOLVENCY.—The term "insolvent" has the same meaning as in section 101(32) of the Bankruptcy Code.

[(D) PRESUMPTION OF INSOLVENCY.—For purposes of this paragraph, the covered financial company is presumed to have been insolvent on and during the 90-day period preceding the date of appointment of the Corporation as receiver.

[(E) LIMITATION.—Nothing in this paragraph (12) shall be the basis for any right of setoff where no such right exists under applicable noninsolvency law.

[(F) PRIORITY CLAIM.—Except as otherwise provided in this title, the Corporation as receiver for the covered financial company may sell or transfer any assets free and clear

of the setoff rights of any party, except that such party shall be entitled to a claim, subordinate to the claims payable under subparagraphs (A), (B), (C), and (D) of subsection (b)(1), but senior to all other unsecured liabilities defined in subsection (b)(1)(E), in an amount equal to the value of such setoff rights.

[(13) ATTACHMENT OF ASSETS AND OTHER INJUNCTIVE RELIEF.—Subject to paragraph (14), any court of competent jurisdiction may, at the request of the Corporation as receiver for a covered financial company, issue an order in accordance with Rule 65 of the Federal Rules of Civil Procedure, including an order placing the assets of any person designated by the Corporation under the control of the court and appointing a trustee to hold such assets.

[(14) STANDARDS.—

[(A) SHOWING.—Rule 65 of the Federal Rules of Civil Procedure shall apply with respect to any proceeding under paragraph (13), without regard to the requirement that the applicant show that the injury, loss, or damage is irreparable and immediate.

[(B) STATE PROCEEDING.—If, in the case of any proceeding in a State court, the court determines that rules of civil procedure available under the laws of the State provide substantially similar protections of the right of the parties to due process as provided under Rule 65 (as modified with respect to such proceeding by subparagraph (A)), the relief sought by the Corporation pursuant to paragraph (14) may be requested under the laws of such State.

[(15) TREATMENT OF CLAIMS ARISING FROM BREACH OF CONTRACTS EXECUTED BY THE CORPORATION AS RECEIVER.—Notwithstanding any other provision of this title, any final and non-appealable judgment for monetary damages entered against the Corporation as receiver for a covered financial company for the breach of an agreement executed or approved by the Corporation after the date of its appointment shall be paid as an administrative expense of the receiver. Nothing in this paragraph shall be construed to limit the power of a receiver to exercise any rights under contract or law, including to terminate, breach, cancel, or otherwise discontinue such agreement.

[(16) ACCOUNTING AND RECORDKEEPING REQUIREMENTS.—

[(A) IN GENERAL.—The Corporation as receiver for a covered financial company shall, consistent with the accounting and reporting practices and procedures established by the Corporation, maintain a full accounting of each receivership or other disposition of any covered financial company.

[(B) ANNUAL ACCOUNTING OR REPORT.—With respect to each receivership to which the Corporation is appointed, the Corporation shall make an annual accounting or report, as appropriate, available to the Secretary and the Comptroller General of the United States.

[(C) AVAILABILITY OF REPORTS.—Any report prepared pursuant to subparagraph (B) and section 203(c)(3) shall be made available to the public by the Corporation.

[(D) RECORDKEEPING REQUIREMENT.—

[(i) IN GENERAL.—The Corporation shall prescribe such regulations and establish such retention schedules as are necessary to maintain the documents and records of the Corporation generated in exercising the authorities of this title and the records of a covered financial company for which the Corporation is appointed receiver, with due regard for—

[(I) the avoidance of duplicative record retention; and

[(II) the expected evidentiary needs of the Corporation as receiver for a covered financial company and the public regarding the records of covered financial companies.

[(ii) RETENTION OF RECORDS.—Unless otherwise required by applicable Federal law or court order, the Corporation may not, at any time, destroy any records that are subject to clause (i).

[(iii) RECORDS DEFINED.—As used in this subparagraph, the terms "records" and "records of a covered financial company" mean any document, book, paper, map, photograph, microfiche, microfilm, computer or electronically-created record generated or maintained by the covered financial company in the course of and necessary to its transaction of business.

[(b) PRIORITY OF EXPENSES AND UNSECURED CLAIMS.—

[(1) IN GENERAL.—Unsecured claims against a covered financial company, or the Corporation as receiver for such covered financial company under this section, that are proven to the satisfaction of the receiver shall have priority in the following order:

[(A) Administrative expenses of the receiver.

[(B) Any amounts owed to the United States, unless the United States agrees or consents otherwise.

[(C) Wages, salaries, or commissions, including vacation, severance, and sick leave pay earned by an individual (other than an individual described in subparagraph (G)), but only to the extent of 11,725 for each individual (as indexed for inflation, by regulation of the Corporation) earned not later than 180 days before the date of appointment of the Corporation as receiver.

[(D) Contributions owed to employee benefit plans arising from services rendered not later than 180 days before the date of appointment of the Corporation as receiver, to the extent of the number of employees covered by each such plan, multiplied by 11,725 (as indexed for inflation, by regulation of the Corporation), less the aggregate amount paid to such employees under subparagraph (C), plus the aggregate amount paid by the receivership on behalf of such employees to any other employee benefit plan.

[(E) Any other general or senior liability of the covered financial company (which is not a liability described under subparagraph (F), (G), or (H)).

[(F) Any obligation subordinated to general creditors (which is not an obligation described under subparagraph (G) or (H)).

[(G) Any wages, salaries, or commissions, including vacation, severance, and sick leave pay earned, owed to senior executives and directors of the covered financial company.

[(H) Any obligation to shareholders, members, general partners, limited partners, or other persons, with interests in the equity of the covered financial company arising as a result of their status as shareholders, members, general partners, limited partners, or other persons with interests in the equity of the covered financial company.

[(2) POST-RECEIVERSHIP FINANCING PRIORITY.—In the event that the Corporation, as receiver for a covered financial company, is unable to obtain unsecured credit for the covered financial company from commercial sources, the Corporation as receiver may obtain credit or incur debt on the part of the covered financial company, which shall have priority over any or all administrative expenses of the receiver under paragraph (1)(A).

[(3) CLAIMS OF THE UNITED STATES.—Unsecured claims of the United States shall, at a minimum, have a higher priority than liabilities of the covered financial company that count as regulatory capital.

[(4) CREDITORS SIMILARLY SITUATED.—All claimants of a covered financial company that are similarly situated under paragraph (1) shall be treated in a similar manner, except that the Corporation may take any action (including making payments, subject to subsection (o)(1)(D)(i)) that does not comply with this subsection, if—

[(A) the Corporation determines that such action is necessary—

[(i) to maximize the value of the assets of the covered financial company;

[(ii) to initiate and continue operations essential to implementation of the receivership or any bridge financial company;

[(iii) to maximize the present value return from the sale or other disposition of the assets of the covered financial company; or

[(iv) to minimize the amount of any loss realized upon the sale or other disposition of the assets of the covered financial company; and

[(B) all claimants that are similarly situated under paragraph (1) receive not less than the amount provided in paragraphs (2) and (3) of subsection (d).

[(5) SECURED CLAIMS UNAFFECTED.—This section shall not affect secured claims or security entitlements in respect of assets or property held by the covered financial company, except to the extent that the security is insufficient to satisfy the

claim, and then only with regard to the difference between the claim and the amount realized from the security.

[(6) PRIORITY OF EXPENSES AND UNSECURED CLAIMS IN THE ORDERLY LIQUIDATION OF SIPC MEMBER.—Where the Corporation is appointed as receiver for a covered broker or dealer, unsecured claims against such covered broker or dealer, or the Corporation as receiver for such covered broker or dealer under this section, that are proven to the satisfaction of the receiver under section 205(e), shall have the priority prescribed in paragraph (1), except that—

[(A) SIPC shall be entitled to recover administrative expenses incurred in performing its responsibilities under section 205 on an equal basis with the Corporation, in accordance with paragraph (1)(A);

[(B) the Corporation shall be entitled to recover any amounts paid to customers or to SIPC pursuant to section 205(f), in accordance with paragraph (1)(B);

[(C) SIPC shall be entitled to recover any amounts paid out of the SIPC Fund to meet its obligations under section 205 and under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.), which claim shall be subordinate to the claims payable under subparagraphs (A) and (B) of paragraph (1), but senior to all other claims; and

[(D) the Corporation may, after paying any proven claims to customers under section 205 and the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.), and as provided above, pay dividends on other proven claims, in its discretion, and to the extent that funds are available, in accordance with the priorities set forth in paragraph (1).

[(c) PROVISIONS RELATING TO CONTRACTS ENTERED INTO BEFORE APPOINTMENT OF RECEIVER.—

[(1) AUTHORITY TO REPUDIATE CONTRACTS.—In addition to any other rights that a receiver may have, the Corporation as receiver for any covered financial company may disaffirm or repudiate any contract or lease—

[(A) to which the covered financial company is a party;

[(B) the performance of which the Corporation as receiver, in the discretion of the Corporation, determines to be burdensome; and

[(C) the disaffirmance or repudiation of which the Corporation as receiver determines, in the discretion of the Corporation, will promote the orderly administration of the affairs of the covered financial company.

[(2) TIMING OF REPUDIATION.—The Corporation, as receiver for any covered financial company, shall determine whether or not to exercise the rights of repudiation under this section within a reasonable period of time.

[(3) CLAIMS FOR DAMAGES FOR REPUDIATION.—

[(A) IN GENERAL.—Except as provided in paragraphs (4), (5), and (6) and in subparagraphs (C), (D), and (E) of this paragraph, the liability of the Corporation as receiver for a covered financial company for the disaffirmance or repu-

diation of any contract pursuant to paragraph (1) shall be—

[(i) limited to actual direct compensatory damages; and

[(ii) determined as of—

[(I) the date of the appointment of the Corporation as receiver; or

[(II) in the case of any contract or agreement referred to in paragraph (8), the date of the disaffirmance or repudiation of such contract or agreement.

[(B) NO LIABILITY FOR OTHER DAMAGES.—For purposes of subparagraph (A), the term "actual direct compensatory damages" does not include—

[(i) punitive or exemplary damages;

[(ii) damages for lost profits or opportunity; or

[(iii) damages for pain and suffering.

[(C) MEASURE OF DAMAGES FOR REPUDIATION OF QUALIFIED FINANCIAL CONTRACTS.—In the case of any qualified financial contract or agreement to which paragraph (8) applies, compensatory damages shall be—

[(i) deemed to include normal and reasonable costs of cover or other reasonable measures of damages utilized in the industries for such contract and agreement claims; and

[(ii) paid in accordance with this paragraph and subsection (d), except as otherwise specifically provided in this subsection.

[(D) MEASURE OF DAMAGES FOR REPUDIATION OR DISAFFIRMANCE OF DEBT OBLIGATION.—In the case of any debt for borrowed money or evidenced by a security, actual direct compensatory damages shall be no less than the amount lent plus accrued interest plus any accreted original issue discount as of the date the Corporation was appointed receiver of the covered financial company and, to the extent that an allowed secured claim is secured by property the value of which is greater than the amount of such claim and any accrued interest through the date of repudiation or disaffirmance, such accrued interest pursuant to paragraph (1).

[(E) MEASURE OF DAMAGES FOR REPUDIATION OR DISAFFIRMANCE OF CONTINGENT OBLIGATION.—In the case of any contingent obligation of a covered financial company consisting of any obligation under a guarantee, letter of credit, loan commitment, or similar credit obligation, the Corporation may, by rule or regulation, prescribe that actual direct compensatory damages shall be no less than the estimated value of the claim as of the date the Corporation was appointed receiver of the covered financial company, as such value is measured based on the likelihood that such contingent claim would become fixed and the probable magnitude thereof.

[(4) LEASES UNDER WHICH THE COVERED FINANCIAL COMPANY IS THE LESSEE.—

[(A) IN GENERAL.—If the Corporation as receiver disaffirms or repudiates a lease under which the covered financial company is the lessee, the receiver shall not be liable for any damages (other than damages determined pursuant to subparagraph (B)) for the disaffirmance or repudiation of such lease.

[(B) PAYMENTS OF RENT.—Notwithstanding subparagraph (A), the lessor under a lease to which subparagraph (A) would otherwise apply shall—

[(i) be entitled to the contractual rent accruing before the later of the date on which—

[(I) the notice of disaffirmance or repudiation is mailed; or

[(II) the disaffirmance or repudiation becomes effective, unless the lessor is in default or breach of the terms of the lease;

[(ii) have no claim for damages under any acceleration clause or other penalty provision in the lease; and

[(iii) have a claim for any unpaid rent, subject to all appropriate offsets and defenses, due as of the date of the appointment which shall be paid in accordance with this paragraph and subsection (d).

[(5) LEASES UNDER WHICH THE COVERED FINANCIAL COMPANY IS THE LESSOR.—

[(A) IN GENERAL.—If the Corporation as receiver for a covered financial company repudiates an unexpired written lease of real property of the covered financial company under which the covered financial company is the lessor and the lessee is not, as of the date of such repudiation, in default, the lessee under such lease may either—

[(i) treat the lease as terminated by such repudiation; or

[(ii) remain in possession of the leasehold interest for the balance of the term of the lease, unless the lessee defaults under the terms of the lease after the date of such repudiation.

[(B) PROVISIONS APPLICABLE TO LESSEE REMAINING IN POSSESSION.—If any lessee under a lease described in subparagraph (A) remains in possession of a leasehold interest pursuant to clause (ii) of subparagraph (A)—

[(i) the lessee—

[(I) shall continue to pay the contractual rent pursuant to the terms of the lease after the date of the repudiation of such lease; and

[(II) may offset against any rent payment which accrues after the date of the repudiation of the lease, any damages which accrue after such date due to the nonperformance of any obligation of the covered financial company under the lease after such date; and

[(ii) the Corporation as receiver shall not be liable to the lessee for any damages arising after such date as a result of the repudiation, other than the amount of any offset allowed under clause (i)(II).

[(6) CONTRACTS FOR THE SALE OF REAL PROPERTY.—

[(A) IN GENERAL.—If the receiver repudiates any contract (which meets the requirements of subsection (a)(6)) for the sale of real property, and the purchaser of such real property under such contract is in possession and is not, as of the date of such repudiation, in default, such purchaser may either—

[(i) treat the contract as terminated by such repudiation; or

[(ii) remain in possession of such real property.

[(B) PROVISIONS APPLICABLE TO PURCHASER REMAINING IN POSSESSION.—If any purchaser of real property under any contract described in subparagraph (A) remains in possession of such property pursuant to clause (ii) of subparagraph (A)—

[(i) the purchaser—

[(I) shall continue to make all payments due under the contract after the date of the repudiation of the contract; and

[(II) may offset against any such payments any damages which accrue after such date due to the nonperformance (after such date) of any obligation of the covered financial company under the contract; and

[(ii) the Corporation as receiver shall—

[(I) not be liable to the purchaser for any damages arising after such date as a result of the repudiation, other than the amount of any offset allowed under clause (i)(II);

[(II) deliver title to the purchaser in accordance with the provisions of the contract; and

[(III) have no obligation under the contract other than the performance required under subclause (II).

[(C) ASSIGNMENT AND SALE ALLOWED.—

[(i) IN GENERAL.—No provision of this paragraph shall be construed as limiting the right of the Corporation as receiver to assign the contract described in subparagraph (A) and sell the property, subject to the contract and the provisions of this paragraph.

[(ii) NO LIABILITY AFTER ASSIGNMENT AND SALE.—If an assignment and sale described in clause (i) is consummated, the Corporation as receiver shall have no further liability under the contract described in subparagraph (A) or with respect to the real property which was the subject of such contract.

[(7) PROVISIONS APPLICABLE TO SERVICE CONTRACTS.—

[(A) SERVICES PERFORMED BEFORE APPOINTMENT.—In the case of any contract for services between any person and any covered financial company for which the Corporation has been appointed receiver, any claim of such person for services performed before the date of appointment shall be—

[(i) a claim to be paid in accordance with subsections (a), (b), and (d); and

[(ii) deemed to have arisen as of the date on which the receiver was appointed.

[(B) SERVICES PERFORMED AFTER APPOINTMENT AND PRIOR TO REPUDIATION.—If, in the case of any contract for services described in subparagraph (A), the Corporation as receiver accepts performance by the other person before making any determination to exercise the right of repudiation of such contract under this section—

[(i) the other party shall be paid under the terms of the contract for the services performed; and

[(ii) the amount of such payment shall be treated as an administrative expense of the receivership.

[(C) ACCEPTANCE OF PERFORMANCE NO BAR TO SUBSEQUENT REPUDIATION.—The acceptance by the Corporation as receiver for services referred to in subparagraph (B) in connection with a contract described in subparagraph (B) shall not affect the right of the Corporation as receiver to repudiate such contract under this section at any time after such performance.

[(8) CERTAIN QUALIFIED FINANCIAL CONTRACTS.—

[(A) RIGHTS OF PARTIES TO CONTRACTS.—Subject to subsection (a)(8) and paragraphs (9) and (10) of this subsection, and notwithstanding any other provision of this section, any other provision of Federal law, or the law of any State, no person shall be stayed or prohibited from exercising—

[(i) any right that such person has to cause the termination, liquidation, or acceleration of any qualified financial contract with a covered financial company which arises upon the date of appointment of the Corporation as receiver for such covered financial company or at any time after such appointment;

[(ii) any right under any security agreement or arrangement or other credit enhancement related to one or more qualified financial contracts described in clause (i); or

[(iii) any right to offset or net out any termination value, payment amount, or other transfer obligation arising under or in connection with 1 or more contracts or agreements described in clause (i), including any master agreement for such contracts or agreements.

[(B) APPLICABILITY OF OTHER PROVISIONS.—Subsection (a)(8) shall apply in the case of any judicial action or proceeding brought against the Corporation as receiver referred to in subparagraph (A), or the subject covered financial company, by any party to a contract or agreement described in subparagraph (A)(i) with such covered financial company.

[(C) CERTAIN TRANSFERS NOT AVOIDABLE.—

[(i) IN GENERAL.—Notwithstanding subsection (a)(11), (a)(12), or (c)(12), section 5242 of the Revised

Statutes of the United States, or any other provision of Federal or State law relating to the avoidance of preferential or fraudulent transfers, the Corporation, whether acting as the Corporation or as receiver for a covered financial company, may not avoid any transfer of money or other property in connection with any qualified financial contract with a covered financial company.

[(ii) EXCEPTION FOR CERTAIN TRANSFERS.—Clause (i) shall not apply to any transfer of money or other property in connection with any qualified financial contract with a covered financial company if the transferee had actual intent to hinder, delay, or defraud such company, the creditors of such company, or the Corporation as receiver appointed for such company.

[(D) CERTAIN CONTRACTS AND AGREEMENTS DEFINED.—For purposes of this subsection, the following definitions shall apply:

[(i) QUALIFIED FINANCIAL CONTRACT.—The term "qualified financial contract" means any securities contract, commodity contract, forward contract, repurchase agreement, swap agreement, and any similar agreement that the Corporation determines by regulation, resolution, or order to be a qualified financial contract for purposes of this paragraph.

[(ii) SECURITIES CONTRACT.—The term "securities contract"—

[(I) means a contract for the purchase, sale, or loan of a security, a certificate of deposit, a mortgage loan, any interest in a mortgage loan, a group or index of securities, certificates of deposit, or mortgage loans or interests therein (including any interest therein or based on the value thereof), or any option on any of the foregoing, including any option to purchase or sell any such security, certificate of deposit, mortgage loan, interest, group or index, or option, and including any repurchase or reverse repurchase transaction on any such security, certificate of deposit, mortgage loan, interest, group or index, or option (whether or not such repurchase or reverse repurchase transaction is a "repurchase agreement", as defined in clause (v));

[(II) does not include any purchase, sale, or repurchase obligation under a participation in a commercial mortgage loan unless the Corporation determines by regulation, resolution, or order to include any such agreement within the meaning of such term;

[(III) means any option entered into on a national securities exchange relating to foreign currencies;

[(IV) means the guarantee (including by novation) by or to any securities clearing agency of any

settlement of cash, securities, certificates of deposit, mortgage loans or interests therein, group or index of securities, certificates of deposit or mortgage loans or interests therein (including any interest therein or based on the value thereof) or an option on any of the foregoing, including any option to purchase or sell any such security, certificate of deposit, mortgage loan, interest, group or index, or option (whether or not such settlement is in connection with any agreement or transaction referred to in subclauses (I) through (XII) (other than subclause (II)));

[(V) means any margin loan;

[(VI) means any extension of credit for the clearance or settlement of securities transactions;

[(VII) means any loan transaction coupled with a securities collar transaction, any prepaid securities forward transaction, or any total return swap transaction coupled with a securities sale transaction;

[(VIII) means any other agreement or transaction that is similar to any agreement or transaction referred to in this clause;

[(IX) means any combination of the agreements or transactions referred to in this clause;

[(X) means any option to enter into any agreement or transaction referred to in this clause;

[(XI) means a master agreement that provides for an agreement or transaction referred to in any of subclauses (I) through (X), other than subclause (II), together with all supplements to any such master agreement, without regard to whether the master agreement provides for an agreement or transaction that is not a securities contract under this clause, except that the master agreement shall be considered to be a securities contract under this clause only with respect to each agreement or transaction under the master agreement that is referred to in any of subclauses (I) through (X), other than subclause (II); and

[(XII) means any security agreement or arrangement or other credit enhancement related to any agreement or transaction referred to in this clause, including any guarantee or reimbursement obligation in connection with any agreement or transaction referred to in this clause.

[(iii) COMMODITY CONTRACT.—The term "commodity contract" means—

[(I) with respect to a futures commission merchant, a contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a contract market or board of trade;

[(II) with respect to a foreign futures commission merchant, a foreign future;

[(III) with respect to a leverage transaction merchant, a leverage transaction;

[(IV) with respect to a clearing organization, a contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a contract market or board of trade that is cleared by such clearing organization, or commodity option traded on, or subject to the rules of, a contract market or board of trade that is cleared by such clearing organization;

[(V) with respect to a commodity options dealer, a commodity option;

[(VI) any other agreement or transaction that is similar to any agreement or transaction referred to in this clause;

[(VII) any combination of the agreements or transactions referred to in this clause;

[(VIII) any option to enter into any agreement or transaction referred to in this clause;

[(IX) a master agreement that provides for an agreement or transaction referred to in any of subclauses (I) through (VIII), together with all supplements to any such master agreement, without regard to whether the master agreement provides for an agreement or transaction that is not a commodity contract under this clause, except that the master agreement shall be considered to be a commodity contract under this clause only with respect to each agreement or transaction under the master agreement that is referred to in any of subclauses (I) through (VIII); or

[(X) any security agreement or arrangement or other credit enhancement related to any agreement or transaction referred to in this clause, including any guarantee or reimbursement obligation in connection with any agreement or transaction referred to in this clause.

[(iv) FORWARD CONTRACT.—The term "forward contract" means—

[(I) a contract (other than a commodity contract) for the purchase, sale, or transfer of a commodity or any similar good, article, service, right, or interest which is presently or in the future becomes the subject of dealing in the forward contract trade, or product or byproduct thereof, with a maturity date that is more than 2 days after the date on which the contract is entered into, including a repurchase or reverse repurchase transaction (whether or not such repurchase or reverse repurchase transaction is a "repurchase agreement", as defined in clause (v)), consignment, lease, swap, hedge transaction, deposit, loan, option, allocated transaction, unallocated transaction, or any other similar agreement;

[(II) any combination of agreements or transactions referred to in subclauses (I) and (III);

[(III) any option to enter into any agreement or transaction referred to in subclause (I) or (II);

[(IV) a master agreement that provides for an agreement or transaction referred to in subclause (I), (II), or (III), together with all supplements to any such master agreement, without regard to whether the master agreement provides for an agreement or transaction that is not a forward contract under this clause, except that the master agreement shall be considered to be a forward contract under this clause only with respect to each agreement or transaction under the master agreement that is referred to in subclause (I), (II), or (III); or

[(V) any security agreement or arrangement or other credit enhancement related to any agreement or transaction referred to in subclause (I), (II), (III), or (IV), including any guarantee or reimbursement obligation in connection with any agreement or transaction referred to in any such subclause.

[(v) REPURCHASE AGREEMENT.—The term "repurchase agreement" (which definition also applies to a reverse repurchase agreement)—

[(I) means an agreement, including related terms, which provides for the transfer of one or more certificates of deposit, mortgage related securities (as such term is defined in section 3 of the Securities Exchange Act of 1934), mortgage loans, interests in mortgage-related securities or mortgage loans, eligible bankers' acceptances, qualified foreign government securities (which, for purposes of this clause, means a security that is a direct obligation of, or that is fully guaranteed by, the central government of a member of the Organization for Economic Cooperation and Development, as determined by regulation or order adopted by the Board of Governors), or securities that are direct obligations of, or that are fully guaranteed by, the United States or any agency of the United States against the transfer of funds by the transferee of such certificates of deposit, eligible bankers' acceptances, securities, mortgage loans, or interests with a simultaneous agreement by such transferee to transfer to the transferor thereof certificates of deposit, eligible bankers' acceptances, securities, mortgage loans, or interests as described above, at a date certain not later than 1 year after such transfers or on demand, against the transfer of funds, or any other similar agreement;

[(II) does not include any repurchase obligation under a participation in a commercial mortgage

loan, unless the Corporation determines, by regulation, resolution, or order to include any such participation within the meaning of such term;

[(III) means any combination of agreements or transactions referred to in subclauses (I) and (IV);

[(IV) means any option to enter into any agreement or transaction referred to in subclause (I) or (III);

[(V) means a master agreement that provides for an agreement or transaction referred to in subclause (I), (III), or (IV), together with all supplements to any such master agreement, without regard to whether the master agreement provides for an agreement or transaction that is not a repurchase agreement under this clause, except that the master agreement shall be considered to be a repurchase agreement under this subclause only with respect to each agreement or transaction under the master agreement that is referred to in subclause (I), (III), or (IV); and

[(VI) means any security agreement or arrangement or other credit enhancement related to any agreement or transaction referred to in subclause (I), (III), (IV), or (V), including any guarantee or reimbursement obligation in connection with any agreement or transaction referred to in any such subclause.

[(vi) SWAP AGREEMENT.—The term "swap agreement" means—

[(I) any agreement, including the terms and conditions incorporated by reference in any such agreement, which is an interest rate swap, option, future, or forward agreement, including a rate floor, rate cap, rate collar, cross-currency rate swap, and basis swap; a spot, same day-tomorrow, tomorrow-next, forward, or other foreign exchange, precious metals, or other commodity agreement; a currency swap, option, future, or forward agreement; an equity index or equity swap, option, future, or forward agreement; a debt index or debt swap, option, future, or forward agreement; a total return, credit spread or credit swap, option, future, or forward agreement; a commodity index or commodity swap, option, future, or forward agreement; weather swap, option, future, or forward agreement; an emissions swap, option, future, or forward agreement; or an inflation swap, option, future, or forward agreement;

[(II) any agreement or transaction that is similar to any other agreement or transaction referred to in this clause and that is of a type that has been, is presently, or in the future becomes, the subject of recurrent dealings in the swap or other derivatives markets (including terms and condi-

tions incorporated by reference in such agreement) and that is a forward, swap, future, option, or spot transaction on one or more rates, currencies, commodities, equity securities or other equity instruments, debt securities or other debt instruments, quantitative measures associated with an occurrence, extent of an occurrence, or contingency associated with a financial, commercial, or economic consequence, or economic or financial indices or measures of economic or financial risk or value;

[(III) any combination of agreements or transactions referred to in this clause;

[(IV) any option to enter into any agreement or transaction referred to in this clause;

[(V) a master agreement that provides for an agreement or transaction referred to in subclause (I), (II), (III), or (IV), together with all supplements to any such master agreement, without regard to whether the master agreement contains an agreement or transaction that is not a swap agreement under this clause, except that the master agreement shall be considered to be a swap agreement under this clause only with respect to each agreement or transaction under the master agreement that is referred to in subclause (I), (II), (III), or (IV); and

[(VI) any security agreement or arrangement or other credit enhancement related to any agreement or transaction referred to in any of subclauses (I) through (V), including any guarantee or reimbursement obligation in connection with any agreement or transaction referred to in any such clause.

[(vii) DEFINITIONS RELATING TO DEFAULT.—When used in this paragraph and paragraphs (9) and (10)—

[(I) the term "default" means, with respect to a covered financial company, any adjudication or other official decision by any court of competent jurisdiction, or other public authority pursuant to which the Corporation has been appointed receiver; and

[(II) the term "in danger of default" means a covered financial company with respect to which the Corporation or appropriate State authority has determined that—

[(aa) in the opinion of the Corporation or such authority—

[(AA) the covered financial company is not likely to be able to pay its obligations in the normal course of business; and

[(BB) there is no reasonable prospect that the covered financial company will be able to pay such obligations without Federal assistance; or

[(bb) in the opinion of the Corporation or such authority—

[(AA) the covered financial company has incurred or is likely to incur losses that will deplete all or substantially all of its capital; and

[(BB) there is no reasonable prospect that the capital will be replenished without Federal assistance.

[(viii) TREATMENT OF MASTER AGREEMENT AS ONE AGREEMENT.—Any master agreement for any contract or agreement described in any of clauses (i) through (vi) (or any master agreement for such master agreement or agreements), together with all supplements to such master agreement, shall be treated as a single agreement and a single qualified financial contact. If a master agreement contains provisions relating to agreements or transactions that are not themselves qualified financial contracts, the master agreement shall be deemed to be a qualified financial contract only with respect to those transactions that are themselves qualified financial contracts.

[(ix) TRANSFER.—The term "transfer" means every mode, direct or indirect, absolute or conditional, voluntary or involuntary, of disposing of or parting with property or with an interest in property, including retention of title as a security interest and foreclosure of the equity of redemption of the covered financial company.

[(x) PERSON.—The term "person" includes any governmental entity in addition to any entity included in the definition of such term in section 1, title 1, United States Code.

[(E) CLARIFICATION.—No provision of law shall be construed as limiting the right or power of the Corporation, or authorizing any court or agency to limit or delay, in any manner, the right or power of the Corporation to transfer any qualified financial contract or to disaffirm or repudiate any such contract in accordance with this subsection.

[(F) WALKAWAY CLAUSES NOT EFFECTIVE.—

[(i) IN GENERAL.—Notwithstanding the provisions of subparagraph (A) of this paragraph and sections 403 and 404 of the Federal Deposit Insurance Corporation Improvement Act of 1991, no walkaway clause shall be enforceable in a qualified financial contract of a covered financial company in default.

[(ii) LIMITED SUSPENSION OF CERTAIN OBLIGATIONS.—In the case of a qualified financial contract referred to in clause (i), any payment or delivery obligations otherwise due from a party pursuant to the qualified financial contract shall be suspended from the time at which the Corporation is appointed as receiver until the earlier of—

[(I) the time at which such party receives notice that such contract has been transferred pursuant to paragraph (10)(A); or

[(II) 5:00 p.m. (eastern time) on the business day following the date of the appointment of the Corporation as receiver.

[(iii) WALKAWAY CLAUSE DEFINED.—For purposes of this subparagraph, the term "walkaway clause" means any provision in a qualified financial contract that suspends, conditions, or extinguishes a payment obligation of a party, in whole or in part, or does not create a payment obligation of a party that would otherwise exist, solely because of the status of such party as a nondefaulting party in connection with the insolvency of a covered financial company that is a party to the contract or the appointment of or the exercise of rights or powers by the Corporation as receiver for such covered financial company, and not as a result of the exercise by a party of any right to offset, setoff, or net obligations that exist under the contract, any other contract between those parties, or applicable law.

[(G) CERTAIN OBLIGATIONS TO CLEARING ORGANIZATIONS.—In the event that the Corporation has been appointed as receiver for a covered financial company which is a party to any qualified financial contract cleared by or subject to the rules of a clearing organization (as defined in paragraph (9)(D)), the receiver shall use its best efforts to meet all margin, collateral, and settlement obligations of the covered financial company that arise under qualified financial contracts (other than any margin, collateral, or settlement obligation that is not enforceable against the receiver under paragraph (8)(F)(i) or paragraph (10)(B)), as required by the rules of the clearing organization when due. Notwithstanding any other provision of this title, if the receiver fails to satisfy any such margin, collateral, or settlement obligations under the rules of the clearing organization, the clearing organization shall have the immediate right to exercise, and shall not be stayed from exercising, all of its rights and remedies under its rules and applicable law with respect to any qualified financial contract of the covered financial company, including, without limitation, the right to liquidate all positions and collateral of such covered financial company under the company's qualified financial contracts, and suspend or cease to act for such covered financial company, all in accordance with the rules of the clearing organization.

[(H) RECORDKEEPING.—

[(i) JOINT RULEMAKING.—The Federal primary financial regulatory agencies shall jointly prescribe regulations requiring that financial companies maintain such records with respect to qualified financial contracts (including market valuations) that the Federal primary financial regulatory agencies determine to be necessary or appropriate in order to assist the Cor-

poration as receiver for a covered financial company in being able to exercise its rights and fulfill its obligations under this paragraph or paragraph (9) or (10).

[(ii) TIME FRAME.—The Federal primary financial regulatory agencies shall prescribe joint final or interim final regulations not later than 24 months after the date of enactment of this Act.

[(iii) BACK-UP RULEMAKING AUTHORITY.—If the Federal primary financial regulatory agencies do not prescribe joint final or interim final regulations within the time frame in clause (ii), the Chairperson of the Council shall prescribe, in consultation with the Corporation, the regulations required by clause (i).

[(iv) CATEGORIZATION AND TIERING.—The joint regulations prescribed under clause (i) shall, as appropriate, differentiate among financial companies by taking into consideration their size, risk, complexity, leverage, frequency and dollar amount of qualified financial contracts, interconnectedness to the financial system, and any other factors deemed appropriate.

[(9) TRANSFER OF QUALIFIED FINANCIAL CONTRACTS.—

[(A) IN GENERAL.—In making any transfer of assets or liabilities of a covered financial company in default, which includes any qualified financial contract, the Corporation as receiver for such covered financial company shall either—

[(i) transfer to one financial institution, other than a financial institution for which a conservator, receiver, trustee in bankruptcy, or other legal custodian has been appointed or which is otherwise the subject of a bankruptcy or insolvency proceeding—

[(I) all qualified financial contracts between any person or any affiliate of such person and the covered financial company in default;

[(II) all claims of such person or any affiliate of such person against such covered financial company under any such contract (other than any claim which, under the terms of any such contract, is subordinated to the claims of general unsecured creditors of such company);

[(III) all claims of such covered financial company against such person or any affiliate of such person under any such contract; and

[(IV) all property securing or any other credit enhancement for any contract described in subclause (I) or any claim described in subclause (II) or (III) under any such contract; or

[(ii) transfer none of the qualified financial contracts, claims, property or other credit enhancement referred to in clause (i) (with respect to such person and any affiliate of such person).

[(B) TRANSFER TO FOREIGN BANK, FINANCIAL INSTITUTION, OR BRANCH OR AGENCY THEREOF.—In transferring any qualified financial contracts and related claims and

property under subparagraph (A)(i), the Corporation as receiver for the covered financial company shall not make such transfer to a foreign bank, financial institution organized under the laws of a foreign country, or a branch or agency of a foreign bank or financial institution unless, under the law applicable to such bank, financial institution, branch or agency, to the qualified financial contracts, and to any netting contract, any security agreement or arrangement or other credit enhancement related to one or more qualified financial contracts, the contractual rights of the parties to such qualified financial contracts, netting contracts, security agreements or arrangements, or other credit enhancements are enforceable substantially to the same extent as permitted under this section.

[(C) TRANSFER OF CONTRACTS SUBJECT TO THE RULES OF A CLEARING ORGANIZATION.—In the event that the Corporation as receiver for a financial institution transfers any qualified financial contract and related claims, property, or credit enhancement pursuant to subparagraph (A)(i) and such contract is cleared by or subject to the rules of a clearing organization, the clearing organization shall not be required to accept the transferee as a member by virtue of the transfer.

[(D) DEFINITIONS.—For purposes of this paragraph—

[(i) the term "financial institution" means a broker or dealer, a depository institution, a futures commission merchant, a bridge financial company, or any other institution determined by the Corporation, by regulation, to be a financial institution; and

[(ii) the term "clearing organization" has the same meaning as in section 402 of the Federal Deposit Insurance Corporation Improvement Act of 1991.

[(10) NOTIFICATION OF TRANSFER.—

[(A) IN GENERAL.—

[(i) NOTICE.—The Corporation shall provide notice in accordance with clause (ii), if—

[(I) the Corporation as receiver for a covered financial company in default or in danger of default transfers any assets or liabilities of the covered financial company; and

[(II) the transfer includes any qualified financial contract.

[(ii) TIMING.—The Corporation as receiver for a covered financial company shall notify any person who is a party to any contract described in clause (i) of such transfer not later than 5:00 p.m. (eastern time) on the business day following the date of the appointment of the Corporation as receiver.

[(B) CERTAIN RIGHTS NOT ENFORCEABLE.—

[(i) RECEIVERSHIP.—A person who is a party to a qualified financial contract with a covered financial company may not exercise any right that such person has to terminate, liquidate, or net such contract under paragraph (8)(A) solely by reason of or incidental to

the appointment under this section of the Corporation as receiver for the covered financial company (or the insolvency or financial condition of the covered financial company for which the Corporation has been appointed as receiver)—

[(I) until 5:00 p.m. (eastern time) on the business day following the date of the appointment; or

[(II) after the person has received notice that the contract has been transferred pursuant to paragraph (9)(A).

[(ii) NOTICE.—For purposes of this paragraph, the Corporation as receiver for a covered financial company shall be deemed to have notified a person who is a party to a qualified financial contract with such covered financial company, if the Corporation has taken steps reasonably calculated to provide notice to such person by the time specified in subparagraph (A).

[(C) TREATMENT OF BRIDGE FINANCIAL COMPANY.—For purposes of paragraph (9), a bridge financial company shall not be considered to be a financial institution for which a conservator, receiver, trustee in bankruptcy, or other legal custodian has been appointed, or which is otherwise the subject of a bankruptcy or insolvency proceeding.

[(D) BUSINESS DAY DEFINED.—For purposes of this paragraph, the term "business day" means any day other than any Saturday, Sunday, or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

[(11) DISAFFIRMANCE OR REPUDIATION OF QUALIFIED FINANCIAL CONTRACTS.—In exercising the rights of disaffirmance or repudiation of the Corporation as receiver with respect to any qualified financial contract to which a covered financial company is a party, the Corporation shall either—

[(A) disaffirm or repudiate all qualified financial contracts between—

[(i) any person or any affiliate of such person; and

[(ii) the covered financial company in default; or

[(B) disaffirm or repudiate none of the qualified financial contracts referred to in subparagraph (A) (with respect to such person or any affiliate of such person).

[(12) CERTAIN SECURITY AND CUSTOMER INTERESTS NOT AVOIDABLE.—No provision of this subsection shall be construed as permitting the avoidance of any—

[(A) legally enforceable or perfected security interest in any of the assets of any covered financial company, except in accordance with subsection (a)(11); or

[(B) legally enforceable interest in customer property, security entitlements in respect of assets or property held by the covered financial company for any security entitlement holder.

[(13) AUTHORITY TO ENFORCE CONTRACTS.—

[(A) IN GENERAL.—The Corporation, as receiver for a covered financial company, may enforce any contract, other

than a liability insurance contract of a director or officer, a financial institution bond entered into by the covered financial company, notwithstanding any provision of the contract providing for termination, default, acceleration, or exercise of rights upon, or solely by reason of, insolvency, the appointment of or the exercise of rights or powers by the Corporation as receiver, the filing of the petition pursuant to section 202(a)(1), or the issuance of the recommendations or determination, or any actions or events occurring in connection therewith or as a result thereof, pursuant to section 203.

[(B) CERTAIN RIGHTS NOT AFFECTED.—No provision of this paragraph may be construed as impairing or affecting any right of the Corporation as receiver to enforce or recover under a liability insurance contract of a director or officer or financial institution bond under other applicable law.

[(C) CONSENT REQUIREMENT AND IPSO FACTO CLAUSES.—

[(i) IN GENERAL.—Except as otherwise provided by this section, no person may exercise any right or power to terminate, accelerate, or declare a default under any contract to which the covered financial company is a party (and no provision in any such contract providing for such default, termination, or acceleration shall be enforceable), or to obtain possession of or exercise control over any property of the covered financial company or affect any contractual rights of the covered financial company, without the consent of the Corporation as receiver for the covered financial company during the 90 day period beginning from the appointment of the Corporation as receiver.

[(ii) EXCEPTIONS.—No provision of this subparagraph shall apply to a director or officer liability insurance contract or a financial institution bond, to the rights of parties to certain qualified financial contracts pursuant to paragraph (8), or to the rights of parties to netting contracts pursuant to subtitle A of title IV of the Federal Deposit Insurance Corporation Improvement Act of 1991 (12 U.S.C. 4401 et seq.), or shall be construed as permitting the Corporation as receiver to fail to comply with otherwise enforceable provisions of such contract.

[(D) CONTRACTS TO EXTEND CREDIT.—Notwithstanding any other provision in this title, if the Corporation as receiver enforces any contract to extend credit to the covered financial company or bridge financial company, any valid and enforceable obligation to repay such debt shall be paid by the Corporation as receiver, as an administrative expense of the receivership.

[(14) EXCEPTION FOR FEDERAL RESERVE BANKS AND CORPORATION SECURITY INTEREST.—No provision of this subsection shall apply with respect to—

[(A) any extension of credit from any Federal reserve bank or the Corporation to any covered financial company; or

[(B) any security interest in the assets of the covered financial company securing any such extension of credit.

[(15) SAVINGS CLAUSE.—The meanings of terms used in this subsection are applicable for purposes of this subsection only, and shall not be construed or applied so as to challenge or affect the characterization, definition, or treatment of any similar terms under any other statute, regulation, or rule, including the Gramm-Leach-Bliley Act, the Legal Certainty for Bank Products Act of 2000, the securities laws (as that term is defined in section 3(a)(47) of the Securities Exchange Act of 1934), and the Commodity Exchange Act.

[(16) ENFORCEMENT OF CONTRACTS GUARANTEED BY THE COVERED FINANCIAL COMPANY.—

[(A) IN GENERAL.—The Corporation, as receiver for a covered financial company or as receiver for a subsidiary of a covered financial company (including an insured depository institution) shall have the power to enforce contracts of subsidiaries or affiliates of the covered financial company, the obligations under which are guaranteed or otherwise supported by or linked to the covered financial company, notwithstanding any contractual right to cause the termination, liquidation, or acceleration of such contracts based solely on the insolvency, financial condition, or receivership of the covered financial company, if—

[(i) such guaranty or other support and all related assets and liabilities are transferred to and assumed by a bridge financial company or a third party (other than a third party for which a conservator, receiver, trustee in bankruptcy, or other legal custodian has been appointed, or which is otherwise the subject of a bankruptcy or insolvency proceeding) within the same period of time as the Corporation is entitled to transfer the qualified financial contracts of such covered financial company; or

[(ii) the Corporation, as receiver, otherwise provides adequate protection with respect to such obligations.

[(B) RULE OF CONSTRUCTION.—For purposes of this paragraph, a bridge financial company shall not be considered to be a third party for which a conservator, receiver, trustee in bankruptcy, or other legal custodian has been appointed, or which is otherwise the subject of a bankruptcy or insolvency proceeding.

[(d) VALUATION OF CLAIMS IN DEFAULT.—

[(1) IN GENERAL.—Notwithstanding any other provision of Federal law or the law of any State, and regardless of the method utilized by the Corporation for a covered financial company, including transactions authorized under subsection (h), this subsection shall govern the rights of the creditors of any such covered financial company.

[(2) MAXIMUM LIABILITY.—The maximum liability of the Corporation, acting as receiver for a covered financial company or

in any other capacity, to any person having a claim against the Corporation as receiver or the covered financial company for which the Corporation is appointed shall equal the amount that such claimant would have received if—

[(A) the Corporation had not been appointed receiver with respect to the covered financial company; and

[(B) the covered financial company had been liquidated under chapter 7 of the Bankruptcy Code, or any similar provision of State insolvency law applicable to the covered financial company.

[(3) SPECIAL PROVISION FOR ORDERLY LIQUIDATION BY SIPC.—The maximum liability of the Corporation, acting as receiver or in its corporate capacity for any covered broker or dealer to any customer of such covered broker or dealer, with respect to customer property of such customer, shall be—

[(A) equal to the amount that such customer would have received with respect to such customer property in a case initiated by SIPC under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.); and

[(B) determined as of the close of business on the date on which the Corporation is appointed as receiver.

[(4) ADDITIONAL PAYMENTS AUTHORIZED.—

[(A) IN GENERAL.—Subject to subsection (o)(1)(D)(i), the Corporation, with the approval of the Secretary, may make additional payments or credit additional amounts to or with respect to or for the account of any claimant or category of claimants of the covered financial company, if the Corporation determines that such payments or credits are necessary or appropriate to minimize losses to the Corporation as receiver from the orderly liquidation of the covered financial company under this section.

[(B) LIMITATIONS.—

[(i) PROHIBITION.—The Corporation shall not make any payments or credit amounts to any claimant or category of claimants that would result in any claimant receiving more than the face value amount of any claim that is proven to the satisfaction of the Corporation.

[(ii) NO OBLIGATION.—Notwithstanding any other provision of Federal or State law, or the Constitution of any State, the Corporation shall not be obligated, as a result of having made any payment under subparagraph (A) or credited any amount described in subparagraph (A) to or with respect to, or for the account, of any claimant or category of claimants, to make payments to any other claimant or category of claimants.

[(C) MANNER OF PAYMENT.—The Corporation may make payments or credit amounts under subparagraph (A) directly to the claimants or may make such payments or credit such amounts to a company other than a covered financial company or a bridge financial company established with respect thereto in order to induce such other company to accept liability for such claims.

[(e) LIMITATION ON COURT ACTION.—Except as provided in this title, no court may take any action to restrain or affect the exercise of powers or functions of the receiver hereunder, and any remedy against the Corporation or receiver shall be limited to money damages determined in accordance with this title.

[(f) LIABILITY OF DIRECTORS AND OFFICERS.—

[(1) IN GENERAL.—A director or officer of a covered financial company may be held personally liable for monetary damages in any civil action described in paragraph (2) by, on behalf of, or at the request or direction of the Corporation, which action is prosecuted wholly or partially for the benefit of the Corporation—

[(A) acting as receiver for such covered financial company;

[(B) acting based upon a suit, claim, or cause of action purchased from, assigned by, or otherwise conveyed by the Corporation as receiver; or

[(C) acting based upon a suit, claim, or cause of action purchased from, assigned by, or otherwise conveyed in whole or in part by a covered financial company or its affiliate in connection with assistance provided under this title.

[(2) ACTIONS COVERED.—Paragraph (1) shall apply with respect to actions for gross negligence, including any similar conduct or conduct that demonstrates a greater disregard of a duty of care (than gross negligence) including intentional tortious conduct, as such terms are defined and determined under applicable State law.

[(3) SAVINGS CLAUSE.—Nothing in this subsection shall impair or affect any right of the Corporation under other applicable law.

[(g) DAMAGES.—In any proceeding related to any claim against a director, officer, employee, agent, attorney, accountant, or appraiser of a covered financial company, or any other party employed by or providing services to a covered financial company, recoverable damages determined to result from the improvident or otherwise improper use or investment of any assets of the covered financial company shall include principal losses and appropriate interest.

[(h) BRIDGE FINANCIAL COMPANIES.—

[(1) ORGANIZATION.—

[(A) PURPOSE.—The Corporation, as receiver for one or more covered financial companies or in anticipation of being appointed receiver for one or more covered financial companies, may organize one or more bridge financial companies in accordance with this subsection.

[(B) AUTHORITIES.—Upon the creation of a bridge financial company under subparagraph (A) with respect to a covered financial company, such bridge financial company may—

[(i) assume such liabilities (including liabilities associated with any trust or custody business, but excluding any liabilities that count as regulatory capital)

of such covered financial company as the Corporation may, in its discretion, determine to be appropriate;

[(ii) purchase such assets (including assets associated with any trust or custody business) of such covered financial company as the Corporation may, in its discretion, determine to be appropriate; and

[(iii) perform any other temporary function which the Corporation may, in its discretion, prescribe in accordance with this section.

[(2) CHARTER AND ESTABLISHMENT.—

[(A) ESTABLISHMENT.—Except as provided in subparagraph (H), where the covered financial company is a covered broker or dealer, the Corporation, as receiver for a covered financial company, may grant a Federal charter to and approve articles of association for one or more bridge financial company or companies, with respect to such covered financial company which shall, by operation of law and immediately upon issuance of its charter and approval of its articles of association, be established and operate in accordance with, and subject to, such charter, articles, and this section.

[(B) MANAGEMENT.—Upon its establishment, a bridge financial company shall be under the management of a board of directors appointed by the Corporation.

[(C) ARTICLES OF ASSOCIATION.—The articles of association and organization certificate of a bridge financial company shall have such terms as the Corporation may provide, and shall be executed by such representatives as the Corporation may designate.

[(D) TERMS OF CHARTER; RIGHTS AND PRIVILEGES.—Subject to and in accordance with the provisions of this subsection, the Corporation shall—

[(i) establish the terms of the charter of a bridge financial company and the rights, powers, authorities, and privileges of a bridge financial company granted by the charter or as an incident thereto; and

[(ii) provide for, and establish the terms and conditions governing, the management (including the bylaws and the number of directors of the board of directors) and operations of the bridge financial company.

[(E) TRANSFER OF RIGHTS AND PRIVILEGES OF COVERED FINANCIAL COMPANY.—

[(i) IN GENERAL.—Notwithstanding any other provision of Federal or State law, the Corporation may provide for a bridge financial company to succeed to and assume any rights, powers, authorities, or privileges of the covered financial company with respect to which the bridge financial company was established and, upon such determination by the Corporation, the bridge financial company shall immediately and by operation of law succeed to and assume such rights, powers, authorities, and privileges.

[(ii) EFFECTIVE WITHOUT APPROVAL.—Any succession to or assumption by a bridge financial company of

rights, powers, authorities, or privileges of a covered financial company under clause (i) or otherwise shall be effective without any further approval under Federal or State law, assignment, or consent with respect thereto.

[(F) CORPORATE GOVERNANCE AND ELECTION AND DESIGNATION OF BODY OF LAW.—To the extent permitted by the Corporation and consistent with this section and any rules, regulations, or directives issued by the Corporation under this section, a bridge financial company may elect to follow the corporate governance practices and procedures that are applicable to a corporation incorporated under the general corporation law of the State of Delaware, or the State of incorporation or organization of the covered financial company with respect to which the bridge financial company was established, as such law may be amended from time to time.

[(G) CAPITAL.—

[(i) CAPITAL NOT REQUIRED.—Notwithstanding any other provision of Federal or State law, a bridge financial company may, if permitted by the Corporation, operate without any capital or surplus, or with such capital or surplus as the Corporation may in its discretion determine to be appropriate.

[(ii) NO CONTRIBUTION BY THE CORPORATION REQUIRED.—The Corporation is not required to pay capital into a bridge financial company or to issue any capital stock on behalf of a bridge financial company established under this subsection.

[(iii) AUTHORITY.—If the Corporation determines that such action is advisable, the Corporation may cause capital stock or other securities of a bridge financial company established with respect to a covered financial company to be issued and offered for sale in such amounts and on such terms and conditions as the Corporation may, in its discretion, determine.

[(iv) OPERATING FUNDS IN LIEU OF CAPITAL AND IMPLEMENTATION PLAN.—Upon the organization of a bridge financial company, and thereafter as the Corporation may, in its discretion, determine to be necessary or advisable, the Corporation may make available to the bridge financial company, subject to the plan described in subsection (n)(9), funds for the operation of the bridge financial company in lieu of capital.

[(H) BRIDGE BROKERS OR DEALERS.—

[(i) IN GENERAL.—The Corporation, as receiver for a covered broker or dealer, may approve articles of association for one or more bridge financial companies with respect to such covered broker or dealer, which bridge financial company or companies shall, by operation of law and immediately upon approval of its articles of association—

[(I) be established and deemed registered with the Commission under the Securities Exchange Act of 1934 and a member of SIPC;

[(II) operate in accordance with such articles and this section; and

[(III) succeed to any and all registrations and memberships of the covered financial company with or in any self-regulatory organizations.

[(ii) OTHER REQUIREMENTS.—Except as provided in clause (i), and notwithstanding any other provision of this section, the bridge financial company shall be subject to the Federal securities laws and all requirements with respect to being a member of a self-regulatory organization, unless exempted from any such requirements by the Commission, as is necessary or appropriate in the public interest or for the protection of investors.

[(iii) TREATMENT OF CUSTOMERS.—Except as otherwise provided by this title, any customer of the covered broker or dealer whose account is transferred to a bridge financial company shall have all the rights, privileges, and protections under section 205(f) and under the Securities Investor Protection Act of 1970 (15 U.S.C. 78aaa et seq.), that such customer would have had if the account were not transferred from the covered financial company under this subparagraph.

[(iv) OPERATION OF BRIDGE BROKERS OR DEALERS.—Notwithstanding any other provision of this title, the Corporation shall not operate any bridge financial company created by the Corporation under this title with respect to a covered broker or dealer in such a manner as to adversely affect the ability of customers to promptly access their customer property in accordance with applicable law.

[(3) INTERESTS IN AND ASSETS AND OBLIGATIONS OF COVERED FINANCIAL COMPANY.—Notwithstanding paragraph (1) or (2) or any other provision of law—

[(A) a bridge financial company shall assume, acquire, or succeed to the assets or liabilities of a covered financial company (including the assets or liabilities associated with any trust or custody business) only to the extent that such assets or liabilities are transferred by the Corporation to the bridge financial company in accordance with, and subject to the restrictions set forth in, paragraph (1)(B); and

[(B) a bridge financial company shall not assume, acquire, or succeed to any obligation that a covered financial company for which the Corporation has been appointed receiver may have to any shareholder, member, general partner, limited partner, or other person with an interest in the equity of the covered financial company that arises as a result of the status of that person having an equity claim in the covered financial company.

[(4) BRIDGE FINANCIAL COMPANY TREATED AS BEING IN DEFAULT FOR CERTAIN PURPOSES.—A bridge financial company

shall be treated as a covered financial company in default at such times and for such purposes as the Corporation may, in its discretion, determine.

[(5) TRANSFER OF ASSETS AND LIABILITIES.—

[(A) AUTHORITY OF CORPORATION.—The Corporation, as receiver for a covered financial company, may transfer any assets and liabilities of a covered financial company (including any assets or liabilities associated with any trust or custody business) to one or more bridge financial companies, in accordance with and subject to the restrictions of paragraph (1).

[(B) SUBSEQUENT TRANSFERS.—At any time after the establishment of a bridge financial company with respect to a covered financial company, the Corporation, as receiver, may transfer any assets and liabilities of such covered financial company as the Corporation may, in its discretion, determine to be appropriate in accordance with and subject to the restrictions of paragraph (1).

[(C) TREATMENT OF TRUST OR CUSTODY BUSINESS.—For purposes of this paragraph, the trust or custody business, including fiduciary appointments, held by any covered financial company is included among its assets and liabilities.

[(D) EFFECTIVE WITHOUT APPROVAL.—The transfer of any assets or liabilities, including those associated with any trust or custody business of a covered financial company, to a bridge financial company shall be effective without any further approval under Federal or State law, assignment, or consent with respect thereto.

[(E) EQUITABLE TREATMENT OF SIMILARLY SITUATED CREDITORS.—The Corporation shall treat all creditors of a covered financial company that are similarly situated under subsection (b)(1), in a similar manner in exercising the authority of the Corporation under this subsection to transfer any assets or liabilities of the covered financial company to one or more bridge financial companies established with respect to such covered financial company, except that the Corporation may take any action (including making payments, subject to subsection (o)(1)(D)(i)) that does not comply with this subparagraph, if—

[(i) the Corporation determines that such action is necessary—

[(I) to maximize the value of the assets of the covered financial company;

[(II) to maximize the present value return from the sale or other disposition of the assets of the covered financial company; or

[(III) to minimize the amount of any loss realized upon the sale or other disposition of the assets of the covered financial company; and

[(ii) all creditors that are similarly situated under subsection (b)(1) receive not less than the amount provided under paragraphs (2) and (3) of subsection (d).

[(F) LIMITATION ON TRANSFER OF LIABILITIES.—Notwithstanding any other provision of law, the aggregate amount of liabilities of a covered financial company that are transferred to, or assumed by, a bridge financial company from a covered financial company may not exceed the aggregate amount of the assets of the covered financial company that are transferred to, or purchased by, the bridge financial company from the covered financial company.

[(6) STAY OF JUDICIAL ACTION.—Any judicial action to which a bridge financial company becomes a party by virtue of its acquisition of any assets or assumption of any liabilities of a covered financial company shall be stayed from further proceedings for a period of not longer than 45 days (or such longer period as may be agreed to upon the consent of all parties) at the request of the bridge financial company.

[(7) AGREEMENTS AGAINST INTEREST OF THE BRIDGE FINANCIAL COMPANY.—No agreement that tends to diminish or defeat the interest of the bridge financial company in any asset of a covered financial company acquired by the bridge financial company shall be valid against the bridge financial company, unless such agreement—

[(A) is in writing;

[(B) was executed by an authorized officer or representative of the covered financial company or confirmed in the ordinary course of business by the covered financial company; and

[(C) has been on the official record of the company, since the time of its execution, or with which, the party claiming under the agreement provides documentation of such agreement and its authorized execution or confirmation by the covered financial company that is acceptable to the receiver.

[(8) NO FEDERAL STATUS.—

[(A) AGENCY STATUS.—A bridge financial company is not an agency, establishment, or instrumentality of the United States.

[(B) EMPLOYEE STATUS.—Representatives for purposes of paragraph (1)(B), directors, officers, employees, or agents of a bridge financial company are not, solely by virtue of service in any such capacity, officers or employees of the United States. Any employee of the Corporation or of any Federal instrumentality who serves at the request of the Corporation as a representative for purposes of paragraph (1)(B), director, officer, employee, or agent of a bridge financial company shall not—

[(i) solely by virtue of service in any such capacity lose any existing status as an officer or employee of the United States for purposes of title 5, United States Code, or any other provision of law; or

[(ii) receive any salary or benefits for service in any such capacity with respect to a bridge financial company in addition to such salary or benefits as are obtained through employment with the Corporation or such Federal instrumentality.

[(9) FUNDING AUTHORIZED.—The Corporation may, subject to the plan described in subsection (n)(9), provide funding to facilitate any transaction described in subparagraph (A), (B), (C), or (D) of paragraph (13) with respect to any bridge financial company, or facilitate the acquisition by a bridge financial company of any assets, or the assumption of any liabilities, of a covered financial company for which the Corporation has been appointed receiver.

[(10) EXEMPT TAX STATUS.—Notwithstanding any other provision of Federal or State law, a bridge financial company, its franchise, property, and income shall be exempt from all taxation now or hereafter imposed by the United States, by any territory, dependency, or possession thereof, or by any State, county, municipality, or local taxing authority.

[(11) FEDERAL AGENCY APPROVAL; ANTITRUST REVIEW.—If a transaction involving the merger or sale of a bridge financial company requires approval by a Federal agency, the transaction may not be consummated before the 5th calendar day after the date of approval by the Federal agency responsible for such approval with respect thereto. If, in connection with any such approval a report on competitive factors from the Attorney General is required, the Federal agency responsible for such approval shall promptly notify the Attorney General of the proposed transaction and the Attorney General shall provide the required report within 10 days of the request. If a notification is required under section 7A of the Clayton Act with respect to such transaction, the required waiting period shall end on the 15th day after the date on which the Attorney General and the Federal Trade Commission receive such notification, unless the waiting period is terminated earlier under section 7A(b)(2) of the Clayton Act, or extended under section 7A(e)(2) of that Act.

[(12) DURATION OF BRIDGE FINANCIAL COMPANY.—Subject to paragraphs (13) and (14), the status of a bridge financial company as such shall terminate at the end of the 2-year period following the date on which it was granted a charter. The Corporation may, in its discretion, extend the status of the bridge financial company as such for no more than 3 additional 1-year periods.

[(13) TERMINATION OF BRIDGE FINANCIAL COMPANY STATUS.—The status of any bridge financial company as such shall terminate upon the earliest of—

[(A) the date of the merger or consolidation of the bridge financial company with a company that is not a bridge financial company;

[(B) at the election of the Corporation, the sale of a majority of the capital stock of the bridge financial company to a company other than the Corporation and other than another bridge financial company;

[(C) the sale of 80 percent, or more, of the capital stock of the bridge financial company to a person other than the Corporation and other than another bridge financial company;

[(D) at the election of the Corporation, either the assumption of all or substantially all of the liabilities of the bridge financial company by a company that is not a bridge financial company, or the acquisition of all or substantially all of the assets of the bridge financial company by a company that is not a bridge financial company, or other entity as permitted under applicable law; and

[(E) the expiration of the period provided in paragraph (12), or the earlier dissolution of the bridge financial company, as provided in paragraph (15).

[(14) EFFECT OF TERMINATION EVENTS.—

[(A) MERGER OR CONSOLIDATION.—A merger or consolidation, described in paragraph (13)(A) shall be conducted in accordance with, and shall have the effect provided in, the provisions of applicable law. For the purpose of effecting such a merger or consolidation, the bridge financial company shall be treated as a corporation organized under the laws of the State of Delaware (unless the law of another State has been selected by the bridge financial company in accordance with paragraph (2)(F)), and the Corporation shall be treated as the sole shareholder thereof, notwithstanding any other provision of State or Federal law.

[(B) CHARTER CONVERSION.—Following the sale of a majority of the capital stock of the bridge financial company, as provided in paragraph (13)(B), the Corporation may amend the charter of the bridge financial company to reflect the termination of the status of the bridge financial company as such, whereupon the company shall have all of the rights, powers, and privileges under its constituent documents and applicable Federal or State law. In connection therewith, the Corporation may take such steps as may be necessary or convenient to reincorporate the bridge financial company under the laws of a State and, notwithstanding any provisions of Federal or State law, such State-chartered corporation shall be deemed to succeed by operation of law to such rights, titles, powers, and interests of the bridge financial company as the Corporation may provide, with the same effect as if the bridge financial company had merged with the State-chartered corporation under provisions of the corporate laws of such State.

[(C) SALE OF STOCK.—Following the sale of 80 percent or more of the capital stock of a bridge financial company, as provided in paragraph (13)(C), the company shall have all of the rights, powers, and privileges under its constituent documents and applicable Federal or State law. In connection therewith, the Corporation may take such steps as may be necessary or convenient to reincorporate the bridge financial company under the laws of a State and, notwithstanding any provisions of Federal or State law, the State-chartered corporation shall be deemed to succeed by operation of law to such rights, titles, powers and interests of the bridge financial company as the Corporation may provide, with the same effect as if the bridge financial com-

pany had merged with the State-chartered corporation under provisions of the corporate laws of such State.

[(D) ASSUMPTION OF LIABILITIES AND SALE OF ASSETS.—Following the assumption of all or substantially all of the liabilities of the bridge financial company, or the sale of all or substantially all of the assets of the bridge financial company, as provided in paragraph (13)(D), at the election of the Corporation, the bridge financial company may retain its status as such for the period provided in paragraph (12) or may be dissolved at the election of the Corporation.

[(E) AMENDMENTS TO CHARTER.—Following the consummation of a transaction described in subparagraph (A), (B), (C), or (D) of paragraph (13), the charter of the resulting company shall be amended to reflect the termination of bridge financial company status, if appropriate.

[(15) DISSOLUTION OF BRIDGE FINANCIAL COMPANY.—

[(A) IN GENERAL.—Notwithstanding any other provision of Federal or State law, if the status of a bridge financial company as such has not previously been terminated by the occurrence of an event specified in subparagraph (A), (B), (C), or (D) of paragraph (13)—

[(i) the Corporation may, in its discretion, dissolve the bridge financial company in accordance with this paragraph at any time; and

[(ii) the Corporation shall promptly commence dissolution proceedings in accordance with this paragraph upon the expiration of the 2-year period following the date on which the bridge financial company was chartered, or any extension thereof, as provided in paragraph (12).

[(B) PROCEDURES.—The Corporation shall remain the receiver for a bridge financial company for the purpose of dissolving the bridge financial company. The Corporation as receiver for a bridge financial company shall wind up the affairs of the bridge financial company in conformity with the provisions of law relating to the liquidation of covered financial companies under this title. With respect to any such bridge financial company, the Corporation as receiver shall have all the rights, powers, and privileges and shall perform the duties related to the exercise of such rights, powers, or privileges granted by law to the Corporation as receiver for a covered financial company under this title and, notwithstanding any other provision of law, in the exercise of such rights, powers, and privileges, the Corporation shall not be subject to the direction or supervision of any State agency or other Federal agency.

[(16) AUTHORITY TO OBTAIN CREDIT.—

[(A) IN GENERAL.—A bridge financial company may obtain unsecured credit and issue unsecured debt.

[(B) INABILITY TO OBTAIN CREDIT.—If a bridge financial company is unable to obtain unsecured credit or issue unsecured debt, the Corporation may authorize the obtaining

of credit or the issuance of debt by the bridge financial company—

[(i) with priority over any or all of the obligations of the bridge financial company;

[(ii) secured by a lien on property of the bridge financial company that is not otherwise subject to a lien; or

[(iii) secured by a junior lien on property of the bridge financial company that is subject to a lien.

[(C) LIMITATIONS.—

[(i) IN GENERAL.—The Corporation, after notice and a hearing, may authorize the obtaining of credit or the issuance of debt by a bridge financial company that is secured by a senior or equal lien on property of the bridge financial company that is subject to a lien, only if—

[(I) the bridge financial company is unable to otherwise obtain such credit or issue such debt; and

[(II) there is adequate protection of the interest of the holder of the lien on the property with respect to which such senior or equal lien is proposed to be granted.

[(ii) HEARING.—The hearing required pursuant to this subparagraph shall be before a court of the United States, which shall have jurisdiction to conduct such hearing and to authorize a bridge financial company to obtain secured credit under clause (i).

[(D) BURDEN OF PROOF.—In any hearing under this paragraph, the Corporation has the burden of proof on the issue of adequate protection.

[(E) QUALIFIED FINANCIAL CONTRACTS.—No credit or debt obtained or issued by a bridge financial company may contain terms that impair the rights of a counterparty to a qualified financial contract upon a default by the bridge financial company, other than the priority of such counterparty's unsecured claim (after the exercise of rights) relative to the priority of the bridge financial company's obligations in respect of such credit or debt, unless such counterparty consents in writing to any such impairment.

[(17) EFFECT ON DEBTS AND LIENS.—The reversal or modification on appeal of an authorization under this subsection to obtain credit or issue debt, or of a grant under this section of a priority or a lien, does not affect the validity of any debt so issued, or any priority or lien so granted, to an entity that extended such credit in good faith, whether or not such entity knew of the pendency of the appeal, unless such authorization and the issuance of such debt, or the granting of such priority or lien, were stayed pending appeal.

[(i) SHARING RECORDS.—If the Corporation has been appointed as receiver for a covered financial company, other Federal regulators shall make all records relating to the covered financial company available to the Corporation, which may be used by the Cor-

poration in any manner that the Corporation determines to be appropriate.

[(j) EXPEDITED PROCEDURES FOR CERTAIN CLAIMS.—

[(1) TIME FOR FILING NOTICE OF APPEAL.—The notice of appeal of any order, whether interlocutory or final, entered in any case brought by the Corporation against a director, officer, employee, agent, attorney, accountant, or appraiser of the covered financial company, or any other person employed by or providing services to a covered financial company, shall be filed not later than 30 days after the date of entry of the order. The hearing of the appeal shall be held not later than 120 days after the date of the notice of appeal. The appeal shall be decided not later than 180 days after the date of the notice of appeal.

[(2) SCHEDULING.—The court shall expedite the consideration of any case brought by the Corporation against a director, officer, employee, agent, attorney, accountant, or appraiser of a covered financial company or any other person employed by or providing services to a covered financial company. As far as practicable, the court shall give such case priority on its docket.

[(3) JUDICIAL DISCRETION.—The court may modify the schedule and limitations stated in paragraphs (1) and (2) in a particular case, based on a specific finding that the ends of justice that would be served by making such a modification would outweigh the best interest of the public in having the case resolved expeditiously.

[(k) FOREIGN INVESTIGATIONS.—The Corporation, as receiver for any covered financial company, and for purposes of carrying out any power, authority, or duty with respect to a covered financial company—

[(1) may request the assistance of any foreign financial authority and provide assistance to any foreign financial authority in accordance with section 8(v) of the Federal Deposit Insurance Act, as if the covered financial company were an insured depository institution, the Corporation were the appropriate Federal banking agency for the company, and any foreign financial authority were the foreign banking authority; and

[(2) may maintain an office to coordinate foreign investigations or investigations on behalf of foreign financial authorities.

[(l) PROHIBITION ON ENTERING SECRECY AGREEMENTS AND PROTECTIVE ORDERS.—The Corporation may not enter into any agreement or approve any protective order which prohibits the Corporation from disclosing the terms of any settlement of an administrative or other action for damages or restitution brought by the Corporation in its capacity as receiver for a covered financial company.

[(m) LIQUIDATION OF CERTAIN COVERED FINANCIAL COMPANIES OR BRIDGE FINANCIAL COMPANIES.—

[(1) IN GENERAL.—Except as specifically provided in this section, and notwithstanding any other provision of law, the Corporation, in connection with the liquidation of any covered fi-

nancial company or bridge financial company with respect to which the Corporation has been appointed as receiver, shall—

[(A) in the case of any covered financial company or bridge financial company that is a stockbroker, but is not a member of the Securities Investor Protection Corporation, apply the provisions of subchapter III of chapter 7 of the Bankruptcy Code, in respect of the distribution to any customer of all customer name security and customer property and member property, as if such covered financial company or bridge financial company were a debtor for purposes of such subchapter; or

[(B) in the case of any covered financial company or bridge financial company that is a commodity broker, apply the provisions of subchapter IV of chapter 7 the Bankruptcy Code, in respect of the distribution to any customer of all customer property and member property, as if such covered financial company or bridge financial company were a debtor for purposes of such subchapter.

[(2) DEFINITIONS.—For purposes of this subsection—

[(A) the terms "customer", "customer name security", and "customer property and member property" have the same meanings as in sections 741 and 761 of title 11, United States Code; and

[(B) the terms "commodity broker" and "stockbroker" have the same meanings as in section 101 of the Bankruptcy Code.

[(n) ORDERLY LIQUIDATION FUND.—

[(1) ESTABLISHMENT.—There is established in the Treasury of the United States a separate fund to be known as the "Orderly Liquidation Fund", which shall be available to the Corporation to carry out the authorities contained in this title, for the cost of actions authorized by this title, including the orderly liquidation of covered financial companies, payment of administrative expenses, the payment of principal and interest by the Corporation on obligations issued under paragraph (5), and the exercise of the authorities of the Corporation under this title.

[(2) PROCEEDS.—Amounts received by the Corporation, including assessments received under subsection (o), proceeds of obligations issued under paragraph (5), interest and other earnings from investments, and repayments to the Corporation by covered financial companies, shall be deposited into the Fund.

[(3) MANAGEMENT.—The Corporation shall manage the Fund in accordance with this subsection and the policies and procedures established under section 203(d).

[(4) INVESTMENTS.—At the request of the Corporation, the Secretary may invest such portion of amounts held in the Fund that are not, in the judgment of the Corporation, required to meet the current needs of the Corporation, in obligations of the United States having suitable maturities, as determined by the Corporation. The interest on and the proceeds from the sale or redemption of such obligations shall be credited to the Fund.

[(5) AUTHORITY TO ISSUE OBLIGATIONS.—

[(A) CORPORATION AUTHORIZED TO ISSUE OBLIGATIONS.—Upon appointment by the Secretary of the Corporation as receiver for a covered financial company, the Corporation is authorized to issue obligations to the Secretary.

[(B) SECRETARY AUTHORIZED TO PURCHASE OBLIGATIONS.—The Secretary may, under such terms and conditions as the Secretary may require, purchase or agree to purchase any obligations issued under subparagraph (A), and for such purpose, the Secretary is authorized to use as a public debt transaction the proceeds of the sale of any securities issued under chapter 31 of title 31, United States Code, and the purposes for which securities may be issued under chapter 31 of title 31, United States Code, are extended to include such purchases.

[(C) INTEREST RATE.—Each purchase of obligations by the Secretary under this paragraph shall be upon such terms and conditions as to yield a return at a rate determined by the Secretary, taking into consideration the current average yield on outstanding marketable obligations of the United States of comparable maturity, plus an interest rate surcharge to be determined by the Secretary, which shall be greater than the difference between—

[(i) the current average rate on an index of corporate obligations of comparable maturity; and

[(ii) the current average rate on outstanding marketable obligations of the United States of comparable maturity.

[(D) SECRETARY AUTHORIZED TO SELL OBLIGATIONS.—The Secretary may sell, upon such terms and conditions as the Secretary shall determine, any of the obligations acquired under this paragraph.

[(E) PUBLIC DEBT TRANSACTIONS.—All purchases and sales by the Secretary of such obligations under this paragraph shall be treated as public debt transactions of the United States, and the proceeds from the sale of any obligations acquired by the Secretary under this paragraph shall be deposited into the Treasury of the United States as miscellaneous receipts.

[(6) MAXIMUM OBLIGATION LIMITATION.—The Corporation may not, in connection with the orderly liquidation of a covered financial company, issue or incur any obligation, if, after issuing or incurring the obligation, the aggregate amount of such obligations outstanding under this subsection for each covered financial company would exceed—

[(A) an amount that is equal to 10 percent of the total consolidated assets of the covered financial company, based on the most recent financial statement available, during the 30-day period immediately following the date of appointment of the Corporation as receiver (or a shorter time period if the Corporation has calculated the amount described under subparagraph (B)); and

[(B) the amount that is equal to 90 percent of the fair value of the total consolidated assets of each covered finan-

cial company that are available for repayment, after the time period described in subparagraph (A).

[(7) RULEMAKING.—The Corporation and the Secretary shall jointly, in consultation with the Council, prescribe regulations governing the calculation of the maximum obligation limitation defined in this paragraph.

[(8) RULE OF CONSTRUCTION.—

[(A) IN GENERAL.—Nothing in this section shall be construed to affect the authority of the Corporation under subsection (a) or (b) of section 14 or section 15(c)(5) of the Federal Deposit Insurance Act (12 U.S.C. 1824, 1825(c)(5)), the management of the Deposit Insurance Fund by the Corporation, or the resolution of insured depository institutions, provided that—

[(i) the authorities of the Corporation contained in this title shall not be used to assist the Deposit Insurance Fund or to assist any financial company under applicable law other than this Act;

[(ii) the authorities of the Corporation relating to the Deposit Insurance Fund, or any other responsibilities of the Corporation under applicable law other than this title, shall not be used to assist a covered financial company pursuant to this title; and

[(iii) the Deposit Insurance Fund may not be used in any manner to otherwise circumvent the purposes of this title.

[(B) VALUATION.—For purposes of determining the amount of obligations under this subsection—

[(i) the Corporation shall include as an obligation any contingent liability of the Corporation pursuant to this title; and

[(ii) the Corporation shall value any contingent liability at its expected cost to the Corporation.

[(9) ORDERLY LIQUIDATION AND REPAYMENT PLANS.—

[(A) ORDERLY LIQUIDATION PLAN.—Amounts in the Fund shall be available to the Corporation with regard to a covered financial company for which the Corporation is appointed receiver after the Corporation has developed an orderly liquidation plan that is acceptable to the Secretary with regard to such covered financial company, including the provision and use of funds, including taking any actions specified under section 204(d) and subsection (h)(2)(G)(iv) and (h)(9) of this section, and payments to third parties. The orderly liquidation plan shall take into account actions to avoid or mitigate potential adverse effects on low income, minority, or underserved communities affected by the failure of the covered financial company, and shall provide for coordination with the primary financial regulatory agencies, as appropriate, to ensure that such actions are taken. The Corporation may, at any time, amend any orderly liquidation plan approved by the Secretary with the concurrence of the Secretary.

[(B) MANDATORY REPAYMENT PLAN.—

[(i) IN GENERAL.—No amount authorized under paragraph (6)(B) may be provided by the Secretary to the Corporation under paragraph (5), unless an agreement is in effect between the Secretary and the Corporation that—

[(I) provides a specific plan and schedule to achieve the repayment of the outstanding amount of any borrowing under paragraph (5); and

[(II) demonstrates that income to the Corporation from the liquidated assets of the covered financial company and assessments under subsection (o) will be sufficient to amortize the outstanding balance within the period established in the repayment schedule and pay the interest accruing on such balance within the time provided in subsection (o)(1)(B).

[(ii) CONSULTATION WITH AND REPORT TO CONGRESS.—The Secretary and the Corporation shall—

[(I) consult with the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives on the terms of any repayment schedule agreement; and

[(II) submit a copy of the repayment schedule agreement to the Committees described in subclause (I) before the end of the 30-day period beginning on the date on which any amount is provided by the Secretary to the Corporation under paragraph (5).

[(10) IMPLEMENTATION EXPENSES.—

[(A) IN GENERAL.—Reasonable implementation expenses of the Corporation incurred after the date of enactment of this Act shall be treated as expenses of the Council.

[(B) REQUESTS FOR REIMBURSEMENT.—The Corporation shall periodically submit a request for reimbursement for implementation expenses to the Chairperson of the Council, who shall arrange for prompt reimbursement to the Corporation of reasonable implementation expenses.

[(C) DEFINITION.—As used in this paragraph, the term "implementation expenses"—

[(i) means costs incurred by the Corporation beginning on the date of enactment of this Act, as part of its efforts to implement this title that do not relate to a particular covered financial company; and

[(ii) includes the costs incurred in connection with the development of policies, procedures, rules, and regulations and other planning activities of the Corporation consistent with carrying out this title.

[(o) ASSESSMENTS.—

[(1) RISK-BASED ASSESSMENTS.—

[(A) ELIGIBLE FINANCIAL COMPANIES DEFINED.—For purposes of this subsection, the term "eligible financial company" means any bank holding company with total consolidated assets equal to or greater than $50,000,000,000 and

any nonbank financial company supervised by the Board of Governors.

[(B) ASSESSMENTS.—The Corporation shall charge one or more risk-based assessments in accordance with the provisions of subparagraph (D), if such assessments are necessary to pay in full the obligations issued by the Corporation to the Secretary under this title within 60 months of the date of issuance of such obligations.

[(C) EXTENSIONS AUTHORIZED.—The Corporation may, with the approval of the Secretary, extend the time period under subparagraph (B), if the Corporation determines that an extension is necessary to avoid a serious adverse effect on the financial system of the United States.

[(D) APPLICATION OF ASSESSMENTS.—To meet the requirements of subparagraph (B), the Corporation shall—

[(i) impose assessments, as soon as practicable, on any claimant that received additional payments or amounts from the Corporation pursuant to subsection (b)(4), (d)(4), or (h)(5)(E), except for payments or amounts necessary to initiate and continue operations essential to implementation of the receivership or any bridge financial company, to recover on a cumulative basis, the entire difference between—

[(I) the aggregate value the claimant received from the Corporation on a claim pursuant to this title (including pursuant to subsection (b)(4), (d)(4), and (h)(5)(E)), as of the date on which such value was received; and

[(II) the value the claimant was entitled to receive from the Corporation on such claim solely from the proceeds of the liquidation of the covered financial company under this title; and

[(ii) if the amounts to be recovered on a cumulative basis under clause (i) are insufficient to meet the requirements of subparagraph (B), after taking into account the considerations set forth in paragraph (4), impose assessments on—

[(I) eligible financial companies; and

[(II) financial companies with total consolidated assets equal to or greater than $50,000,000,000 that are not eligible financial companies.

[(E) PROVISION OF FINANCING.—Payments or amounts necessary to initiate and continue operations essential to implementation of the receivership or any bridge financial company described in subparagraph (D)(i) shall not include the provision of financing, as defined by rule of the Corporation, to third parties.

[(2) GRADUATED ASSESSMENT RATE.—The Corporation shall impose assessments on a graduated basis, with financial companies having greater assets and risk being assessed at a higher rate.

[(3) NOTIFICATION AND PAYMENT.—The Corporation shall notify each financial company of that company's assessment under this subsection. Any financial company subject to assess-

ment under this subsection shall pay such assessment in accordance with the regulations prescribed pursuant to paragraph (6).

[(4) RISK-BASED ASSESSMENT CONSIDERATIONS.—In imposing assessments under paragraph (1)(D)(ii), the Corporation shall use a risk matrix. The Council shall make a recommendation to the Corporation on the risk matrix to be used in imposing such assessments, and the Corporation shall take into account any such recommendation in the establishment of the risk matrix to be used to impose such assessments. In recommending or establishing such risk matrix, the Council and the Corporation, respectively, shall take into account—

[(A) economic conditions generally affecting financial companies so as to allow assessments to increase during more favorable economic conditions and to decrease during less favorable economic conditions;

[(B) any assessments imposed on a financial company or an affiliate of a financial company that—

[(i) is an insured depository institution, assessed pursuant to section 7 or 13(c)(4)(G) of the Federal Deposit Insurance Act;

[(ii) is a member of the Securities Investor Protection Corporation, assessed pursuant to section 4 of the Securities Investor Protection Act of 1970 (15 U.S.C. 78ddd);

[(iii) is an insured credit union, assessed pursuant to section 202(c)(1)(A)(i) of the Federal Credit Union Act (12 U.S.C. 1782(c)(1)(A)(i)); or

[(iv) is an insurance company, assessed pursuant to applicable State law to cover (or reimburse payments made to cover) the costs of the rehabilitation, liquidation, or other State insolvency proceeding with respect to 1 or more insurance companies;

[(C) the risks presented by the financial company to the financial system and the extent to which the financial company has benefitted, or likely would benefit, from the orderly liquidation of a financial company under this title, including—

[(i) the amount, different categories, and concentrations of assets of the financial company and its affiliates, including both on-balance sheet and off-balance sheet assets;

[(ii) the activities of the financial company and its affiliates;

[(iii) the relevant market share of the financial company and its affiliates;

[(iv) the extent to which the financial company is leveraged;

[(v) the potential exposure to sudden calls on liquidity precipitated by economic distress;

[(vi) the amount, maturity, volatility, and stability of the company's financial obligations to, and relationship with, other financial companies;

[(vii) the amount, maturity, volatility, and stability of the liabilities of the company, including the degree of reliance on short-term funding, taking into consideration existing systems for measuring a company's risk-based capital;

[(viii) the stability and variety of the company's sources of funding;

[(ix) the company's importance as a source of credit for households, businesses, and State and local governments and as a source of liquidity for the financial system;

[(x) the extent to which assets are simply managed and not owned by the financial company and the extent to which ownership of assets under management is diffuse; and

[(xi) the amount, different categories, and concentrations of liabilities, both insured and uninsured, contingent and noncontingent, including both on-balance sheet and off-balance sheet liabilities, of the financial company and its affiliates;

[(D) any risks presented by the financial company during the 10-year period immediately prior to the appointment of the Corporation as receiver for the covered financial company that contributed to the failure of the covered financial company; and

[(E) such other risk-related factors as the Corporation, or the Council, as applicable, may determine to be appropriate.

[(5) COLLECTION OF INFORMATION.—The Corporation may impose on covered financial companies such collection of information requirements as the Corporation deems necessary to carry out this subsection after the appointment of the Corporation as receiver under this title.

[(6) RULEMAKING.—

[(A) IN GENERAL.—The Corporation shall prescribe regulations to carry out this subsection. The Corporation shall consult with the Secretary in the development and finalization of such regulations.

[(B) EQUITABLE TREATMENT.—The regulations prescribed under subparagraph (A) shall take into account the differences in risks posed to the financial stability of the United States by financial companies, the differences in the liability structures of financial companies, and the different bases for other assessments that such financial companies may be required to pay, to ensure that assessed financial companies are treated equitably and that assessments under this subsection reflect such differences.

[(p) UNENFORCEABILITY OF CERTAIN AGREEMENTS.—

[(1) IN GENERAL.—No provision described in paragraph (2) shall be enforceable against or impose any liability on any person, as such enforcement or liability shall be contrary to public policy.

[(2) PROHIBITED PROVISIONS.—A provision described in this paragraph is any term contained in any existing or future

standstill, confidentiality, or other agreement that, directly or indirectly—

[(A) affects, restricts, or limits the ability of any person to offer to acquire or acquire;

[(B) prohibits any person from offering to acquire or acquiring; or

[(C) prohibits any person from using any previously disclosed information in connection with any such offer to acquire or acquisition of,

all or part of any covered financial company, including any liabilities, assets, or interest therein, in connection with any transaction in which the Corporation exercises its authority under this title.

[(q) OTHER EXEMPTIONS.—

[(1) IN GENERAL.—When acting as a receiver under this title—

[(A) the Corporation, including its franchise, its capital, reserves and surplus, and its income, shall be exempt from all taxation imposed by any State, county, municipality, or local taxing authority, except that any real property of the Corporation shall be subject to State, territorial, county, municipal, or local taxation to the same extent according to its value as other real property is taxed, except that, notwithstanding the failure of any person to challenge an assessment under State law of the value of such property, such value, and the tax thereon, shall be determined as of the period for which such tax is imposed;

[(B) no property of the Corporation shall be subject to levy, attachment, garnishment, foreclosure, or sale without the consent of the Corporation, nor shall any involuntary lien attach to the property of the Corporation; and

[(C) the Corporation shall not be liable for any amounts in the nature of penalties or fines, including those arising from the failure of any person to pay any real property, personal property, probate, or recording tax or any recording or filing fees when due; and

[(D) the Corporation shall be exempt from all prosecution by the United States or any State, county, municipality, or local authority for any criminal offense arising under Federal, State, county, municipal, or local law, which was allegedly committed by the covered financial company, or persons acting on behalf of the covered financial company, prior to the appointment of the Corporation as receiver.

[(2) LIMITATION.—Paragraph (1) shall not apply with respect to any tax imposed (or other amount arising) under the Internal Revenue Code of 1986.

[(r) CERTAIN SALES OF ASSETS PROHIBITED.—

[(1) PERSONS WHO ENGAGED IN IMPROPER CONDUCT WITH, OR CAUSED LOSSES TO, COVERED FINANCIAL COMPANIES.—The Corporation shall prescribe regulations which, at a minimum, shall prohibit the sale of assets of a covered financial company by the Corporation to—

[(A) any person who—

[(i) has defaulted, or was a member of a partnership or an officer or director of a corporation that has defaulted, on 1 or more obligations, the aggregate amount of which exceeds $1,000,000, to such covered financial company;

[(ii) has been found to have engaged in fraudulent activity in connection with any obligation referred to in clause (i); and

[(iii) proposes to purchase any such asset in whole or in part through the use of the proceeds of a loan or advance of credit from the Corporation or from any covered financial company;

[(B) any person who participated, as an officer or director of such covered financial company or of any affiliate of such company, in a material way in any transaction that resulted in a substantial loss to such covered financial company; or

[(C) any person who has demonstrated a pattern or practice of defalcation regarding obligations to such covered financial company.

[(2) CONVICTED DEBTORS.—Except as provided in paragraph (3), a person may not purchase any asset of such institution from the receiver, if that person—

[(A) has been convicted of an offense under section 215, 656, 657, 1005, 1006, 1007, 1008, 1014, 1032, 1341, 1343, or 1344 of title 18, United States Code, or of conspiring to commit such an offense, affecting any covered financial company; and

[(B) is in default on any loan or other extension of credit from such covered financial company which, if not paid, will cause substantial loss to the Fund or the Corporation.

[(3) SETTLEMENT OF CLAIMS.—Paragraphs (1) and (2) shall not apply to the sale or transfer by the Corporation of any asset of any covered financial company to any person, if the sale or transfer of the asset resolves or settles, or is part of the resolution or settlement, of 1 or more claims that have been, or could have been, asserted by the Corporation against the person.

[(4) DEFINITION OF DEFAULT.—For purposes of this subsection, the term "default" means a failure to comply with the terms of a loan or other obligation to such an extent that the property securing the obligation is foreclosed upon.

[(s) RECOUPMENT OF COMPENSATION FROM SENIOR EXECUTIVES AND DIRECTORS.—

[(1) IN GENERAL.—The Corporation, as receiver of a covered financial company, may recover from any current or former senior executive or director substantially responsible for the failed condition of the covered financial company any compensation received during the 2-year period preceding the date on which the Corporation was appointed as the receiver of the covered financial company, except that, in the case of fraud, no time limit shall apply.

[(2) COST CONSIDERATIONS.—In seeking to recover any such compensation, the Corporation shall weigh the financial and

deterrent benefits of such recovery against the cost of executing the recovery.

[(3) RULEMAKING.—The Corporation shall promulgate regulations to implement the requirements of this subsection, including defining the term "compensation" to mean any financial remuneration, including salary, bonuses, incentives, benefits, severance, deferred compensation, or golden parachute benefits, and any profits realized from the sale of the securities of the covered financial company.

[SEC. 211. MISCELLANEOUS PROVISIONS.

[(a) CLARIFICATION OF PROHIBITION REGARDING CONCEALMENT OF ASSETS FROM RECEIVER OR LIQUIDATING AGENT.—Section 1032(1) of title 18, United States Code, is amended by inserting "the Federal Deposit Insurance Corporation acting as receiver for a covered financial company, in accordance with title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act," before "or the National Credit".

[(b) CONFORMING AMENDMENT.—Section 1032 of title 18, United States Code, is amended in the section heading, by striking "OF FINANCIAL INSTITUTION".

[(c) FEDERAL DEPOSIT INSURANCE CORPORATION IMPROVEMENT ACT OF 1991.—Section 403(a) of the Federal Deposit Insurance Corporation Improvement Act of 1991 (12 U.S.C. 4403(a)) is amended by inserting "section 210(c) of the Dodd-Frank Wall Street Reform and Consumer Protection Act, section 1367 of the Federal Housing Enterprises Financial Safety and Soundness Act of 1992 (12 U.S.C. 4617(d))," after "section 11(e) of the Federal Deposit Insurance Act,".

[(d) FDIC INSPECTOR GENERAL REVIEWS.—

[(1) SCOPE.—The Inspector General of the Corporation shall conduct, supervise, and coordinate audits and investigations of the liquidation of any covered financial company by the Corporation as receiver under this title, including collecting and summarizing—

[(A) a description of actions taken by the Corporation as receiver;

[(B) a description of any material sales, transfers, mergers, obligations, purchases, and other material transactions entered into by the Corporation;

[(C) an evaluation of the adequacy of the policies and procedures of the Corporation under section 203(d) and orderly liquidation plan under section 210(n)(14);

[(D) an evaluation of the utilization by the Corporation of the private sector in carrying out its functions, including the adequacy of any conflict-of-interest reviews; and

[(E) an evaluation of the overall performance of the Corporation in liquidating the covered financial company, including administrative costs, timeliness of liquidation process, and impact on the financial system.

[(2) FREQUENCY.—Not later than 6 months after the date of appointment of the Corporation as receiver under this title and every 6 months thereafter, the Inspector General of the Corporation shall conduct the audit and investigation described in paragraph (1).

[(3) REPORTS AND TESTIMONY.—The Inspector General of the Corporation shall include in the semiannual reports required by section 5(a) of the Inspector General Act of 1978 (5 U.S.C. App.), a summary of the findings and evaluations under paragraph (1), and shall appear before the appropriate committees of Congress, if requested, to present each such report.

[(4) FUNDING.—

[(A) INITIAL FUNDING.—The expenses of the Inspector General of the Corporation in carrying out this subsection shall be considered administrative expenses of the receivership.

[(B) ADDITIONAL FUNDING.—If the maximum amount available to the Corporation as receiver under this title is insufficient to enable the Inspector General of the Corporation to carry out the duties under this subsection, the Corporation shall pay such additional amounts from assessments imposed under section 210.

[(5) TERMINATION OF RESPONSIBILITIES.—The duties and responsibilities of the Inspector General of the Corporation under this subsection shall terminate 1 year after the date of termination of the receivership under this title.

[(e) TREASURY INSPECTOR GENERAL REVIEWS.—

[(1) SCOPE.—The Inspector General of the Department of the Treasury shall conduct, supervise, and coordinate audits and investigations of actions taken by the Secretary related to the liquidation of any covered financial company under this title, including collecting and summarizing—

[(A) a description of actions taken by the Secretary under this title;

[(B) an analysis of the approval by the Secretary of the policies and procedures of the Corporation under section 203 and acceptance of the orderly liquidation plan of the Corporation under section 210; and

[(C) an assessment of the terms and conditions underlying the purchase by the Secretary of obligations of the Corporation under section 210.

[(2) FREQUENCY.—Not later than 6 months after the date of appointment of the Corporation as receiver under this title and every 6 months thereafter, the Inspector General of the Department of the Treasury shall conduct the audit and investigation described in paragraph (1).

[(3) REPORTS AND TESTIMONY.—The Inspector General of the Department of the Treasury shall include in the semiannual reports required by section 5(a) of the Inspector General Act of 1978 (5 U.S.C. App.), a summary of the findings and assessments under paragraph (1), and shall appear before the appropriate committees of Congress, if requested, to present each such report.

[(4) TERMINATION OF RESPONSIBILITIES.—The duties and responsibilities of the Inspector General of the Department of the Treasury under this subsection shall terminate 1 year after the date on which the obligations purchased by the Secretary from the Corporation under section 210 are fully redeemed.

[(f) PRIMARY FINANCIAL REGULATORY AGENCY INSPECTOR GENERAL REVIEWS.—

[(1) SCOPE.—Upon the appointment of the Corporation as receiver for a covered financial company supervised by a Federal primary financial regulatory agency or the Board of Governors under section 165, the Inspector General of the agency or the Board of Governors shall make a written report reviewing the supervision by the agency or the Board of Governors of the covered financial company, which shall—

[(A) evaluate the effectiveness of the agency or the Board of Governors in carrying out its supervisory responsibilities with respect to the covered financial company;

[(B) identify any acts or omissions on the part of agency or Board of Governors officials that contributed to the covered financial company being in default or in danger of default;

[(C) identify any actions that could have been taken by the agency or the Board of Governors that would have prevented the company from being in default or in danger of default; and

[(D) recommend appropriate administrative or legislative action.

[(2) REPORTS AND TESTIMONY.—Not later than 1 year after the date of appointment of the Corporation as receiver under this title, the Inspector General of the Federal primary financial regulatory agency or the Board of Governors shall provide the report required by paragraph (1) to such agency or the Board of Governors, and along with such agency or the Board of Governors, as applicable, shall appear before the appropriate committees of Congress, if requested, to present the report required by paragraph (1). Not later than 90 days after the date of receipt of the report required by paragraph (1), such agency or the Board of Governors, as applicable, shall provide a written report to Congress describing any actions taken in response to the recommendations in the report, and if no such actions were taken, describing the reasons why no actions were taken.

[SEC. 212. PROHIBITION OF CIRCUMVENTION AND PREVENTION OF CONFLICTS OF INTEREST.

[(a) NO OTHER FUNDING.—Funds for the orderly liquidation of any covered financial company under this title shall only be provided as specified under this title.

[(b) LIMIT ON GOVERNMENTAL ACTIONS.—No governmental entity may take any action to circumvent the purposes of this title.

[(c) CONFLICT OF INTEREST.—In the event that the Corporation is appointed receiver for more than 1 covered financial company or is appointed receiver for a covered financial company and receiver for any insured depository institution that is an affiliate of such covered financial company, the Corporation shall take appropriate action, as necessary to avoid any conflicts of interest that may arise in connection with multiple receiverships.

[SEC. 213. BAN ON CERTAIN ACTIVITIES BY SENIOR EXECUTIVES AND DIRECTORS.

[(a) PROHIBITION AUTHORITY.—The Board of Governors or, if the covered financial company was not supervised by the Board of Governors, the Corporation, may exercise the authority provided by this section.

[(b) AUTHORITY TO ISSUE ORDER.—The appropriate agency described in subsection (a) may take any action authorized by subsection (c), if the agency determines that—

[(1) a senior executive or a director of the covered financial company, prior to the appointment of the Corporation as receiver, has, directly or indirectly—

[(A) violated—

[(i) any law or regulation;

[(ii) any cease-and-desist order which has become final;

[(iii) any condition imposed in writing by a Federal agency in connection with any action on any application, notice, or request by such company or senior executive; or

[(iv) any written agreement between such company and such agency;

[(B) engaged or participated in any unsafe or unsound practice in connection with any financial company; or

[(C) committed or engaged in any act, omission, or practice which constitutes a breach of the fiduciary duty of such senior executive or director;

[(2) by reason of the violation, practice, or breach described in any subparagraph of paragraph (1), such senior executive or director has received financial gain or other benefit by reason of such violation, practice, or breach and such violation, practice, or breach contributed to the failure of the company; and

[(3) such violation, practice, or breach—

[(A) involves personal dishonesty on the part of such senior executive or director; or

[(B) demonstrates willful or continuing disregard by such senior executive or director for the safety or soundness of such company.

[(c) AUTHORIZED ACTIONS.—

[(1) IN GENERAL.—The appropriate agency for a financial company, as described in subsection (a), may serve upon a senior executive or director described in subsection (b) a written notice of the intention of the agency to prohibit any further participation by such person, in any manner, in the conduct of the affairs of any financial company for a period of time determined by the appropriate agency to be commensurate with such violation, practice, or breach, provided such period shall be not less than 2 years.

[(2) PROCEDURES.—The due process requirements and other procedures under section 8(e) of the Federal Deposit Insurance Act (12 U.S.C. 1818(e)) shall apply to actions under this section as if the covered financial company were an insured depository institution and the senior executive or director were an institution-affiliated party, as those terms are defined in that Act.

[(d) REGULATIONS.—The Corporation and the Board of Governors, in consultation with the Council, shall jointly prescribe rules or regulations to administer and carry out this section, including rules, regulations, or guidelines to further define the term senior executive for the purposes of this section.

[SEC. 214. PROHIBITION ON TAXPAYER FUNDING.

[(a) LIQUIDATION REQUIRED.—All financial companies put into receivership under this title shall be liquidated. No taxpayer funds shall be used to prevent the liquidation of any financial company under this title.

[(b) RECOVERY OF FUNDS.—All funds expended in the liquidation of a financial company under this title shall be recovered from the disposition of assets of such financial company, or shall be the responsibility of the financial sector, through assessments.

[(c) NO LOSSES TO TAXPAYERS.—Taxpayers shall bear no losses from the exercise of any authority under this title.

[SEC. 215. STUDY ON SECURED CREDITOR HAIRCUTS.

[(a) STUDY REQUIRED.—The Council shall conduct a study evaluating the importance of maximizing United States taxpayer protections and promoting market discipline with respect to the treatment of fully secured creditors in the utilization of the orderly liquidation authority authorized by this Act. In carrying out such study, the Council shall—

[(1) not be prejudicial to current or past laws or regulations with respect to secured creditor treatment in a resolution process;

[(2) study the similarities and differences between the resolution mechanisms authorized by the Bankruptcy Code, the Federal Deposit Insurance Corporation Improvement Act of 1991, and the orderly liquidation authority authorized by this Act;

[(3) determine how various secured creditors are treated in such resolution mechanisms and examine how a haircut (of various degrees) on secured creditors could improve market discipline and protect taxpayers;

[(4) compare the benefits and dynamics of prudent lending practices by depository institutions in secured loans for consumers and small businesses to the lending practices of secured creditors to large, interconnected financial firms;

[(5) consider whether credit differs according to different types of collateral and different terms and timing of the extension of credit; amd

[(6) include an examination of stakeholders who were unsecured or under-collateralized and seek collateral when a firm is failing, and the impact that such behavior has on financial stability and an orderly resolution that protects taxpayers if the firm fails.

[(b) REPORT.—Not later than the end of the 1-year period beginning on the date of enactment of this Act, the Council shall issue a report to the Congress containing all findings and conclusions made by the Council in carrying out the study required under subsection (a).

[SEC. 216. STUDY ON BANKRUPTCY PROCESS FOR FINANCIAL AND NONBANK FINANCIAL INSTITUTIONS.

[(a) STUDY.—

[(1) IN GENERAL.—Upon enactment of this Act, the Board of Governors, in consultation with the Administrative Office of the United States Courts, shall conduct a study regarding the resolution of financial companies under the Bankruptcy Code, under chapter 7 or 11 thereof.

[(2) ISSUES TO BE STUDIED.—Issues to be studied under this section include—

[(A) the effectiveness of chapter 7 and chapter 11 of the Bankruptcy Code in facilitating the orderly resolution or reorganization of systemic financial companies;

[(B) whether a special financial resolution court or panel of special masters or judges should be established to oversee cases involving financial companies to provide for the resolution of such companies under the Bankruptcy Code, in a manner that minimizes adverse impacts on financial markets without creating moral hazard;

[(C) whether amendments to the Bankruptcy Code should be adopted to enhance the ability of the Code to resolve financial companies in a manner that minimizes adverse impacts on financial markets without creating moral hazard;

[(D) whether amendments should be made to the Bankruptcy Code, the Federal Deposit Insurance Act, and other insolvency laws to address the manner in which qualified financial contracts of financial companies are treated; and

[(E) the implications, challenges, and benefits to creating a new chapter or subchapter of the Bankruptcy Code to deal with financial companies.

[(b) REPORTS TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, and in each successive year until the fifth year after the date of enactment of this Act, the Administrative Office of the United States courts shall submit to the Committees on Banking, Housing, and Urban Affairs and the Judiciary of the Senate and the Committees on Financial Services and the Judiciary of the House of Representatives a report summarizing the results of the study conducted under subsection (a).

[SEC. 217. STUDY ON INTERNATIONAL COORDINATION RELATING TO BANKRUPTCY PROCESS FOR NONBANK FINANCIAL INSTITUTIONS.

[(a) STUDY.—

[(1) IN GENERAL.—The Board of Governors, in consultation with the Administrative Office of the United States Courts, shall conduct a study regarding international coordination relating to the resolution of systemic financial companies under the United States Bankruptcy Code and applicable foreign law.

[(2) ISSUES TO BE STUDIED.—With respect to the bankruptcy process for financial companies, issues to be studied under this section include—

[(A) the extent to which international coordination currently exists;

[(B) current mechanisms and structures for facilitating international cooperation;

[(C) barriers to effective international coordination; and

[(D) ways to increase and make more effective international coordination of the resolution of financial companies, so as to minimize the impact on the financial system without creating moral hazard.

[(b) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, the Administrative office of the United States Courts shall submit to the Committees on Banking, Housing, and Urban Affairs and the Judiciary of the Senate and the Committees on Financial Services and the Judiciary of the House of Representatives a report summarizing the results of the study conducted under subsection (a).]

* * * * * * *

TITLE VII—WALL STREET TRANSPARENCY AND ACCOUNTABILITY

* * * * * * *

Subtitle A—Regulation of Over-the-Counter Swaps Markets

PART I—REGULATORY AUTHORITY

* * * * * * *

SEC. 716. PROHIBITION AGAINST FEDERAL GOVERNMENT BAILOUTS OF SWAPS ENTITIES.

(a) * * *

* * * * * * *

(g) EXCLUDED ENTITIES.—For purposes of this section, the term "swaps entity" shall not include any insured depository institution under the Federal Deposit Insurance Act [or a covered financial company under title II] which is in a conservatorship, receivership, or a bridge bank operated by the Federal Deposit Insurance Corporation.

* * * * * * *

TITLE XI—FEDERAL RESERVE SYSTEM PROVISIONS

* * * * * * *

SEC. 1100D. AMENDMENTS TO THE PAPERWORK REDUCTION ACT.

[(a) DESIGNATION AS AN INDEPENDENT AGENCY.—Section 2(5) of the Paperwork Reduction Act (44 U.S.C. 3502(5)) is amended by inserting "the Bureau of Consumer Financial Protection, the Office of Financial Research," after "the Securities and Exchange Commission,".]

(a) DESIGNATION AS AN INDEPENDENT AGENCY.—Section 3502(5) of subchapter I of chapter 35 of title 44, United States Code (commonly known as the Paperwork Reduction Act) is amended by inserting "the Bureau of Consumer Financial Protection," after "the Securities and Exchange Commission,".

* * * * * * *

SEC. 1105. EMERGENCY FINANCIAL STABILIZATION.

(a) * * *

* * * * * * *

(e) FUNDING.—

(1) * * *

* * * * * * *

(5) AUTHORITY OF THE SECRETARY.—The Secretary may purchase any obligations issued under paragraph (3)(A). For such purpose, the Secretary may use the proceeds of the sale of any securities issued under chapter 31 of title 31, United States Code, and the purposes for which securities may be issued under that chapter 31 are extended to include such purchases, and the [amount of any securities issued under that chapter 31 for such purpose shall be treated in the same manner as securities issued under section 208(n)(5)(E)] *issuances of such securities under that chapter 31 for such purpose shall by treated as public debt transactions of the United States, and the proceeds from the sale of any obligations acquired by the Secretary under this paragraph shall be deposited into the Treasury of the United States as miscellaneous receipts.*

* * * * * * *

SEC. 1106. ADDITIONAL RELATED AMENDMENTS.

(a) * * *

* * * * * * *

(c) EFFECT OF DEFAULT ON AN FDIC GUARANTEE.—If an insured depository institution or depository institution holding company (as those terms are defined in section 3 of the Federal Deposit Insurance Act) participating in a program under section 1105, or any participant in a debt guarantee program established pursuant to section 13(c)(4)(G)(i) of the Federal Deposit Insurance Act defaults on any obligation guaranteed by the Corporation after the date of enactment of this Act, the Corporation shall—

(1) * * *

(2) with respect to any other participating company that is not an insured depository institution that defaults—

[(A) require—

[(i) consideration of whether a determination shall be made, as provided in section 203 to resolve the company under section 202; and

[(ii) the company to file a petition for bankruptcy under section 301 of title 11, United States Code, if the Corporation is not appointed receiver pursuant to section 202 within 30 days of the date of default; or]

(A) require the company to file a petition for bankruptcy under section 301 of title 11, United States Code; or

* * * * * * *

FEDERAL DEPOSIT INSURANCE ACT

* * * * * * *

SEC. 10. (a) * * *

(b) EXAMINATIONS.—

(1) * * *

* * * * * * *

(3) SPECIAL EXAMINATION OF ANY INSURED DEPOSITORY INSTITUTION.—

(A) IN GENERAL.—In addition to the examinations authorized under paragraph (2), any examiner appointed under paragraph (1) shall have power, on behalf of the Corporation, to make any special examination of any insured depository institution or nonbank financial company supervised by the Board of Governors or a bank holding company described in section 165(a) of the Financial Stability Act of 2010, whenever the Board of Directors determines that a special examination of any such depository institution is necessary to determine the condition of such depository institution for insurance purposes[, or of such nonbank financial company supervised by the Board of Governors or bank holding company described in section 165(a) of the Financial Stability Act of 2010, for the purpose of implementing its authority to provide for orderly liquidation of any such company under title II of that Act], provided that such authority may not be used with respect to any such company that is in a generally sound condition.

* * * * * * *

FEDERAL RESERVE ACT

* * * * * * *

POWERS OF FEDERAL RESERVE BANKS.

SEC. 13. Any Federal reserve bank may receive from any of its member banks or other depository institutions, and from the United States, deposits of current funds in lawful money, national-bank notes, Federal reserve notes, or checks, and drafts, payable upon presentation or other items, and also, for collection, maturing notes and bills; or, solely for purposes of exchange or of collection, may receive from other Federal reserve banks deposits of current funds in lawful money, national-bank notes, or checks upon other Federal reserve banks, and checks and drafts, payable upon presentation within its district or other items, and maturing notes and bills payable within its district; or, solely for the purposes of exchange or of collection, may receive from any nonmember bank or trust company or other depository institution deposits of current

funds in lawful money, national-bank notes, Federal reserve notes, checks and drafts payable upon presentation or other items, or maturing notes and bills: *Provided,* Such nonmember bank or trust company or other depository institution maintains with the Federal reserve bank of its district a balance in such amount as the Board determines taking into account items in transit, services provided by the Federal Reserve bank, and other factors as the Board may deem appropriate: *Provided further,* That nothing in this or any other section of this Act shall be construed as prohibiting a member or nonmember bank or other depository institution from making reasonable charges, to be determined and regulated by the Board of Governors of the Federal Reserve System, but in no case to exceed 10 cents per $100 or fraction thereof, based on the total of checks and drafts presented at any one time, for collection or payment of checks and drafts and remission therefor by exchange or otherwise; but no such charges shall be made against the Federal reserve banks.

Upon the indorsement of any of its member banks, which shall be deemed a waiver of demand, notice and protest by such bank as to its own indorsement exclusively, any Federal reserve bank may discount notes, drafts, and bills of exchange arising out of actual commercial transactions; that is, notes, drafts, and bills of exchange issued or drawn for agricultural, industrial, or commercial purposes, or the proceeds of which have been used, or are to be used, for such purposes, the Board of Governors of the Federal Reserve System to have the right to determine or define the character of the paper thus eligible for discount, within the meaning of this Act. Nothing in this Act contained shall be construed to prohibit such notes, drafts, and bills of exchange, secured by staple agricultural products, or other goods, wares, or merchandise from being eligible for such discount, and the notes, drafts, and bills of exchange of factors issued as such making advances exclusively to producers of staple agricultural products in their raw state shall be eligible for such discount; but such definition shall not include notes, drafts, or bills covering merely investments or issued or drawn for the purpose of carrying or trading in stocks, bonds, or other investment securities, except bonds and notes of the Government of the United States. Notes, drafts, and bills admitted to discount under the terms of this paragraph must have a maturity at the time of discount of not more than 90 days, exclusive of grace.

(3)(A) * * *

(B)(i) * * *

(ii) The Board shall establish procedures to prohibit borrowing from programs and facilities by borrowers that are insolvent. Such procedures may include a certification from the chief executive officer (or other authorized officer) of the borrower, at the time the borrower initially borrows under the program or facility (with a duty by the borrower to update the certification if the information in the certification materially changes), that the borrower is not insolvent. A borrower shall be considered insolvent for purposes of this subparagraph, if the borrower is in bankruptcy**[**, resolution under title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, or**]** *or is subject to res-*

olution under any other Federal or State insolvency proceeding.

(iii) A program or facility that is structured to remove assets from the balance sheet of a single and specific company, or that is established for the purpose of assisting a single and specific company avoid bankruptcy[, resolution under title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, or] *or resolution under* any other Federal or State insolvency proceeding, shall not be considered a program or facility with broad-based eligibility.

* * * * * * *

[(E) If an entity to which a Federal reserve bank has provided a loan under this paragraph becomes a covered financial company, as defined in section 201 of the Dodd-Frank Wall Street Reform and Consumer Protection Act, at any time while such loan is outstanding, and the Federal reserve bank incurs a realized net loss on the loan, then the Federal reserve bank shall have a claim equal to the amount of the net realized loss against the covered entity, with the same priority as an obligation to the Secretary of the Treasury under section 210(b) of the Dodd-Frank Wall Street Reform and Consumer Protection Act.]

* * * * * * *

EMERGENCY ECONOMIC STABILIZATION ACT OF 2008

DIVISION A—EMERGENCY ECONOMIC STABILIZATION

* * * * * * *

TITLE I—TROUBLED ASSETS RELIEF PROGRAM

* * * * * * *

SEC. 120. TERMINATION OF AUTHORITY.

(a) * * *

* * * * * * *

(c) TERMINATION OF AUTHORITY TO PROVIDE NEW ASSISTANCE UNDER THE HOME AFFORDABLE MODIFICATION PROGRAM.—

(1) IN GENERAL.—Except as provided under paragraph (2), after the date of the enactment of this subsection the Secretary may not provide any assistance under the Home Affordable Modification Program under the Making Home Affordable initiative of the Secretary, authorized under this Act, on behalf of any homeowner.

(2) PROTECTION OF EXISTING OBLIGATIONS ON BEHALF OF HOMEOWNERS ALREADY EXTENDED AN OFFER TO PARTICIPATE IN

THE PROGRAM.—Paragraph (1) shall not apply with respect to assistance provided on behalf of a homeowner who, before the date of the enactment of this subsection, was extended an offer to participate in the Home Affordable Modification Program on a trial or permanent basis.

(3) DEFICIT REDUCTION.—

(A) USE OF UNOBLIGATED FUNDS.—Notwithstanding any other provision of this title, the amounts described in subparagraph (B) shall not be available after the date of the enactment of this subsection for obligation or expenditure under the Home Affordable Modification Program of the Secretary, but should be covered into the General Fund of the Treasury and should be used only for reducing the budget deficit of the Federal Government.

(B) IDENTIFICATION OF UNOBLIGATED FUNDS.—The amounts described in this subparagraph are any amounts made available under title I of the Emergency Economic Stabilization Act of 2008 that—

(i) have been allocated for use, but not yet obligated as of the date of the enactment of this subsection, under the Home Affordable Modification Program of the Secretary; and

(ii) are not necessary for providing assistance under such Program on behalf of homeowners who, pursuant to paragraph (2), may be provided assistance after the date of the enactment of this subsection.

(4) STUDY OF USE OF PROGRAM BY MEMBERS OF THE ARMED FORCES, VETERANS, AND GOLD STAR RECIPIENTS.—

(A) STUDY.—The Secretary shall conduct a study to determine the extent of usage of the Home Affordable Modification Program by, and the impact of such Program on, covered homeowners.

(B) REPORT.—Not later than the expiration of the 90-day period beginning on the date of the enactment of this subsection, the Secretary shall submit to the Congress a report setting forth the results of the study under subparagraph (A) and identifying best practices, derived from studying the Home Affordable Modification Program, that could be applied to existing mortgage assistance programs available to covered homeowners.

(C) COVERED HOMEOWNER.—For purposes of this subsection, the term "covered homeowner" means a homeowner who is—

(i) a member of the Armed Forces of the United States on active duty or the spouse or parent of such a member;

(ii) a veteran, as such term is defined in section 101 of title 38, United States Code; or

(iii) eligible to receive a Gold Star lapel pin under section 1126 of title 10, United States Code, as a widow, parent, or next of kin of a member of the Armed Forces person who died in a manner described in subsection (a) of such section.

(5) PUBLICATION OF MEMBER AVAILABILITY FOR ASSISTANCE.—Not later than 5 days after the date of the enactment of this subsection, the Secretary of the Treasury shall publish to its Website on the World Wide Web in a prominent location, large point font, and boldface type the following statement: "The Home Affordable Modification Program (HAMP) has been terminated. If you are having trouble paying your mortgage and need help contacting your lender or servicer for purposes of negotiating or acquiring a loan modification, please contact your Member of Congress to assist you in contacting your lender or servicer for the purpose of negotiating or acquiring a loan modification.".

(6) NOTIFICATION TO HAMP APPLICANTS REQUIRED.—Not later than 30 days after the date of the enactment of this subsection, the Secretary of the Treasury shall inform each individual who applied for the Home Affordable Modification Program and will not be considered for a modification under such Program due to termination of such Program under this subsection—

(A) that such Program has been terminated;

(B) that loan modifications under such Program are no longer available;

(C) of the name and contact information of such individual's Member of Congress; and

(D) that the individual should contact his or her Member of Congress to assist the individual in contacting the individual's lender or servicer for the purpose of negotiating or acquiring a loan modification.

* * * * * * *

CONSUMER FINANCIAL PROTECTION ACT OF 2010

* * * * * * *

TITLE X—BUREAU OF CONSUMER FINANCIAL PROTECTION

* * * * * * *

Subtitle A—Bureau of Consumer Financial Protection

* * * * * * *

SEC. 1017. FUNDING; PENALTIES AND FINES.—

(a) [TRANSFER OF FUNDS FROM BOARD OF GOVERNORS.—] *BUDGET, FINANCIAL MANAGEMENT, AND AUDIT.—*

[(1) IN GENERAL.—Each year (or quarter of such year), beginning on the designated transfer date, and each quarter thereafter, the Board of Governors shall transfer to the Bureau from the combined earnings of the Federal Reserve System, the amount determined by the Director to be reasonably necessary to carry out the authorities of the Bureau under Federal con-

sumer financial law, taking into account such other sums made available to the Bureau from the preceding year (or quarter of such year).

[(2) FUNDING CAP.—

[(A) IN GENERAL.—Notwithstanding paragraph (1), and in accordance with this paragraph, the amount that shall be transferred to the Bureau in each fiscal year shall not exceed a fixed percentage of the total operating expenses of the Federal Reserve System, as reported in the Annual Report, 2009, of the Board of Governors, equal to—

[(i) 10 percent of such expenses in fiscal year 2011;

[(ii) 11 percent of such expenses in fiscal year 2012; and

[(iii) 12 percent of such expenses in fiscal year 2013, and in each year thereafter.

[(B) ADJUSTMENT OF AMOUNT.—The dollar amount referred to in subparagraph (A)(iii) shall be adjusted annually, using the percent increase, if any, in the employment cost index for total compensation for State and local government workers published by the Federal Government, or the successor index thereto, for the 12-month period ending on September 30 of the year preceding the transfer.

[(C) REVIEWABILITY.—Notwithstanding any other provision in this title, the funds derived from the Federal Reserve System pursuant to this subsection shall not be subject to review by the Committees on Appropriations of the House of Representatives and the Senate.

[(3) TRANSITION PERIOD.—Beginning on the date of enactment of this Act and until the designated transfer date, the Board of Governors shall transfer to the Bureau the amount estimated by the Secretary needed to carry out the authorities granted to the Bureau under Federal consumer financial law, from the date of enactment of this Act until the designated transfer date.]

[(4)] *(1)* BUDGET AND FINANCIAL MANAGEMENT.—

(A) * * *

* * * * * * *

[(E) RULE OF CONSTRUCTION.—This subsection may not be construed as implying any obligation on the part of the Director to consult with or obtain the consent or approval of the Director of the Office of Management and Budget with respect to any report, plan, forecast, or other information referred to in subparagraph (A) or any jurisdiction or oversight over the affairs or operations of the Bureau.

[(F) FINANCIAL STATEMENTS.—The financial statements of the Bureau shall not be consolidated with the financial statements of either the Board of Governors or the Federal Reserve System.]

[(5)] *(2)* AUDIT OF THE BUREAU.—

(A) * * *

* * * * * * *

[(b) CONSUMER FINANCIAL PROTECTION FUND.—

[(1) SEPARATE FUND IN FEDERAL RESERVE ESTABLISHED.—There is established in the Federal Reserve a separate fund, to be known as the "Bureau of Consumer Financial Protection Fund" (referred to in this section as the "Bureau Fund"). The Bureau Fund shall be maintained and established at a Federal reserve bank, in accordance with such requirements as the Board of Governors may impose.

[(2) FUND RECEIPTS.—All amounts transferred to the Bureau under subsection (a) shall be deposited into the Bureau Fund.

[(3) INVESTMENT AUTHORITY.—

[(A) AMOUNTS IN BUREAU FUND MAY BE INVESTED.—The Bureau may request the Board of Governors to direct the investment of the portion of the Bureau Fund that is not, in the judgment of the Bureau, required to meet the current needs of the Bureau.

[(B) ELIGIBLE INVESTMENTS.—Investments authorized by this paragraph shall be made in obligations of the United States or obligations that are guaranteed as to principal and interest by the United States, with maturities suitable to the needs of the Bureau Fund, as determined by the Bureau.

[(C) INTEREST AND PROCEEDS CREDITED.—The interest on, and the proceeds from the sale or redemption of, any obligations held in the Bureau Fund shall be credited to the Bureau Fund.

[(c) USE OF FUNDS.—

[(1) IN GENERAL.—Funds obtained by, transferred to, or credited to the Bureau Fund shall be immediately available to the Bureau and under the control of the Director, and shall remain available until expended, to pay the expenses of the Bureau in carrying out its duties and responsibilities. The compensation of the Director and other employees of the Bureau and all other expenses thereof may be paid from, obtained by, transferred to, or credited to the Bureau Fund under this section.

[(2) FUNDS THAT ARE NOT GOVERNMENT FUNDS.—Funds obtained by or transferred to the Bureau Fund shall not be construed to be Government funds or appropriated monies.

[(3) AMOUNTS NOT SUBJECT TO APPORTIONMENT.—Notwithstanding any other provision of law, amounts in the Bureau Fund and in the Civil Penalty Fund established under subsection (d) shall not be subject to apportionment for purposes of chapter 15 of title 31, United States Code, or under any other authority.

[(d) PENALTIES AND FINES.—

[(1) ESTABLISHMENT OF VICTIMS RELIEF FUND.—There is established in the Federal Reserve a separate fund, to be known as the "Consumer Financial Civil Penalty Fund" (referred to in this section as the "Civil Penalty Fund"). The Civil Penalty Fund shall be maintained and established at a Federal reserve bank, in accordance with such requirements as the Board of Governors may impose. If the Bureau obtains a civil penalty against any person in any judicial or administrative action under Federal consumer financial laws, the Bureau shall de-

posit into the Civil Penalty Fund, the amount of the penalty collected.

[(2) PAYMENT TO VICTIMS.—Amounts in the Civil Penalty Fund shall be available to the Bureau, without fiscal year limitation, for payments to the victims of activities for which civil penalties have been imposed under the Federal consumer financial laws. To the extent that such victims cannot be located or such payments are otherwise not practicable, the Bureau may use such funds for the purpose of consumer education and financial literacy programs.]

[(e)] *(b)* AUTHORIZATION OF APPROPRIATIONS; ANNUAL REPORT.—

[(1) DETERMINATION REGARDING NEED FOR APPROPRIATED FUNDS.—

[(A) IN GENERAL.—The Director is authorized to determine that sums available to the Bureau under this section will not be sufficient to carry out the authorities of the Bureau under Federal consumer financial law for the upcoming year.

[(B) REPORT REQUIRED.—When making a determination under subparagraph (A), the Director shall prepare a report regarding the funding of the Bureau, including the assets and liabilities of the Bureau, and the extent to which the funding needs of the Bureau are anticipated to exceed the level of the amount set forth in subsection (a)(2). The Director shall submit the report to the President and to the Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives.

[(2) AUTHORIZATION OF APPROPRIATIONS.—If the Director makes the determination and submits the report pursuant to paragraph (1), there are hereby authorized to be appropriated to the Bureau, for the purposes of carrying out the authorities granted in Federal consumer financial law, $200,000,000 for each of fiscal years 2010, 2011, 2012, 2013, and 2014.

[(3) APPORTIONMENT.—Notwithstanding any other provision of law, the amounts in paragraph (2) shall be subject to apportionment under section 1517 of title 31, United States Code, and restrictions that generally apply to the use of appropriated funds in title 31, United States Code, and other laws.]

(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $200,000,000 to carry out this title for each of fiscal years 2012 and 2013.

[(4)] *(2)* ANNUAL REPORT.—The Director shall prepare and submit a report, on an annual basis, to the Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives regarding the financial operating plans and forecasts of the Director, the financial condition and results of operations of the Bureau, and the sources and application of funds of the Bureau, including any funds appropriated in accordance with this subsection.

* * * * * * *

NATIONAL FLOOD INSURANCE ACT OF 1968

TITLE XIII—NATIONAL FLOOD INSURANCE

SHORT TITLE

SEC. 1301. This title may be cited as the "National Flood Insurance Act of 1968".

* * * * * * *

CHAPTER I—THE NATIONAL FLOOD INSURANCE PROGRAM

BASIC AUTHORITY

SEC. 1304. (a) To carry out the purposes of this title, the [Director] *Administrator* of the Federal Emergency Management Agency is authorized to establish and carry out a national flood insurance program which will enable interested persons to purchase insurance against loss resulting from physical damage to or loss of real property or personal property related thereto arising from any flood occurring in the United States.

(b) ADDITIONAL COVERAGE FOR COMPLIANCE WITH LAND USE AND CONTROL MEASURES.—The national flood insurance program established pursuant to subsection (a) shall enable the purchase of insurance to cover the cost of implementing measures that are consistent with land use and control measures established by the community under section 1361 for—

(1) * * *

* * * * * * *

(3) properties that have sustained flood damage on multiple occasions, if the [Director] *Administrator* determines that it is cost-effective and in the best interests of the National Flood Insurance Fund to require compliance with the land use and control measures.

(4) properties for which an offer of mitigation assistance is made under—

(A) * * *

[(B) section 1368 (Repetitive Loss Priority Program and Individual Priority Property Program);]

[(C)] *(B)* the Hazard Mitigation Grant Program authorized under section 404 of the Robert T. Stafford Disaster Assistance and Emergency Relief Act (42 U.S.C. 5170c);

[(D)] *(C)* the Predisaster Hazard Mitigation Program under section 203 of the Robert T. Stafford Disaster Assistance and Emergency Relief Act (42 U.S.C. 5133); and

[(E)] *(D)* any programs authorized or for which funds are appropriated to address any unmet needs or for which supplemental funds are made available.

The [Director] *Administrator* shall impose a surcharge on each insured of not more than $75 per policy to provide cost of compliance coverage in accordance with the provisions of this subsection.

(c) In carrying out the flood insurance program the [Director] *Administrator* shall, to the maxmium extent practicable, encourage and arrange for—

(1) * * *

* * * * * * *

SCOPE OF PROGRAM AND PRIORITIES

SEC. 1305. (a) In carrying out the flood insurance program the [Director] *Administrator* shall afford a priority to making flood insurance available to cover residential properties which are designed for the occupancy of from one to four families, church properties, and business properties which are owned or leased and operated by small business concerns.

(b) If on the basis of—

(1) * * *

* * * * * * *

the [Director] *Administrator* determines that it would be feasible to extend the flood insurance program to cover other properties, he may take such action under this title as from time to time may be necessary in order to make flood insurance available to cover, on such basis as may be feasible, any types and classes of—

(A) * * *

* * * * * * *

and any such extensions of the program to any types and classes of these properties shall from time to time be prescribed in regulations.

(c) The [Director] *Administrator* shall make flood insurance available in only those States or areas (or subdivisions thereof) which he has determined have—

(1) * * *

* * * * * * *

NATURE AND LIMITATION OF INSURANCE COVERAGE

SEC. 1306. (a) The [Director] *Administrator* shall from time to time, after consultation with the advisory committee authorized under section 1318, appropriate representatives of the pool formed or otherwise created under section 1331, and appropriate representatives of the insurance authorities of the respective States, provide by regulation for general terms and conditions of insurability which shall be applicable to properties eligible for flood insurance coverage under section 1305, including—

(1) * * *

* * * * * * *

(b) In addition to any other terms and conditions under subsection (a), such regulations shall provide that—

(1) any flood insurance coverage based on chargeable premium rates under section 1308 which are less than the estimated premium rates under section 1307(a)(1) shall not exceed—

(A) * * *

(B) in the case of business properties which are owned or leased and operated by small business concerns, an aggregate liability with respect to any single structure, including any contents thereof related to premises of small

business occupants (as term is defined by the [Director] *Administrator*), which shall be equal to (i) $100,000 plus (ii) $100,000 multiplied by the number of such occupants and shall be allocated among such occupants (or among the occupant or occupants and the owner) under regulations prescribed by the [Director] *Administrator*; except that the aggregate liability for the structure itself may in no case exceed $100,000; and

* * * * * * *

(2) [in the case of any residential property] *in the case of any residential building designed for the occupancy of from one to four families* for which the risk premium rate is determined in accordance with the provisions of section 1307(a)(1), additional flood insurance in excess of the limits specified in clause (i) of subparagraph (A) of paragraph (1) [shall be made available to every insured upon renewal and every applicant for insurance so as to enable such insured or applicant to receive coverage up to a total amount (including such limits specified in paragraph (1)(A)(i)) of $250,000] *shall be made available, with respect to any single such building, up to an aggregate liability (including such limits specified in paragraph (1)(A)(i)) of $250,000*;

* * * * * * *

(4) [in the case of any nonresidential property, including churches,] *in the case of any nonresidential building, including a church,* for which the risk premium rate is determined in accordance with the provisions of section 1307(a)(1), additional flood insurance in excess of the limits specified in subparagraphs (B) and (C) of paragraph (1) [shall be made available to every insured upon renewal and every applicant for insurance, in respect to any single structure, up to a total amount (including such limit specified in subparagraph (B) or (C) of paragraph (1), as applicable) of $500,000 for each structure and $500,000 for any contents related to each structure] *shall be made available with respect to any single such building, up to an aggregate liability (including such limits specified in subparagraph (B) or (C) of paragraph (1), as applicable) of $500,000, and coverage shall be made available up to a total of $500,000 aggregate liability for contents owned by the building owner and $500,000 aggregate liability for each unit within the building for contents owned by the tenant*; [and]

(5) the Administrator may provide that, in the case of any residential property, each renewal or new contract for flood insurance coverage may provide not more than $5,000 aggregate liability per dwelling unit for any necessary increases in living expenses incurred by the insured when losses from a flood make the residence unfit to live in, except that—

(A) purchase of such coverage shall be at the option of the insured;

(B) any such coverage shall be made available only at chargeable rates that are not less than the estimated premium rates for such coverage determined in accordance with section 1307(a)(1); and

(C) the Administrator may make such coverage available only if the Administrator makes a determination and causes notice of such determination to be published in the Federal Register that—

(i) a competitive private insurance market for such coverage does not exist; and

(ii) the national flood insurance program has the capacity to make such coverage available without borrowing funds from the Secretary of the Treasury under section 1309 or otherwise;

(6) the Administrator may provide that, in the case of any commercial property or other residential property, including multifamily rental property, coverage for losses resulting from any partial or total interruption of the insured's business caused by damage to, or loss of, such property from a flood may be made available to every insured upon renewal and every applicant, up to a total amount of $20,000 per property, except that—

(A) purchase of such coverage shall be at the option of the insured;

(B) any such coverage shall be made available only at chargeable rates that are not less than the estimated premium rates for such coverage determined in accordance with section 1307(a)(1); and

(C) the Administrator may make such coverage available only if the Administrator makes a determination and causes notice of such determination to be published in the Federal Register that—

(i) a competitive private insurance market for such coverage does not exist; and

(ii) the national flood insurance program has the capacity to make such coverage available without borrowing funds from the Secretary of the Treasury under section 1309 or otherwise;

[(5)**]** *(7)* any flood insurance coverage which may be made available in excess of the limits specified in subparagraph (A), (B), or (C) of paragraph (1), shall be based only on chargeable premium rates under section 1308 which are not less than the estimated premium rates under section 1307(a)(1), and the amount of such excess coverage shall not in any case exceed an amount equal to the applicable limit so specified (or allocated) under paragraph (1)(C), (2), (3), or (4), as applicable**[**.**]***; and*

(8) each of the dollar amount limitations under paragraphs (2), (3), (4), (5), and (6) shall be adjusted effective on the date of the enactment of the Flood Insurance Reform Act of 2012, such adjustments shall be calculated using the percentage change, over the period beginning on September 30, 1994, and ending on such date of enactment, in such inflationary index as the Administrator shall, by regulation, specify, and the dollar amount of such adjustment shall be rounded to the next lower dollar; and the Administrator shall cause to be published in the Federal Register the adjustments under this paragraph to such dollar amount limitations; except that in the case of coverage for a property that is made available, pursuant to this para-

graph, in an amount that exceeds the limitation otherwise applicable to such coverage as specified in paragraph (2), (3), (4), (5), or (6), the total of such coverage shall be made available only at chargeable rates that are not less than the estimated premium rates for such coverage determined in accordance with section 1307(a)(1).

(c) EFFECTIVE DATE OF POLICIES.—

(1) WAITING PERIOD.—Except as provided in paragraph (2), coverage under a new contract for flood insurance coverage under this title entered into after the date of enactment of the Riegle Community Development and Regulatory Improvement Act of 1994, and any modification to coverage under an existing flood insurance contract made after such date, shall become effective upon the expiration of the 30-day period beginning on the date that all obligations for such coverage (including completion of the application and payment of any initial premiums owed) are satisfactorily completed. *With respect to any flood that has commenced or is in progress before the expiration of such 30-day period, such flood insurance coverage for a property shall take effect upon the expiration of such 30-day period and shall cover damage to such property occurring after the expiration of such period that results from such flood, but only if the property has not suffered damage or loss as a result of such flood before the expiration of such 30-day period.*

* * * * * * *

(d) PAYMENT OF PREMIUMS IN INSTALLMENTS FOR RESIDENTIAL PROPERTIES.—

(1) AUTHORITY.—In addition to any other terms and conditions under subsection (a), such regulations shall provide that, in the case of any residential property, premiums for flood insurance coverage made available under this title for such property may be paid in installments.

(2) LIMITATIONS.—In implementing the authority under paragraph (1), the Administrator may establish increased chargeable premium rates and surcharges, and deny coverage and establish such other sanctions, as the Administrator considers necessary to ensure that insureds purchase, pay for, and maintain coverage for the full term of a contract for flood insurance coverage or to prevent insureds from purchasing coverage only for periods during a year when risk of flooding is comparatively higher or canceling coverage for periods when such risk is comparatively lower.

ESTIMATES OF PREMIUM RATES

SEC. 1307. (a) The [Director] *Administrator* is authorized to undertake and carry out such studies and investigations and receive or exchange such information as may be necessary to estimate, and shall from time to time estimate, on an area, subdivision, or other appropriate basis—

(1) * * *

* * * * * * *

(b) In carrying out subsection (a), the [Director] *Administrator* shall, to the maximum extent feasible and on a reimbursable basis,

utilize the services of the Department of the Army, the Department of the Interior, The Department of Agriculture, the Department of Commerce, and the Tennessee Valley Authority, and, as appropriate, other Federal departments or agencies, and for such purposes may enter into agreements or other appropriate arrangements with any persons.

(c) The [Director] *Administrator* shall give priority to conducting studies and investigations and making estimates under this section in those States or areas (or subdivisions thereof) which he has determined have evidenced a positive interest in securing flood insurance coverage under the flood insurance program.

(d) Notwithstanding any other provision of law, any structure existing on the date of enactment of the Flood Disaster Protection Act of 1973 and located within Avoyelles, Evangeline, Rapides, or Saint Landry Parish in the State of Louisiana, which the [Director] *Administrator* determines is subject to additional flood hazards as a result of the construction or operation of the Atchafalaya Basin Levee System, shall be eligible for flood insurance under this title (if and to the extent it is eligible for such insurance under the other provisions of this title) at premium rates that shall not exceed those which would be applicable if such additional hazards did not exist.

(e) Notwithstanding any other provision of law, any community that has made adequate progress, acceptable to the [Director] *Administrator*, on the [construction of a flood protection system] *construction, reconstruction, or improvement of a flood protection system (without respect to the level of Federal investment or participation)* which will afford flood protection for the one-hundred-year frequency flood as determined by the [Director] *Administrator*, shall be eligible for flood insurance under this title (if and to the extent it is eligible for such insurance under the other provisions of this title) at premium rates not exceeding those which would be applicable under this section if such flood protection system had been completed. The [Director] *Administrator* shall find that adequate progress on the [construction of a flood protection system] *construction, reconstruction, or improvement of a flood protection system* as required herein has been only if (1) 100 percent of the project cost of the system has been authorized, (2) at least 60 percent of the project cost of the system has been appropriated, (3) at least 50 percent of the project cost of the system has been expended *based on the present value of the completed system*, and (4) the system is at least 50 percent completed.

(f) Notwithstanding any other provision of law, this subsection shall only apply in a community which has been determined by the [Director] *Administrator* of the Federal Emergency Management Agency to be in the process of restoring flood protection afforded by a flood protection system that had been previously accredited on a Flood Insurance Rate Map as providing 100-year frequency flood protection but no longer does so *(without respect to the level of Federal investment or participation)*. Except as provided in this subsection, in such a community, flood insurance shall be made available to those properties impacted by the disaccreditation of the flood protection system at premium rates that do not exceed those which would be applicable to any property located in an area of

special flood hazard, the construction of which was started prior to the effective date of the initial Flood Insurance Rate Map published by the [Director] *Administrator* for the community in which such property is located. A revised Flood Insurance Rate Map shall be prepared for the community to delineate as Zone AR the areas of special flood hazard*, whether coastal or riverine,* that result from the disaccreditation of the flood protection system. A community will be considered to be in the process of restoration if—

(1) the flood protection system has been deemed restorable by [a Federal agency in consultation with the local project sponsor] *the entity or entities that own, operate, maintain, or repair such system*;

* * * * * * *

Communities that the [Director] *Administrator* of the Federal Emergency Management Agency determines to meet the criteria set forth in paragraphs (1) and (2) as of January 1, 1992, shall not be subject to revised Flood Insurance Rate Maps that contravene the intent of this subsection. Such communities shall remain eligible for C zone rates for properties located in zone AR for any policy written prior to promulgation of final regulations for this section. Floodplain management criteria for such communities shall not require the elevation of improvements to existing structures and shall not exceed 3 feet above existing grade for new construction, provided the base flood elevation based on the disaccredited flood control system does not exceed five feet above existing grade, or the remaining new construction in such communities is limited to infill sites, rehabilitation of existing structures, or redevelopment of previously developed areas.

The [Director] *Administrator* of the Federal Emergency Management Agency shall develop and promulgate regulations to implement this subsection, including minimum floodplain management criteria, within 24 months after the date of enactment of this subsection.

ESTABLISHMENT OF CHARGEABLE PREMIUM RATES

SEC. 1308. (a) On the basis of estimates made under section 1307 and such other information as may be necessary, the [Director] *Administrator* shall from time to time, after consultation with the advisory committee authorized under section 1318, appropriate representatives of the pool formed or otherwise created under section 1331, and appropriate representatives of the insurance authorities of the respective States, prescribe by regulation *or notice*—

(1) * * *

* * * * * * *

(c) ACTUARIAL RATE PROPERTIES.—Subject only to [the limitations provided under paragraphs (1) and (2)] *subsection (e) and subsection (g)*, the chargeable rate shall not be less than the applicable estimated risk premium rate for such area (or subdivision thereof) under section 1307(a)(1) with respect to the following properties:

(1) POST-FIRM PROPERTIES.—Any property the construction or substantial improvement of which the [Director] *Administrator* determines has been started after December 31, 1974, or

started after the effective date of the initial rate map published by the [Director] *Administrator* under paragraph (2) of section 1360 for the area in which such property is located, whichever is later[, except that the chargeable rate for properties under this paragraph shall be subject to the limitation under subsection (e)].

(2) COMMERCIAL PROPERTIES.—Any nonresidential property.

(3) SECOND HOMES AND VACATION HOMES.—Any residential property that is not the primary residence of any individual.

(4) HOMES SOLD TO NEW OWNERS.—Any single family property that—

(A) has been constructed or substantially improved and for which such construction or improvement was started, as determined by the Administrator, before December 31, 1974, or before the effective date of the initial rate map published by the Administrator under paragraph (2) of section 1360(a) for the area in which such property is located, whichever is later; and

(B) is purchased after the effective date of this paragraph, pursuant to section 345(c)(3)(A) of the Flood Insurance Reform Act of 2012.

(5) HOMES DAMAGED OR IMPROVED.—Any property that, on or after the date of the enactment of the Flood Insurance Reform Act of 2012, has experienced or sustained—

(A) substantial flood damage exceeding 50 percent of the fair market value of such property; or

(B) substantial improvement exceeding 30 percent of the fair market value of such property.

(6) HOMES WITH MULTIPLE CLAIMS.—Any severe repetitive loss property (as such term is defined in section 1366(j)).

[(2)] *(7)* CERTAIN LEASED COASTAL AND RIVER PROPERTIES.—Any property leased from the Federal Government (including residential and nonresidential properties) that the [Director] *Administrator* determines is located on the river-facing side of any dike, levee, or other riverine flood control structure, or seaward of any seawall or other coastal flood control structure.

(d) With respect to any chargeable premium rate prescribed under this section, a sum equal to the portion of the rate that covers any administrative expenses of carrying out the flood insurance and floodplain management programs which have been estimated under paragraphs (1)(B)(ii) and (1)(B)(iii) of section 1307(a) or paragraph (2) of such section (including the fees under such paragraphs), shall be paid to the [Director] *Administrator*. The [Director] *Administrator* shall deposit the sum in the National Flood Insurance Fund established under section 1310.

(e) ANNUAL LIMITATION ON PREMIUM INCREASES.—Except with respect to properties described under [paragraph (2) or (3)] *paragraph (7)* of subsection (c) *or subsection (h)*, and notwithstanding any other provision of this title, the chargeable risk premium rates for flood insurance under this title for any properties within any single risk classification may not be increased by an amount that would result in the average of such rate increases for properties within the risk classification during any 12-month period exceeding [10 percent] *20 percent* of the average of the risk premium rates

for properties within the risk classification upon the commencement of such 12-month period.

(f) ADJUSTMENT OF PREMIUM.—Notwithstanding any other provision of law, if the [Director] *Administrator* determines that the holder of a flood insurance policy issued under this Act is paying a lower premium than is required under this section due to an error in the flood plain determination, the [Director] *Administrator* may only prospectively charge the higher premium rate.

(g) 5-YEAR PHASE-IN OF FLOOD INSURANCE RATES FOR CERTAIN PROPERTIES IN NEWLY MAPPED AREAS.—

(1) 5-YEAR PHASE-IN PERIOD.—Notwithstanding subsection (c) or any other provision of law relating to chargeable risk premium rates for flood insurance coverage under this title, in the case of any area that was not previously designated as an area having special flood hazards and that, pursuant to any issuance, revision, updating, or other change in flood insurance maps, becomes designated as such an area, during the 5-year period that begins, except as provided in paragraph (2), upon the date that such maps, as issued, revised, updated, or otherwise changed, become effective, the chargeable premium rate for flood insurance under this title with respect to any covered property that is located within such area shall be the rate described in paragraph (3).

(2) APPLICABILITY TO PREFERRED RISK RATE AREAS.—In the case of any area described in paragraph (1) that consists of or includes an area that, as of date of the effectiveness of the flood insurance maps for such area referred to in paragraph (1) as so issued, revised, updated, or changed, is eligible for any reason for preferred risk rate method premiums for flood insurance coverage and was eligible for such premiums as of the enactment of the Flood Insurance Reform Act of 2012, the 5-year period referred to in paragraph (1) for such area eligible for preferred risk rate method premiums shall begin upon the expiration of the period during which such area is eligible for such preferred risk rate method premiums.

(3) PHASE-IN OF FULL ACTUARIAL RATES.—With respect to any area described in paragraph (1), the chargeable risk premium rate for flood insurance under this title for a covered property that is located in such area shall be—

(A) for the first year of the 5-year period referred to in paragraph (1), the greater of—

(i) 20 percent of the chargeable risk premium rate otherwise applicable under this title to the property; and

(ii) in the case of any property that, as of the beginning of such first year, is eligible for preferred risk rate method premiums for flood insurance coverage, such preferred risk rate method premium for the property;

(B) for the second year of such 5-year period, 40 percent of the chargeable risk premium rate otherwise applicable under this title to the property;

(C) for the third year of such 5-year period, 60 percent of the chargeable risk premium rate otherwise applicable under this title to the property;

(D) for the fourth year of such 5-year period, 80 percent of the chargeable risk premium rate otherwise applicable under this title to the property; and

(E) for the fifth year of such 5-year period, 100 percent of the chargeable risk premium rate otherwise applicable under this title to the property.

(4) COVERED PROPERTIES.—For purposes of the subsection, the term "covered property" means any residential property occupied by its owner or a bona fide tenant as a primary residence.

(h) PROHIBITION OF EXTENSION OF SUBSIDIZED RATES TO LAPSED POLICIES.—Notwithstanding any other provision of law relating to chargeable risk premium rates for flood insurance coverage under this title, the Administrator shall not provide flood insurance coverage under this title for any property for which a policy for such coverage for the property has previously lapsed in coverage as a result of the deliberate choice of the holder of such policy, at a rate less than the applicable estimated risk premium rates for the area (or subdivision thereof) in which such property is located.

SEC. 1308A. NOTIFICATION TO TENANTS OF AVAILABILITY OF CONTENTS INSURANCE.

(a) IN GENERAL.—The Administrator shall, upon entering into a contract for flood insurance coverage under this title for any property—

(1) provide to the insured sufficient copies of the notice developed pursuant to subsection (b); and

(2) require the insured to provide a copy of the notice, or otherwise provide notification of the information under subsection (b) in the manner that the manager or landlord deems most appropriate, to each such tenant and to each new tenant upon commencement of such a tenancy.

(b) NOTICE.—Notice to a tenant of a property in accordance with this subsection is written notice that clearly informs a tenant—

(1) whether the property is located in an area having special flood hazards;

(2) that flood insurance coverage is available under the national flood insurance program under this title for contents of the unit or structure leased by the tenant;

(3) of the maximum amount of such coverage for contents available under this title at that time; and

(4) of where to obtain information regarding how to obtain such coverage, including a telephone number, mailing address, and Internet site of the Administrator where such information is available.

FINANCING

SEC. 1309. (a) All authority which was vested in the Housing and Home Finance Administrator by virtue of section 15(e) of the Federal Flood Insurance Act of 1956 (70 Stat. 1084) (pertaining to the issue of notes or other obligations or the Secretary of the Treasury), as amended by subsections (a) and (b) of section 1303 of this Act, shall be available to the [Director] *Administrator* for the purpose of carrying out the flood insurance program under this title; except that the total amount of notes and obligations which may be issued

by the [Director] *Administrator* pursuant to such authority (1) without the approval of the President, may not exceed $500,000,000, and (2) with the approval of the President, may not exceed $1,500,000,000 through the date specified in section 1319, and $1,000,000,000 thereafter; except that, through [the earlier of the date of the enactment into law of an Act that specifically amends the date specified in this section or May 31, 2012] *September 30, 2016*, clause (2) of this sentence shall be applied by substituting "$20,725,000,000" for "$1,500,000,000". The [Director] *Administrator* shall report to the Committee on Banking, Finance and Urban Affairs of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate at any time when he requests the approval of the President in accordance with the preceding sentence.

(b) Any funds borrowed by the [Director] *Administrator* under this authority shall, from time to time, be deposited in the National Flood Insurance Fund established under section 1310.

NATIONAL FLOOD INSURANCE FUND

SEC. 1310. (a) To carry out the flood insurance program authorized by this title, the [Director] *Administrator* shall establish in the Treasury of the United States a National Flood Insurance Fund (hereinafter referred to as the "fund") which shall be an account separate from any other accounts or funds available to the [Director] *Administrator* and shall be available as described in subsection (f), without fiscal year limitation (except as otherwise provided in this section)—

(1) * * *

* * * * * * *

(6) for carrying out the program under section 1315(b);

(7) for transfers to the National Flood Mitigation Fund, but only to the extent provided in section 1367(b)(1)[;]*; and*

[(8) for financial assistance under section 1361A to States and communities for taking actions under such section with respect to severe repetitive loss properties, but only to the extent provided in section 1361A(i); and

[(9) for funding, not to exceed $10,000,000 in any fiscal year, for mitigation actions under section 1323, except that, notwithstanding any other provision of this title, amounts made available pursuant to this paragraph shall not be subject to offsetting collections through premium rates for flood insurance coverage under this title.]

(8) for transfers to the National Flood Insurance Reserve Fund under section 1310A, in accordance with such section.

(b) The fund shall be credited with—

(1) * * *

* * * * * * *

(5) such sums as are required to be paid to the [Director] *Administrator* under section 1308(d); and

* * * * * * *

(c) If, after—

(1) * * *

* * * * * * *

the [Director] *Administrator* determines that the moneys of the fund are in excess of current needs, he may request the investment of such amounts as he deems advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

(d) In the event the [Director] *Administrator* makes a determination in accordance with the provisions of section 1340 that operation of the flood insurance program, in whole or in part, should be carried out through the facilities of the Federal Government, the fund shall be available for all purposes incident thereto, including—

(1) * * *

* * * * * * *

for so long as the program is so carried out, and in such event any premiums paid shall be deposited by the [Director] *Administrator* to the credit of the fund.

* * * * * * *

SEC. 1310A. RESERVE FUND.

(a) ESTABLISHMENT OF RESERVE FUND.—In carrying out the flood insurance program authorized by this title, the Administrator shall establish in the Treasury of the United States a National Flood Insurance Reserve Fund (in this section referred to as the "Reserve Fund") which shall—

(1) be an account separate from any other accounts or funds available to the Administrator; and

(2) be available for meeting the expected future obligations of the flood insurance program.

(b) RESERVE RATIO.—Subject to the phase-in requirements under subsection (d), the Reserve Fund shall maintain a balance equal to—

(1) 1 percent of the sum of the total potential loss exposure of all outstanding flood insurance policies in force in the prior fiscal year; or

(2) such higher percentage as the Administrator determines to be appropriate, taking into consideration any circumstance that may raise a significant risk of substantial future losses to the Reserve Fund.

(c) MAINTENANCE OF RESERVE RATIO.—

(1) IN GENERAL.—The Administrator shall have the authority to establish, increase, or decrease the amount of aggregate annual insurance premiums to be collected for any fiscal year necessary—

(A) to maintain the reserve ratio required under subsection (b); and

(B) to achieve such reserve ratio, if the actual balance of such reserve is below the amount required under subsection (b).

(2) CONSIDERATIONS.—In exercising the authority under paragraph (1), the Administrator shall consider—

(A) the expected operating expenses of the Reserve Fund;

(B) the insurance loss expenditures under the flood insurance program;

(C) any investment income generated under the flood insurance program; and

(D) any other factor that the Administrator determines appropriate.

(3) LIMITATIONS.—In exercising the authority under paragraph (1), the Administrator shall be subject to all other provisions of this Act, including any provisions relating to chargeable premium rates and annual increases of such rates.

(d) PHASE-IN REQUIREMENTS.—The phase-in requirements under this subsection are as follows:

(1) IN GENERAL.—Beginning in fiscal year 2012 and not ending until the fiscal year in which the ratio required under subsection (b) is achieved, in each such fiscal year the Administrator shall place in the Reserve Fund an amount equal to not less than 7.5 percent of the reserve ratio required under subsection (b).

(2) AMOUNT SATISFIED.—As soon as the ratio required under subsection (b) is achieved, and except as provided in paragraph (3), the Administrator shall not be required to set aside any amounts for the Reserve Fund.

(3) EXCEPTION.—If at any time after the ratio required under subsection (b) is achieved, the Reserve Fund falls below the required ratio under subsection (b), the Administrator shall place in the Reserve Fund for that fiscal year an amount equal to not less than 7.5 percent of the reserve ratio required under subsection (b).

(e) LIMITATION ON RESERVE RATIO.—In any given fiscal year, if the Administrator determines that the reserve ratio required under subsection (b) cannot be achieved, the Administrator shall submit a report to the Congress that—

(1) describes and details the specific concerns of the Administrator regarding such consequences;

(2) demonstrates how such consequences would harm the long-term financial soundness of the flood insurance program; and

(3) indicates the maximum attainable reserve ratio for that particular fiscal year.

(f) AVAILABILITY OF AMOUNTS.—The reserve ratio requirements under subsection (b) and the phase-in requirements under subsection (d) shall be subject to the availability of amounts in the National Flood Insurance Fund for transfer under section 1310(a)(10), as provided in section 1310(f).

OPERATING COSTS AND ALLOWANCES

SEC. 1311. (a) The [Director] *Administrator* shall from time to time negotiate with appropriate representatives of the insurance industry for the purpose of establishing—

(1) * * *

* * * * * * *

(b) For purposes of subsection (a)—

(1) the term "operating costs" shall (without limiting such term) include—

(A) * * *

* * * * * * *

(D) other direct, actual, and necessary expenses which the [Director] *Administrator* finds are incurred in connection with selling or servicing flood insurance coverage; and

(2) the term "operating allowances" shall (without limiting such term) include amounts for profit and contingencies which the [Director] *Administrator* finds reasonable and necessary to carry out the purposes of this title.

PAYMENT OF CLAIMS

SEC. 1312. [The Director is] *(a) IN GENERAL.—The Administrator is* authorized to prescribe regulations establishing the general method or methods by which proved and approved claims for losses may be adjusted and paid for any damage to or loss of property which is covered by flood insurance made available under the provisions of this title.

(b) MINIMUM ANNUAL DEDUCTIBLES.—

(1) SUBSIDIZED RATE PROPERTIES.—For any structure that is covered by flood insurance under this title, and for which the chargeable rate for such coverage is less than the applicable estimated risk premium rate under section 1307(a)(1) for the area (or subdivision thereof) in which such structure is located, the minimum annual deductible for damage to or loss of such structure shall be $2,000.

(2) ACTUARIAL RATE PROPERTIES.—For any structure that is covered by flood insurance under this title, for which the chargeable rate for such coverage is not less than the applicable estimated risk premium rate under section 1307(a)(1) for the area (or subdivision thereof) in which such structure is located, the minimum annual deductible for damage to or loss of such structure shall be $1,000.

DISSEMINATION OF FLOOD INSURANCE INFORMATION

SEC. 1313. The [Director] *Administrator* shall from time to time take such action as may be necessary in order to make information and data available to the public, and to any State or local agency or official, with regard to—

(1) * * *

* * * * * * *

STATE AND LOCAL LAND USE CONTROLS

SEC. 1315. (a) REQUIREMENT FOR PARTICIPATION IN FLOOD INSURANCE PROGRAM.—

(1) IN GENERAL.—After December 31, 1971, no new flood insurance coverage shall be provided under this title in any area (or subdivision thereof) unless an appropriate public body shall have adopted adequate land use and control measures (with effective enforcement provisions) which the [Director] *Adminis-*

trator finds are consistent with the comprehensive criteria for land management and use under section 1361.

(2) AGRICULTURAL STRUCTURES.—

(A) * * *

(B) PREMIUM RATES AND COVERAGE.—To the extent applicable, an agricultural structure repaired or restored pursuant to subparagraph (A) shall pay chargeable premium rates established under section 1308 at the estimated risk premium rates under section 1307(a)(1). If resources are available, the [Director] *Administrator* shall provide technical assistance and counseling, upon request of the owner of the structure, regarding wet flood-proofing and other flood damage reduction measures for agricultural structures. The [Director] *Administrator* shall not be required to make flood insurance coverage available for such an agricultural structure unless the structure is wet flood-proofed through permanent or contingent measures applied to the structure or its contents that prevent or provide resistance to damage from flooding by allowing flood waters to pass through the structure, as determined by the [Director] *Administrator*.

(C) PROHIBITION ON DISASTER RELIEF.—Notwithstanding any other provision of law, any agricultural structure repaired or restored pursuant to subparagraph (A) shall not be eligible for disaster relief assistance under any program administered by the [Director] *Administrator* or any other Federal agency.

* * * * * * *

(b) COMMUNITY RATING SYSTEM AND INCENTIVES FOR COMMUNITY FLOODPLAIN MANAGEMENT.—

(1) AUTHORITY AND GOALS.—The [Director] *Administrator* shall carry out a community rating system program, under which communities participate voluntarily—

(A) * * *

* * * * * * *

(2) INCENTIVES.—The program shall provide incentives in the form of credits on premium rates for flood insurance coverage in communities that the [Director] *Administrator* determines have adopted and enforced measures that reduce the risk of flood and erosion damage that exceed the criteria set forth in section 1361. In providing incentives under this paragraph, the [Director] *Administrator* may provide for credits to flood insurance premium rates in communities that the [Director] *Administrator* determines have implemented measures that protect natural and beneficial floodplain functions.

(3) CREDITS.—The credits on premium rates for flood insurance coverage shall be based on the estimated reduction in flood and erosion damage risks resulting from the measures adopted by the community under this program. If a community has received mitigation assistance under section 1366, the credits shall be phased in a manner, determined by the [Director] *Administrator*, to recover the amount of such assistance provided for the community.

(4) REPORTS.—Not later than 2 years after the date of enactment of the Riegle Community Development and Regulatory Improvement Act of 1994 and not less than every 2 years thereafter, the [Director] *Administrator* shall submit a report to the Congress regarding the program under this subsection. Each report shall include an analysis of the cost-effectiveness of the program, any other accomplishments or shortcomings of the program, and any recommendations of the [Director] *Administrator* for legislation regarding the program.

PROPERTIES IN VIOLATION OF STATE AND LOCAL LAW

SEC. 1316. No new flood insurance coverage shall be provided under this title for any property which the [Director] *Administrator* finds has been declared by a duly constituted State or local zoning authority, or other authorized public body, to be in violation of State or local laws, regulations or ordinances which are intended to discourage or otherwise restrict land development or occupancy in flood-prone areas.

COORDINATION WITH OTHER PROGRAMS

SEC. 1317. In carrying out this title, the [Director] *Administrator* shall consult with other departments and agencies of the Federal Government, and with interstate, State, and local agencies having responsibilities for flood control, flood forecasting, or flood damage prevention, in order to assure that the programs of such agencies and the flood insurance program authorized under this title are mutually consistent.

ADVISORY COMMITTEE

SEC. 1318. (a) The [Director] *Administrator* shall appoint a flood insurance advisory committee without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and such committee shall advise the [Director] *Administrator* in the preparation of any regulations prescribed in accordance with this title and with respect to policy matters arising in the administration of this title, and shall perform such other responsibilities as the [Director] *Administrator* may, from time to time, assign to such committee.

* * * * * * *

(c) Members of the committee shall, while attending conferences or meetings thereof, be entitled to receive compensation at a rate fixed by the [Director] *Administrator* but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as is authorized under section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

PROGRAM EXPIRATION

SEC. 1319. No new contract for flood insurance under this title shall be entered into after [the earlier of the date of the enactment into law of an Act that specifically amends the date specified in this section or May 31, 2012] *September 30, 2016*.

[REPORT TO THE PRESIDENT] *ANNUAL REPORT TO CONGRESS*

SEC. 1320. (a) IN GENERAL.—The [Director] *Administrator* shall [biennially] submit a report of operations under this title to [the President for submission to] the Congress *not later than June 30 of each year*.

(b) EFFECTS OF FLOOD INSURANCE PROGRAM.—The [Director] *Administrator* shall include, as part of the [biennial] *annual* report submitted under subsection (a), a chapter reporting on the effects on the flood insurance program observed through implementation of requirements under the Riegle Community Development and Regulatory Improvement Act of 1994.

(c) FINANCIAL STATUS OF PROGRAM.—The report under this section for each year shall include information regarding the financial status of the national flood insurance program under this title, including a description of the financial status of the National Flood Insurance Fund and current and projected levels of claims, premium receipts, expenses, and borrowing under the program.

* * * * * * *

[SEC. 1323. GRANTS FOR REPETITIVE INSURANCE CLAIMS PROPERTIES.

[(a) IN GENERAL.—The Director may provide funding for mitigation actions that reduce flood damages to individual properties for which 1 or more claim payments for losses have been made under flood insurance coverage under this title, but only if the Director determines that—

[(1) such activities are in the best interest of the National Flood Insurance Fund; and

[(2) such activities cannot be funded under the program under section 1366 because—

[(A) the requirements of section 1366(g) are not being met by the State or community in which the property is located; or

[(B) the State or community does not have the capacity to manage such activities.

[(b) PRIORITY FOR WORST-CASE PROPERTIES.—In determining the properties for which funding is to be provided under this section, the Director shall consult with the States in which such properties are located and provide assistance for properties in the order that will result in the greatest amount of savings to the National Flood Insurance Fund in the shortest period of time.]

* * * * * * *

SEC. 1325. TREATMENT OF SWIMMING POOL ENCLOSURES OUTSIDE OF HURRICANE SEASON.

In the case of any property that is otherwise in compliance with the coverage and building requirements of the national flood insurance program, the presence of an enclosed swimming pool located at ground level or in the space below the lowest floor of a building after November 30 and before June 1 of any year shall have no effect on the terms of coverage or the ability to receive coverage for such building under the national flood insurance program established pursuant to this title, if the pool is enclosed with non-supporting breakaway walls.

CHAPTER II—ORGANIZATION AND ADMINISTRATION OF THE FLOOD INSURANCE PROGRAM

ORGANIZATION AND ADMINISTRATION

SEC. 1330. Following such consultation with representatives of the insurance industry as may be necessary, the [Director] *Administrator* shall implement the flood insurance program authorized under chapter I in accordance with the provision of part A of this chapter and, if a determination is made by him under section 1340, under part B of this chapter.

PART A—INDUSTRY PROGRAM WITH FEDERAL FINANCIAL ASSISTANCE

INDUSTRY FLOOD INSURANCE POOL

SEC. 1331. (a) The [Director] *Administrator* is authorized to encourage and otherwise assist any insurance companies and other insurers which meet the requirements prescribed under subsection (b) to form, as associate, or otherwise join together in a pool—

(1) * * *

(2) for the purpose of assuming*, including as reinsurance of insurance coverage provided by the flood insurance program*, on such terms and conditions as may be agreed upon, such financial responsibility as will enable such companies and other insurers, with the Federal financial and other assistance available under this title, to assure a reasonable proportion of responsibility for the adjustment and payment of claims for losses under the flood insurance program.

(b) In order to promote the effective administration of the flood insurance program under this part, and to assure that the objectives of this title are furthered, the [Director] *Administrator* is authorized to prescribe appropriate requirements for insurance companies and other insurers participating in such pool including, but not limited to, minimum requirements for capital or surplus or assets.

AGREEMENTS WITH FLOOD INSURANCE POOL

SEC. 1332. (a) The [Director] *Administrator* is authorized to enter into such agreements with the pool formed or otherwise created under this part as he deems necessary to carry out the purposes of this title.

(b) Such agreements shall specify—

(1) * * *

* * * * * * *

(3) the maximum amount of profit, established by the [Director] *Administrator* and set forth in the schedules prescribed under section 1311, which may be realized by such pool (and the companies and other insurers participating therein),

* * * * * * *

(c) In addition, such agreements shall contain such provisions as the [Director] *Administrator* finds necessary to assure that—

(1) * * *

(2) the insurance companies and other insurers participating in the pool will take whatever action may be necessary to provide continuity of flood insurance coverage *or reinsurance* by the pool, and

* * * * * * *

PREMIUM EQUALIZATION PAYMENTS

SEC. 1334. (a) The [Director] *Administrator*, on such terms and conditions as he may from time to time prescribe, shall make periodic payments to the pool formed or otherwise created under section 1331, in recognition of such reductions in chargeable premium rates under section 1308 below estimated premium rates under section 1307(a)(1) as are required in order to make flood insurance available on reasonable terms and conditions.

(b) Designated periods under this section and the methods for determining the sum of premiums paid or payable during such periods shall be established by the [Director] *Administrator*.

REINSURANCE COVERAGE

SEC. 1335. (a)*(1)* The [Director] *Administrator* is authorized to take such action as may be necessary in order to make available, to the pool formed or otherwise created under section 1331, reinsurance for losses (due to claims for proved and approved losses covered by flood insurance) which are in excess of losses assumed by such pool in accordance with the excess loss agreement entered into under subsection (c).

(2) The Administrator is authorized to secure reinsurance coverage of coverage provided by the flood insurance program from private market insurance, reinsurance, and capital market sources at rates and on terms determined by the Administrator to be reasonable and appropriate in an amount sufficient to maintain the ability of the program to pay claims and that minimizes the likelihood that the program will utilize the borrowing authority provided under section 1309.

(b) Such reinsurance shall be made available pursuant to contract, agreement, or any other arrangement, in consideration of such payment of a premium, fee, or other charge as the [Director] *Administrator* finds necessary to cover anticipated losses and other costs of providing such reinsurance.

(c) The [Director] *Administrator* is authoried to negotiate an excess loss agreement, from time to time, under which the amount of flood insurance retained by the pool, after ceding reinsurance, shall be adequate to further the purposes of this title, consistent with the objective of maintaining appropriate financial participation and risk sharing to the maximum extent practicable on the part of participating insurance companies and other insurers.

(d) All reinsurance claims for losses in excess of losses assumed by the pool shall be submitted on a portfolio basis by such pool in accordance with terms and conditions established by the [Director] *Administrator*.

EMERGENCY IMPLEMENTATION OF PROGRAM

SEC. 1336. (a) Notwithstanding any other provisions of this title, for the purpose of providing flood insurance coverage at the earliest possible time, the [Director] *Administrator* shall carry out the flood insurance program authorized under chapter I during the period ending on the date specified in section 1319, in accordance with the provisions of this part and the other provision of this title insofar as they relate to this part but subject to the modifications made by or under subsection (b).

(b) In carrying out the flood insurance program pursuant to subsection (a), the [Director] *Administrator*—

(1) * * *

* * * * * * *

PART B—GOVERNMENT PROGRAM WITH INDUSTRY ASSISTANCE

FEDERAL OPERATION OF THE PROGRAM

SEC. 1340. (a) If at any time, after consultation with representatives of the insurance industry, the [Director] *Administrator* determines that operation of the flood insurance program as provided under part A cannot be carried out, or that such operation, in itself, would be assisted materially by the Federal Government's assumption, in whole or in part, of the operational responsibility for flood insurance under this title (on a temporary or other basis) he shall promptly undertake any necessary arrangements to carry out the program of flood insurance authorized under chapter I through the facilities of the Federal Government, utilizing, for purposes of providing flood insurance coverage, either—

(1) * * *

(2) such other officers and employees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the [Director] *Administrator* and the head of any such agency may from time to time, agree upon, on a reimbursement or other basis, or

* * * * * * *

(b) Upon making the determination referred to in subsection (a), the [Director] *Administrator* shall make a report to the Congress and, at the same time, to the private insurance companies participating in the National Flood Insurance Program pursuant to section 1310 of this Act. Such report shall—

(1) * * *

* * * * * * *

(4) contain such recommendations as the [Director] *Administrator* deems advisable.

The [Director] *Administrator* shall not implement the program of flood insurance authorized under chapter I through the facilities of the Federal Government until 9 months after the date of submission of the report under this subsection unless it would be impossible to continue to effectively carry out the National Flood Insurance Program operations during this time.

ADJUSTMENT AND PAYMENT OF CLAIMS AND JUDICIAL REVIEW

SEC. 1341. In the event the program is carried out as provided in section 1340, the [Director] *Administrator* shall be authorized to adjust and make payment of any claims for proved and approved losses covered by flood insurance, and upon the disallowance by the [Director] *Administrator* of any such claims, or upon the refusal of the claimant to accept the amount allowed upon any such claim, the claimant, within one year after the date of mailing of notice of disallowance or partial disallowance by the [Director] *Administrator*, may institute an action against the [Director] *Administrator* on such claim in the United States district court for the district in which the insured property or the major part thereof shall have been situated, and original exclusive jurisdiction is hereby conferred upon such court to hear and determine such action without regard to the amount in controversy.

PART C—PROVISIONS OF GENERAL APPLICABILITY

SERVICES BY INSURANCE INDUSTRY

SEC. 1345. (a) In administering the flood insurance program under this chapter, the [Director] *Administrator* is authorized to enter into any contracts, agreements, or other appropriate arrangements which may, from time to time, be necessary for the purpose of utilizing, on such terms and conditions as may be agreed upon, the facilities and services of any insurance companies or other insurers, insurance agents and brokers, or insurance adjustment organizations; and such contracts, agreements, or arrangements may include provision for payment of applicable operating costs and allowances for such facilities and services as set forth in the schedules prescribed under section 1311.

* * * * * * *

(c) The [Director] *Administrator* of the Federal Emergency Management Agency shall hold any agent or broker selling or undertaking to sell flood insurance under this title harmless from any judgment for damages against such agent or broker as a result of any court action by a policyholder or applicant arising out of an error or omission on the part of the Federal Emergency Management Agency, and shall provide any such agent or broker with indemnification, including court costs and reasonable attorney fees, arising out of and caused by an error or omission on the part of the Federal Emergency Management Agency and its contractors. The [Director] *Administrator* of the Federal Emergency Management Agency may not hold harmless or indemnify an agent or broker for his or her error or omission.

(d) INFORMATION REGARDING MULTIPLE PERILS CLAIMS.—

(1) IN GENERAL.—Subject to paragraph (2), if an insured having flood insurance coverage under a policy issued under the program under this title by the Administrator or a company, insurer, or entity offering flood insurance coverage under such program (in this subsection referred to as a "participating company") has wind or other homeowners coverage from any company, insurer, or other entity covering property covered by such flood insurance, in the case of damage to such property that

may have been caused by flood or by wind, the Administrator and the participating company, upon the request of the insured, shall provide to the insured, within 30 days of such request—

(A) a copy of the estimate of structure damage;

(B) proofs of loss;

(C) any expert or engineering reports or documents commissioned by or relied upon by the Administrator or participating company in determining whether the damage was caused by flood or any other peril; and

(D) the Administrator's or the participating company's final determination on the claim.

(2) TIMING.—Paragraph (1) shall apply only with respect to a request described in such paragraph made by an insured after the Administrator or the participating company, or both, as applicable, have issued a final decision on the flood claim involved and resolution of all appeals with respect to such claim.

(e) FEMA AUTHORITY TO REJECT TRANSFER OF POLICIES.—Notwithstanding any other provision of this Act, the Administrator may, at the discretion of the Administrator, refuse to accept the transfer of the administration of policies for coverage under the flood insurance program under this title that are written and administered by any insurance company or other insurer, or any insurance agent or broker.

USE OF INSURANCE POOL, COMPANIES, OR OTHER PRIVATE ORGANIZATIONS FOR CERTAIN PAYMENTS

SEC. 1346. (a) In order to provide for maximum efficency in the administration of the flood insurance program and in order to facilitate the expeditious payment of any Federal funds under such program, the [Director] *Administrator* may enter into contracts with a pool formed or otherwise created under section 1331, or any insurance company or other private organization, for the purpose of securing performance by such pool, company, or organization*, or for purposes of securing reinsurance of insurance coverage provided by the program,* of any or all of the following responsibilities:

(1) [estimating] *Estimating* and later determining any amounts of payments to be made[;].

(2) [receiving] *Receiving* from the [Director] *Administrator*, disbursing, and accounting for funds in making such payments[;].

(3) [making] *Making* such audits of the records of any insurance company or other insurer, insurance agent or broker, or insurance adjustment organization as may be necessary to assure that proper payments are made[; and].

(4) Placing reinsurance coverage on insurance provided by such program.

[(4) otherwise] *(5) Otherwise* assisting in such manner as the contract may provide to further the purposes of this title.

(b) Any contract with the pool or an insurance company or other private organization under this section may contain such terms and conditions at the [Director] *Administrator* finds necessary or ap-

propriate for carrying out responsibilities under subsection (a), and may provide for payment of any costs which the [Director] *Administrator* determines are incidental to carrying out such responsibilities which are covered by the contract.

* * * * * * *

(d) No contract may be entered into under this section unless the [Director] *Administrator* finds that the pool, company, or organization will perform its obligations under the contract efficiently and effectively, and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(e)(1) Any such contract may require the pool, company, or organization or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the [Director] *Administrator* may deem appropriate.

* * * * * * *

(f) Any contract entered into under this section shall be for a term of one year, and may be made automatically renewable from term to term in the absence of notice by either party of an intention to terminate at the end of the current term; except that the [Director] *Administrator* may terminate any such contract at any time (after reasonable notice to the pool, company, or organization involved) if he finds that the pool, company, or organization has failed substantially to carry out the contract, or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the flood insurance program authorized under this title.

SETTLEMENT AND ARBITRATION

SEC. 1347. (a) The [Director] *Administrator* is authorized to make final settlement of any claims or demands which may arise as a result of any financial transactions which he is authorized to carry out under this chapter, and may, to assist him in making any such settlement, refer any disputes relating to such claims or demands to arbitration, with the consent of the parties concerned.

(b) Such arbitration shall be advisory in nature, and any award, decision, or recommendation which may be made shall become final only upon the approval of the [Director] *Administrator*.

RECORDS AND AUDITS

SEC. 1348. (a) The flood insurance pool formed or otherwise created under part A of this chapter, and any insurance company or other private organization executing any contract, agreement, or other appropriate arrangement with the [Director] *Administrator* under part B of this chapter or this part, shall keep such records as the [Director] *Administrator* shall prescribe, including records which fully disclose the total costs of the program undertaken or the services being rendered, and such other records as will facilitate an effective audit.

(b) The [Director] *Administrator* and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any

books, documents, papers and any such insurance company or other private organization that are pertinent to the costs of the program undertaken or the services being rendered.

SEC. 1349. NOTIFICATION TO POLICY HOLDERS REGARDING DIRECT MANAGEMENT OF POLICY BY FEMA.

(a) NOTIFICATION.—Not later than 60 days before the date on which a transferred flood insurance policy expires, and annually thereafter until such time as the Federal Emergency Management Agency is no longer directly administering such policy, the Administrator shall notify the holder of such policy that—

(1) the Federal Emergency Management Agency is directly administering the policy;

(2) such holder may purchase flood insurance that is directly administered by an insurance company; and

(3) purchasing flood insurance offered under the National Flood Insurance Program that is directly administered by an insurance company will not alter the coverage provided or the premiums charged to such holder that otherwise would be provided or charged if the policy was directly administered by the Federal Emergency Management Agency.

(b) DEFINITION.—In this section, the term "transferred flood insurance policy" means a flood insurance policy that—

(1) was directly administered by an insurance company at the time the policy was originally purchased by the policy holder; and

(2) at the time of renewal of the policy, direct administration of the policy was or will be transferred to the Federal Emergency Management Agency.

CHAPTER III—COORDINATION OF FLOOD INSURANCE WITH LAND-MANAGEMENT PROGRAMS IN FLOOD-PRONE AREAS

IDENTIFICATION OF FLOOD-PRONE AREAS

SEC. 1360. (a) The [Director] *Administrator* is authorized to consult with, receive information from, and enter into any agreements or other arrangements with the Secretaries of the Army, the Interior, Agriculture, and Commerce, the Tennessee Valley Authority, and the heads of other Federal departments or agencies, on a reimbursement basis, or with the head of any State or local agency, or enter into contracts with any persons or private firms, in order that he may—

(1) * * *

* * * * * * *

(b) The [Director] *Administrator* is directed to accelerate the identification of risk zones within flood-prone and mudslide-prone areas, as provided by subsection (a)(2) of this section, in order to make known the degree of hazard within each such zone at the earliest possible date. To accomplish this objective, the [Director] *Administrator* is authorized, without regard to subsections (a) and (b) of section 3324 of title 31, United States Code, and section 3709 of the Revised Statutes (41 U.S.C. 5), to make grants, provide technical assistance, and enter into contracts, cooperative agreements, or other transactions, on such terms as he may deem appropriate,

or consent to modifications thereof, and to make advance or progress payments in connection therewith.

(c) The Secretary of Defense (through the Army Corps of Engineers), the Secretary of the Interior (through the United States Geological Survey), the Secretary of Agriculture (through the Soil Conservation Service), the Secretary of Commerce (through the National Oceanic and Atmospheric Administration), the head of the Tennessee Valley Authority, and the heads of all other Federal agencies engaged in the identification or delineation of flood-risk zones within the several States shall, in consultation with the [Director] *Administrator*, give the highest practicable priority in the allocation of available manpower and other available resources to the identification and mapping of flood hazard areas and flood-risk zones, in order to assist the [Director] *Administrator* to meet the deadline established by this section.

(d) The [Director] *Administrator* shall, not later than September 30, 1984, submit to the Congress a plan for bringing all communities containing flood-risk zones into full program status by September 30, 1987.

(e) REVIEW OF FLOOD MAPS.—Once during each 5-year period (the 1st such period beginning on the date of enactment of the Riegle Community Development and Regulatory Improvement Act of 1994) or more often as the [Director] *Administrator* determines necessary, the [Director] *Administrator* shall assess the need to revise and update all floodplain areas and flood risk zones identified, delineated, or established under this section, based on an analysis of all natural hazards affecting flood risks.

(f) UPDATING FLOOD MAPS.—The [Director] *Administrator* shall revise and update any floodplain areas and flood-risk zones—

(1) upon the determination of the [Director] *Administrator*, according to the assessment under subsection (e), that revision and updating are necessary for the areas and zones; or

(2) upon the request from any State or local government stating that specific floodplain areas or flood-risk zones in the State or locality need revision or updating, if sufficient technical data justifying the request is submitted and the unit of government making the request agrees to provide funds in an amount determined by the [Director] *Administrator*, but which may not exceed 50 percent of the cost of carrying out the requested revision or update.

(g) AVAILABILITY OF FLOOD MAPS.—To promote compliance with the requirements of this title, the [Director] *Administrator* shall make flood insurance rate maps and related information available free of charge to the Federal entities for lending regulation, Federal agency lenders, State agencies directly responsible for coordinating the national flood insurance program, and appropriate representatives of communities participating in the national flood insurance program, and at a reasonable cost to all other persons. Any receipts resulting from this subsection shall be deposited in the National Flood Insurance Fund, pursuant to section 1310(b)(6).

(h) NOTIFICATION OF FLOOD MAP CHANGES.—The [Director] *Administrator* shall cause notice to be published in the Federal Register (or shall provide notice by another comparable method) of any change to flood insurance map panels and any change to flood in-

surance map panels issued in the form of a letter of map amendment or a letter of map revision. Such notice shall be published or otherwise provided not later than 30 days after the map change or revision becomes effective. Notice by any method other than publication in the Federal Register shall include all pertinent information, provide for regular and frequent distribution, and be at least as accessible to map users as notice in the Federal Register. All notices under this subsection shall include information on how to obtain copies of the changes or revisions.

(i) COMPENDIA OF FLOOD MAP CHANGES.—Every 6 months, the [Director] *Administrator* shall publish separately in their entirety within a compendium, all changes and revisions to flood insurance map panels and all letters of map amendment and letters of map revision for which notice was published in the Federal Register or otherwise provided during the preceding 6 months. The [Director] *Administrator* shall make such compendia available, free of charge, to Federal entities for lending regulation, Federal agency lenders, and States and communities participating in the national flood insurance program pursuant to section 1310 and at cost to all other parties. Any receipts resulting from this subsection shall be deposited in the National Flood Insurance Fund, pursuant to section 1310(b)(6).

(j) PROVISION OF INFORMATION.—In the implementation of revisions to and updates of flood insurance rate maps, the [Director] *Administrator* shall share information, to the extent appropriate, with the Under Secretary of Commerce for Oceans and Atmosphere and representatives from State coastal zone management programs.

(k) TREATMENT OF LEVEES.—The Administrator may not issue flood insurance maps, or make effective updated flood insurance maps, that omit or disregard the actual protection afforded by an existing levee, floodwall, pump or other flood protection feature, regardless of the accreditation status of such feature.

(l) NOTIFICATION TO MEMBERS OF CONGRESS OF MAP MODERNIZATION.—Upon any revision or update of any floodplain area or flood-risk zone pursuant to subsection (f), any decision pursuant to subsection (f)(1) that such revision or update is necessary, any issuance of preliminary maps for such revision or updating, or any other significant action relating to any such revision or update, the Administrator shall notify the Senators for each State affected, and each Member of the House of Representatives for each congressional district affected, by such revision or update in writing of the action taken.

(m) REIMBURSEMENT.—

(1) REQUIREMENT UPON BONA FIDE ERROR.—If an owner of any property located in an area described in section 102(i)(3) of the Flood Disaster Protection Act of 1973, or a community in which such a property is located, obtains a letter of map amendment, or a letter of map revision, due to a bona fide error on the part of the Administrator of the Federal Emergency Management Agency, the Administrator shall reimburse such owner, or such entity or jurisdiction acting on such owner's behalf, or such community, as applicable, for any reasonable costs incurred in obtaining such letter.

(2) REASONABLE COSTS.—The Administrator shall, by regulation or notice, determine a reasonable amount of costs to be reimbursed under paragraph (1), except that such costs shall not include legal or attorneys fees. In determining the reasonableness of costs, the Administrator shall only consider the actual costs to the owner or community, as applicable, of utilizing the services of an engineer, surveyor, or similar services.

(n) ENHANCED COMMUNICATION WITH CERTAIN COMMUNITIES DURING MAP UPDATING PROCESS.—In updating flood insurance maps under this section, the Administrator shall communicate with communities located in areas where flood insurance rate maps have not been updated in 20 years or more and the appropriate State emergency agencies to resolve outstanding issues, provide technical assistance, and disseminate all necessary information to reduce the prevalence of outdated maps in flood-prone areas.

(o) NOTIFICATION TO RESIDENTS NEWLY INCLUDED IN FLOOD HAZARD AREA.—In revising or updating any areas having special flood hazards, the Administrator shall provide to each owner of a property to be newly included in such a special flood hazard area, at the time of issuance of such proposed revised or updated flood insurance maps, a copy of the proposed revised or updated flood insurance maps together with information regarding the appeals process under section 1363 (42 U.S.C. 4104).

CRITERIA FOR LAND MANAGEMENT AND USE

SEC. 1361. (a) The [Director] *Administrator* is authorized to carry out studies and investigations, utilizing to the maximum extent practicable the existing facilities and services of other Federal departments or agencies, and State and local governmental agencies, and any other organizations, with respect to the adequacy of State and local measures in flood-prone areas as to land management and use, flood control, flood zoning, and flood damage prevention, and may enter into any contracts, agreements or other appropriate arrangements to carry out such authority.

* * * * * * *

(c) On the basis of such studies and investigations, and such other information as he deems necessary, the [Director] *Administrator* shall from time to time develop comprehensive critera designed to encourage, where necessary, the adoption of adequate State and local measures which, to the maximum extent feasible, will—

(1) * * *

* * * * * * *

and he shall work closely with and provide any necessary technical assistance to State, interstate, and local governmental agencies, to encourage the application of such criteria and the adoption and enforcement of such measures.

[SEC. 1361A. PILOT PROGRAM FOR MITIGATION OF SEVERE REPETITIVE LOSS PROPERTIES.

[(a) AUTHORITY.—To the extent amounts are made available for use under this section, the Director may, subject to the limitations of this section, provide financial assistance to States and communities that decide to participate in the pilot program established

under this section for taking actions with respect to severe repetitive loss properties (as such term is defined in subsection (b)) to mitigate flood damage to such properties and losses to the National Flood Insurance Fund from such properties.

[(b) SEVERE REPETITIVE LOSS PROPERTY.—For purposes of this section, the term "severe repetitive loss property" has the following meaning:

[(1) SINGLE-FAMILY PROPERTIES.—In the case of a property consisting of 1 to 4 residences, such term means a property that—

[(A) is covered under a contract for flood insurance made available under this title; and

[(B) has incurred flood-related damage—

[(i) for which 4 or more separate claims payments have been made under flood insurance coverage under this title, with the amount of each such claim exceeding $5,000, and with the cumulative amount of such claims payments exceeding $20,000; or

[(ii) for which at least 2 separate claims payments have been made under such coverage, with the cumulative amount of such claims exceeding the value of the property.

[(2) MULTIFAMILY PROPERTIES.—In the case of a property consisting of 5 or more residences, such term shall have such meaning as the Director shall by regulation provide.

[(c) ELIGIBLE ACTIVITIES.—Amounts provided under this section to a State or community may be used only for the following activities:

[(1) MITIGATION ACTIVITIES.—To carry out mitigation activities that reduce flood damages to severe repetitive loss properties, including elevation, relocation, demolition, and floodproofing of structures, and minor physical localized flood control projects, and the demolition and rebuilding of properties to at least Base Flood Elevation or greater, if required by any local ordinance.

[(2) PURCHASE.—To purchase severe repetitive loss properties, subject to subsection (g).

[(d) MATCHING REQUIREMENT.—

[(1) IN GENERAL.—Except as provided in paragraph (2), in any fiscal year the Director may not provide assistance under this section to a State or community in an amount exceeding 3 times the amount that the State or community certifies, as the Director shall require, that the State or community will contribute from non-Federal funds for carrying out the eligible activities to be funded with such assistance amounts.

[(2) REDUCED COMMUNITY MATCH.—With respect to any 1-year period in which assistance is made available under this section, the Director may adjust the contribution required under paragraph (1) by any State, and for the communities located in that State, to not less than 10 percent of the cost of the activities for each severe repetitive loss property for which grant amounts are provided if, for such year—

[(A) the State has an approved State mitigation plan meeting the requirements for hazard mitigation planning

under section 322 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5165) that specifies how the State intends to reduce the number of severe repetitive loss properties; and

[(B) the Director determines, after consultation with the State, that the State has taken actions to reduce the number of such properties.

[(3) NON-FEDERAL FUNDS.—For purposes of this subsection, the term "non-Federal funds" includes State or local agency funds, in-kind contributions, any salary paid to staff to carry out the eligible activities of the recipient, the value of the time and services contributed by volunteers to carry out such activities (at a rate determined by the Director), and the value of any donated material or building and the value of any lease on a building.

[(e) NOTICE OF MITIGATION PROGRAM.—

[(1) IN GENERAL.—Upon selecting a State or community to receive assistance under subsection (a) to carry out eligible activities, the Director shall notify the owners of a severe repetitive loss property, in plain language, within that State or community—

[(A) that their property meets the definition of a severe repetitive loss property under this section;

[(B) that they may receive an offer of assistance under this section;

[(C) of the types of assistance potentially available under this section;

[(D) of the implications of declining such offer of assistance under this section; and

[(E) that there is a right to appeal under this section.

[(2) IDENTIFICATION OF SEVERE REPETITIVE LOSS PROPERTIES.—The Director shall take such steps as are necessary to identify severe repetitive loss properties, and submit that information to the relevant States and communities.

[(f) STANDARDS FOR MITIGATION OFFERS.—The program under this section for providing assistance for eligible activities for severe repetitive loss properties shall be subject to the following limitations:

[(1) PRIORITY.—In determining the properties for which to provide assistance for eligible activities under subsection (c), the Director shall provide assistance for properties in the order that will result in the greatest amount of savings to the National Flood Insurance Fund in the shortest period of time, in a manner consistent with the allocation formula under paragraph (5).

[(2) OFFERS.—The Director shall provide assistance in a manner that permits States and communities to make offers to owners of severe repetitive loss properties to take eligible activities under subsection (c) as soon as practicable.

[(3) CONSULTATION.—In determining for which eligible activities under subsection (c) to provide assistance with respect to a severe repetitive loss property, the relevant States and communities shall consult, to the extent practicable, with the owner of the property.

[(4) DEFERENCE TO LOCAL MITIGATION DECISIONS.—The Director shall not, by rule, regulation, or order, establish a priority for funding eligible activities under this section that gives preference to one type or category of eligible activity over any other type or category of eligible activity.

[(5) ALLOCATION.—

[(A) IN GENERAL.—Subject to subparagraphs (B) and (C), of the total amount made available for assistance under this section in any fiscal year, the Director shall allocate assistance to a State, and the communities located within that State, based upon the percentage of the total number of severe repetitive loss properties located within that State.

[(B) REDISTRIBUTION.—Any funds allocated to a State, and the communities within the State, under subparagraph (A) that have not been obligated by the end of each fiscal year shall be redistributed by the Director to other States and communities to carry out eligible activities in accordance with this section.

[(C) EXCEPTION.—Of the total amount made available for assistance under this section in any fiscal year, 10 percent shall be made available to communities that—

[(i) contain one or more severe repetitive loss properties; and

[(ii) are located in States that receive little or no assistance, as determined by the Director, under the allocation formula under subparagraph (A).

[(6) NOTICE.—Upon making an offer to provide assistance with respect to a property for any eligible activity under subsection (c), the State or community shall notify each holder of a recorded interest on the property of such offer and activity.

[(g) PURCHASE OFFERS.—A State or community may take action under subsection (c)(2) to purchase a severe repetitive loss property only if the following requirements are met:

[(1) USE OF PROPERTY.—The State or community enters into an agreement with the Director that provides assurances that the property purchased will be used in a manner that is consistent with the requirements of section 404(b)(2)(B) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170c(b)(2)(B)) for properties acquired, accepted, or from which a structure will be removed pursuant to a project provided property acquisition and relocation assistance under such section 404(b).

[(2) OFFERS.—The Director shall provide assistance in a manner that permits States and communities to make offers to owners of severe repetitive loss properties and of associated land to engage in eligible activities as soon as possible.

[(3) PURCHASE PRICE.—The amount of purchase offer is not less than the greatest of—

[(A) the amount of the original purchase price of the property, when purchased by the holder of the current policy of flood insurance under this title;

[(B) the total amount owed, at the time the offer to purchase is made, under any loan secured by a recorded interest on the property; and

[(C) an amount equal to the fair market value of the property immediately before the most recent flood event affecting the property, or an amount equal to the current fair market value of the property.

[(4) COMPARABLE HOUSING PAYMENT.—If a purchase offer made under paragraph (2) is less than the cost of the homeowner-occupant to purchase a comparable replacement dwelling outside the flood hazard area in the same community, the Director shall make available an additional relocation payment to the homeowner-occupant to apply to the difference.

[(h) INCREASED PREMIUMS IN CASES OF REFUSAL TO MITIGATE.—

[(1) IN GENERAL.—In any case in which the owner of a severe repetitive loss property refuses an offer to take action under paragraph (1) or (2) of subsection (c) with respect to such property, the Director shall—

[(A) notify each holder of a recorded interest on the property of such refusal; and

[(B) notwithstanding subsections (a) through (c) of section 1308, thereafter the chargeable premium rate with respect to the property shall be the amount equal to 150 percent of the chargeable rate for the property at the time that the offer was made, as adjusted by any other premium adjustments otherwise applicable to the property and any subsequent increases pursuant to paragraph (2) and subject to the limitation under paragraph (3).

[(2) INCREASED PREMIUMS UPON SUBSEQUENT FLOOD DAMAGE.—Notwithstanding subsections (a) through (c) of section 1308, if the owner of a severe repetitive loss property does not accept an offer to take action under paragraph (1) or (2) of subsection (c) with respect to such property and a claim payment exceeding $1,500 is made under flood insurance coverage under this title for damage to the property caused by a flood event occurring after such offer is made, thereafter the chargeable premium rate with respect to the property shall be the amount equal to 150 percent of the chargeable rate for the property at the time of such flood event, as adjusted by any other premium adjustments otherwise applicable to the property and any subsequent increases pursuant to this paragraph and subject to the limitation under paragraph (3).

[(3) LIMITATION ON INCREASED PREMIUMS.—In no case may the chargeable premium rate for a severe repetitive loss property be increased pursuant to this subsection to an amount exceeding the applicable estimated risk premium rate for the area (or subdivision thereof) under section 1307(a)(1).

[(4) TREATMENT OF DEDUCTIBLES.—Any increase in chargeable premium rates required under this subsection for a severe repetitive loss property may be carried out, to the extent appropriate, as determined by the Director, by adjusting any deductible charged in connection with flood insurance coverage under this title for the property.

[(5) NOTICE OF CONTINUED OFFER.—Upon each renewal or modification of any flood insurance coverage under this title for a severe repetitive loss property, the Director shall notify the owner that the offer made pursuant to subsection (c) is still open.

[(6) APPEALS.—

[(A) IN GENERAL.—Any owner of a severe repetitive loss property may appeal a determination of the Director to take action under paragraph (1)(B) or (2) with respect to such property, based only upon the following grounds:

[(i) As a result of such action, the owner of the property will not be able to purchase a replacement primary residence of comparable value and that is functionally equivalent.

[(ii) Based on independent information, such as contractor estimates or appraisals, the property owner believes that the price offered for purchasing the property is not an accurate estimation of the value of the property, or the amount of Federal funds offered for mitigation activities, when combined with funds from non-Federal sources, will not cover the actual cost of mitigation.

[(iii) As a result of such action, the preservation or maintenance of any prehistoric or historic district, site, building, structure, or object included in, or eligible for inclusion in, the National Register of Historic Places will be interfered with, impaired, or disrupted.

[(iv) The flooding that resulted in the flood insurance claims described in subsection (b)(2) for the property resulted from significant actions by a third party in violation of Federal, State, or local law, ordinance, or regulation.

[(v) In purchasing the property, the owner relied upon flood insurance rate maps of the Federal Emergency Management Agency that were current at the time and did not indicate that the property was located in an area having special flood hazards.

[(vi) The owner of the property, based on independent information, such as contractor estimates or other appraisals, demonstrates that an alternative eligible activity under subsection (c) is at least as cost effective as the initial offer of assistance.

[(B) PROCEDURE.—An appeal under this paragraph of a determination of the Director shall be made by filing, with the Director, a request for an appeal within 90 days after receiving notice of such determination. Upon receiving the request, the Director shall select, from a list of independent third parties compiled by the Director for such purpose, a party to hear such appeal. Within 90 days after filing of the request for the appeal, such third party shall review the determination of the Director and shall set aside such determination if the third party determines that the grounds under subparagraph (A) exist. During the pendency of an appeal under this paragraph, the Director

shall stay the applicability of the rates established pursuant to paragraph (1)(B) or (2), as applicable.

[(C) EFFECT OF FINAL DETERMINATION.—In an appeal under this paragraph—

[(i) if a final determination is made in favor of the property owner under subparagraph (A) exist, the third party hearing such appeal shall require the Director to reduce the chargeable risk premium rate for flood insurance coverage for the property involved in the appeal from the amount required under paragraph (1)(B) or (2) to the amount paid prior to the offer to take action under paragraph (1) or (2) of subsection (c); and

[(ii) if a final determination is made that the grounds under subparagraph (A) do not exist, the Director shall promptly increase the chargeable risk premium rate for such property to the amount established pursuant to paragraph (1)(B) or (2), as applicable, and shall collect from the property owner the amount necessary to cover the stay of the applicability of such increased rates during the pendency of the appeal.

[(D) COSTS.—If the third party hearing an appeal under this paragraph is compensated for such service, the costs of such compensation shall be borne—

[(i) by the owner of the property requesting the appeal, if the final determination in the appeal is that the grounds under subparagraph (A) do not exist; and

[(ii) by the National Flood Insurance Fund, if such final determination is that the grounds under subparagraph (A) do exist.

[(E) REPORT.—Not later than 6 months after the date of the enactment of the Bunning-Bereuter-Blumenauer Flood Insurance Reform Act of 2004, the Director shall submit a report describing the rules, procedures, and administration for appeals under this paragraph to—

[(i) the Committee on Banking, Housing, and Urban Affairs of the Senate; and

[(ii) the Committee on Financial Services of the House of Representatives.

[(i) DISCRETIONARY ACTIONS IN CASES OF FRAUDULENT CLAIMS.—If the Director determines that a fraudulent claim was made under flood insurance coverage under this title for a severe repetitive loss property, the Director may—

[(1) cancel the policy and deny the provision to such policyholder of any new flood insurance coverage under this title for the property; or

[(2) refuse to renew the policy with such policyholder upon expiration and deny the provision of any new flood insurance coverage under this title to such policyholder for the property.

[(j) RULES.—

[(1) IN GENERAL.—The Director shall, by rule—

[(A) subject to subsection (f)(4), develop procedures for the distribution of funds to States and communities to carry out eligible activities under this section; and

[(B) ensure that the procedures developed under paragraph (1)—

[(i) require the Director to notify States and communities of the availability of funding under this section, and that participation in the pilot program under this section is optional;

[(ii) provide that the Director may assist States and communities in identifying severe repetitive loss properties within States or communities;

[(iii) allow each State and community to select properties to be the subject of eligible activities, and the appropriate eligible activity to be performed with respect to each severe repetitive loss property; and

[(iv) require each State or community to submit a list of severe repetitive loss properties to the Director that the State or community would like to be the subject of eligible activities under this section.

[(2) CONSULTATION.—Not later than 90 days after the date of enactment of this Act, the Director shall consult with State and local officials in carrying out paragraph (1)(A), and provide an opportunity for an oral presentation, on the record, of data and arguments from such officials.

[(k) FUNDING.—

[(1) IN GENERAL.—Pursuant to section 1310(a)(8), the Director may use amounts from the National Flood Insurance Fund to provide assistance under this section in each of fiscal years 2005, 2006, 2007, 2008, and 2009, except that the amount so used in each such fiscal year may not exceed $40,000,000 and shall remain available until expended. Notwithstanding any other provision of this title, amounts made available pursuant to this subsection shall not be subject to offsetting collections through premium rates for flood insurance coverage under this title.

[(2) ADMINISTRATIVE EXPENSES.—Of the amounts made available under this subsection, the Director may use up to 5 percent for expenses associated with the administration of this section.

[(l) TERMINATION.—The Director may not provide assistance under this section to any State or community after September 30, 2009.]

* * * * * * *

APPEALS

[SEC. 1363. (a) In establishing projected flood elevations for land use purposes with respect to any community pursuant to section 1361, the Director shall first propose such determinations by publication for comment in the Federal Register, by direct notification to the chief executive officer of the community, and by publication in a prominent local newspaper.]

SEC. 1363. (a) In establishing projected flood elevations for land use purposes with respect to any community pursuant to section 1361, the Administrator shall first propose such determinations—

(1) by providing the chief executive officer of each community affected by the proposed elevations, by certified mail, with a return receipt requested, notice of the elevations, including a copy of the maps for the elevations for such community and a statement explaining the process under this section to appeal for changes in such elevations;

(2) by causing notice of such elevations to be published in the Federal Register, which notice shall include information sufficient to identify the elevation determinations and the communities affected, information explaining how to obtain copies of the elevations, and a statement explaining the process under this section to appeal for changes in the elevations;

(3) by publishing in a prominent local newspaper the elevations, a description of the appeals process for flood determinations, and the mailing address and telephone number of a person the owner may contact for more information or to initiate an appeal;

(4) by providing written notification, by first class mail, to each owner of real property affected by the proposed elevations of—

(A) the status of such property, both prior to and after the effective date of the proposed determination, with respect to flood zone and flood insurance requirements under this Act and the Flood Disaster Protection Act of 1973;

(B) the process under this section to appeal a flood elevation determination; and

(C) the mailing address and phone number of a person the owner may contact for more information or to initiate an appeal; and

(5) by notifying a local television and radio station.

[(b) The Director**]** *(b)(1) The Administrator* shall publish notification of flood elevation determinations in a prominent local newspaper at least twice during the ten-day period following notification to the local government *and shall notify a local television and radio station at least once during the same 10-day period*. During the ninety-day period following the second publication, any owner or lessee of real property within the community who believes his property rights to be adversely affected by the **[**Director's**]** *Administrator's* proposed determination may appeal such determination to the local government. The sole basis for such appeal shall be the possession of knowledge or information indicating that elevations being proposed by the **[**Director**]** *Administrator* with respect to an identified area having special flood hazards are scientifically or technically incorrect, and the sole relief which shall be granted under the authority of this section in the event that such appeal is sustained in accordance with subsection (e) or (f) is a modification of the **[**Director's**]** *Administrator's* proposed determination accordingly.

(2) The Administrator shall grant an extension of the 90-day period for appeals referred to in paragraph (1) for 90 additional days if an affected community certifies to the Administrator, after the expiration of at least 60 days of such period, that the community—

(A) believes there are property owners or lessees in the community who are unaware of such period for appeals; and

(B) will utilize the extension under this paragraph to notify property owners or lessees who are affected by the proposed flood elevation determinations of the period for appeals and the opportunity to appeal the determinations proposed by the Administrator.

(c) Appeals by private persons shall be made to the chief executive officer of the community, or to such agency as he shall publicly designate, and shall set forth the data that tend to negate or contradict the [Director's] *Administrator's* finding in such form as the chief executive officer may specify. The community shall review and consolidate all such appeals and issue a written opinion stating whether the evidence presented is sufficient to justify an appeal on behalf of such persions by the community in its own name. Whether or not the community decides to appeal the [Director's] *Administrator's* determination, copies of individual appeals shall be sent to the [Director] *Administrator* as they are received by the community, and the community's appeal or a copy of its decision not to appeal shall be filed with the [Director] *Administrator* not later than ninety days after the date of the second newspaper publication of the [Director's] *Administrator's* notification.

(d) In the event the [Director] *Administrator* does not receive an appeal from the community within the ninety days provided he shall consolidate and review on their own merits, in accordance with the procedures set forth in subsection (e), the appeals filed within the community by private persons and shall make such modifications of his proposed determinations as may be appropriate, taking into account the written opinion, if any, issued by the community in not supporting such appeals. The [Director's] *Administrator's* decision shall be in written form, and copies thereof shall be sent both to the chief executive officer of the community and to each individual appellant.

(e) Upon appeal by any community, as provided by this section, the [Director] *Administrator* shall review and take fully into account any technical or scientific data submitted by the community that tend to negate or contradict the information upon which his proposed determination is based. The [Director] *Administrator* shall resolve such appeal by consultation with officials of the local government involved, by administrative hearing, or by submission of the conflicting data to an independent scientific body or appropriate Federal agency for advice. Until the conflict in data is resolved, and the [Director] *Administrator* makes a final determination on the basis of his findings in the Federal Register, and so notifies the governing body of the community, flood insurance previously available within the community shall continue to be available, and no person shall be denied the right to purchase such insurance at chargeable rates. The [Director] *Administrator* shall make his determination within a reasonable time. The community shall be given a reasonable time after the [Director's] *Administrator's* final determination in which to adopt local land use and control measures consistent with the [Director's] *Administrator's* determination. The reports and other information used by the [Director] *Administrator* in making his final determination shall be made available for public inspection and shall be admissible in a

court of law in the event the community seeks judicial review as provided by this section.

(f) When, incident to any appeal under subsection (b) or (c), the owner or lessee of real property or the community, as the case may be, incurs expense in connection with the services of surveyors, engineers, or similar services, but not including legal services, in the effecting of an appeal which is successful in whole or in part, the [Director] *Administrator* shall reimburse such individual or community to an extent measured by the ratio of the successful portion of the appeal as compared to the entire appeal and applying such ratio to the reasonable value of all such services, but no reimbursement shall be made by the [Director] *Administrator* in respect to any fee or expense payment, the payment of which was agreed to be contingent upon the result of the appeal. There is authorized to be appropriated for purposes of implementing this subsection, not to exceed $250,000.

(g) Any appellant aggrieved by any final determination of the [Director] *Administrator* upon administrative appeal, as provided by this section, may appeal such determination to the United States district court for the district within which the community is located not more than sixty days after receipt of notice of such determination. The scope of review by the court shall be as provided by chapter 7 of title 5, United States Code. During the pendency of any such litigation, all final determinations of the [Director] *Administrator* shall be effective for the purposes of this title unless stayed by the court for good cause shown.

NOTICE REQUIREMENTS

SEC. 1364. (a) NOTIFICATION OF SPECIAL FLOOD HAZARDS.—

(1) REGULATED LENDING INSTITUTIONS.—Each Federal entity for lending regulation (after consultation and coordination with the Financial Institutions Examination Council) shall by regulation require regulated lending institutions, as a condition of making, increasing, extending, or renewing any loan secured by improved real estate or a mobile home that the regulated lending institution determines is located or is to be located in an area that has been identified by the [Director] *Administrator* under this title or the Flood Disaster Protection Act of 1973 as an area having special flood hazards, to notify the purchaser or lessee (or obtain satisfactory assurances that the seller or lessor has notified the purchaser or lessee) and the servicer of the loan of such special flood hazards, in writing, a reasonable period in advance of the signing of the purchase agreement, lease, or other documents involved in the transaction. The regulations shall also require that the regulated lending institution retain a record of the receipt of the notices by the purchaser or lessee and the servicer.

(2) FEDERAL AGENCY LENDERS.—Each Federal agency lender shall by regulation require notification in the manner provided under paragraph (1) with respect to any loan that is made by the Federal agency lender and secured by improved real estate or a mobile home located or to be located in an area that has been identified by the [Director] *Administrator* under this title or the Flood Disaster Protection Act of 1973 as an area having

special flood hazards. Any regulations issued under this paragraph shall be consistent with and substantially identical to the regulations issued under paragraph (1).

(3) CONTENTS OF NOTICE.—Written notification required under this subsection shall include—

(A) a warning, in a form to be established by the [Director] *Administrator*, stating that the building on the improved real estate securing the loan is located, or the mobile home securing the loan is or is to be located, in an area having special flood hazards;

* * * * * * *

(D) any other information that the [Director] *Administrator* considers necessary to carry out the purposes of the national flood insurance program.

(b) NOTIFICATION OF CHANGE OF SERVICER.—

(1) LENDING INSTITUTIONS.—Each Federal entity for lending regulation (after consultation and coordination with the Financial Institutions Examination Council) shall by regulation require regulated lending institutions, in connection with the making, increasing, extending, renewing, selling, or transferring any loan described in subsection (a)(1), to notify the [Director] *Administrator* (or the designee of the [Director] *Administrator*) in writing during the term of the loan of the servicer of the loan. Such institutions shall also notify the [Director] *Administrator* (or such designee) of any change in the servicer of the loan, not later than 60 days after the effective date of such change. The regulations under this subsection shall provide that upon any change in the servicing of a loan, the duty to provide notification under this subsection shall transfer to the transferee servicer of the loan.

* * * * * * *

(c) NOTIFICATION OF EXPIRATION OF INSURANCE.—The [Director] *Administrator* (or the designee of the [Director] *Administrator*) shall, not less than 45 days before the expiration of any contract for flood insurance under this title, issue notice of such expiration by first class mail to the owner of the property covered by the contract, the servicer of any loan secured by the property covered by the contract, and (if known to the [Director] *Administrator*) the owner of the loan.

STANDARD HAZARD DETERMINATION FORMS

SEC. 1365. (a) DEVELOPMENT.—The [Director] *Administrator*, in consultation with representatives of the mortgage and lending industry, the Federal entities for lending regulation, the Federal agency lenders, and any other appropriate individuals, shall develop a standard form for determining, in the case of a loan secured by improved real estate or a mobile home, whether the building or mobile home is located in an area identified by the [Director] *Administrator* as an area having special flood hazards and in which flood insurance under this title is available. The form shall be established by regulations issued not later than 270 days after the date of enactment of the Riegle Community Development and Regulatory Improvement Act of 1994.

(b) DESIGN AND CONTENTS.—

(1) * * *

(2) CONTENTS.—The form shall require identification of the type of flood-risk zone in which the building or mobile home is located, the complete map and panel numbers for the improved real estate or property on which the mobile home is located, the community identification number and community participation status (for purposes of the national flood insurance program) of the community in which the improved real estate or such property is located, and the date of the map used for the determination, with respect to flood hazard information on file with the [Director] *Administrator*. If the building or mobile home is not located in an area having special flood hazards the form shall require a statement to such effect and shall indicate the complete map and panel numbers of the improved real estate or property on which the mobile home is located. If the complete map and panel numbers are not available because the building or mobile home is not located in a community that is participating in the national flood insurance program or because no map exists for the relevant area, the form shall require a statement to such effect. The form shall provide for inclusion or attachment of any relevant documents indicating revisions or amendments to maps.

* * * * * * *

(e) RELIANCE ON PREVIOUS DETERMINATION.—Any person increasing, extending, renewing, or purchasing a loan secured by improved real estate or a mobile home may rely on a previous determination of whether the building or mobile home is located in an area having special flood hazards (and shall not be liable for any error in such previous determination), if the previous determination was made not more than 7 years before the date of the transaction and the basis for the previous determination has been set forth on a form under this section, unless—

(1) * * *

(2) the person contacts the [Director] *Administrator* to determine when the most recent map revisions or updates affecting such property occurred and such revisions and updates have occurred after such previous determination.

* * * * * * *

MITIGATION ASSISTANCE

SEC. 1366. (a) AUTHORITY.—The [Director] *Administrator* shall carry out a program to provide financial assistance to States and communities, using amounts made available from the National Flood Mitigation Fund under section 1367, for planning and carrying out activities designed to reduce the risk of flood damage to structures covered under contracts for flood insurance under this title. [Such financial assistance shall be made available to States and communities in the form of grants under subsection (b) for planning assistance and in the form of grants under this section for carrying out mitigation activities.] *Such financial assistance shall be made available—*

(1) to States and communities in the form of grants under this section for carrying out mitigation activities;

(2) to States and communities in the form of grants under this section for carrying out mitigation activities that reduce flood damage to severe repetitive loss structures; and

(3) to property owners in the form of direct grants under this section for carrying out mitigation activities that reduce flood damage to individual structures for which 2 or more claim payments for losses have been made under flood insurance coverage under this title if the Administrator, after consultation with the State and community, determines that neither the State nor community in which such a structure is located has the capacity to manage such grants.

[(b) PLANNING ASSISTANCE GRANTS.—

[(1) IN GENERAL.—The Director may make grants under this subsection to States and communities to assist in developing mitigation plans under subsection (c).

[(2) FUNDING.—Of any amounts made available from the National Flood Mitigation Fund for use under this section in any fiscal year, the Director may use not more than 7.5 percent of the available funds under this section to provide planning assistance grants under this subsection.

[(3) LIMITATIONS.—

[(A) TIMING.—A grant under this subsection may be awarded to a State or community not more than once every 5 years and each grant may cover a period of 1 to 3 years.

[(B) SINGLE GRANTEE AMOUNT.—A grant for planning assistance may not exceed—

[(i) $150,000, to any State; or

[(ii) $50,000, to any community.

[(C) CUMULATIVE STATE GRANT AMOUNT.—The sum of the amounts of grants made under this subsection in any fiscal year to any one State and all communities located in such State may not exceed $300,000.]

[(c)] *(b)* ELIGIBILITY FOR MITIGATION ASSISTANCE.—To be eligible to receive financial assistance under this section for mitigation activities, a State or community shall develop, and have approved by the [Director] *Administrator*, a [flood risk] *multi-hazard* mitigation plan (in this section referred to as a "mitigation plan"), that describes the mitigation activities to be carried out with assistance provided under this section, is consistent with the criteria established by the [Director] *Administrator* under section 1361, and [provides protection against] *examines reduction of* flood losses to structures for which contracts for flood insurance are available under this title. The mitigation plan shall be consistent with a comprehensive strategy for mitigation activities for the area affected by the mitigation plan, that has been adopted by the State or community following a public hearing.

[(d) NOTIFICATION OF APPROVAL AND GRANT AWARD.—

[(1) IN GENERAL.—The Director shall notify a State or community submitting a mitigation plan of the approval or disapproval of the plan not later than 120 days after submission of the plan.

[(2) NOTIFICATION OF DISAPPROVAL.—If the Director does not approve a mitigation plan submitted under this subsection, the Director shall notify, in writing, the State or community submitting the plan of the reasons for such disapproval.]

[(e)] *(c)* ELIGIBLE MITIGATION ACTIVITIES.—

[(1) USE OF AMOUNTS.—Amounts provided under this section (other than under subsection (b)) may be used only for mitigation activities specified in a mitigation plan approved by the Director under subsection (d).]

(1) REQUIREMENT OF CONSISTENCY WITH APPROVED MITIGATION PLAN.—Amounts provided under this section may be used only for mitigation activities that are consistent with mitigation plans that are approved by the Administrator and identified under subparagraph (4). The [Director] *Administrator* shall provide assistance under this section to the extent amounts are available in the National Flood Mitigation Fund pursuant to appropriation Acts, subject only to the absence of approvable mitigation plans.

[(2) DETERMINATION OF ELIGIBLE PLANS.—The Director may approve only mitigation plans that specify mitigation activities that the Director determines are technically feasible and cost-effective and only such plans that propose activities that are cost-beneficial to the National Flood Mitigation Fund.

[(3) STANDARD FOR APPROVAL.—The Director shall approve mitigation plans meeting the requirements for approval under paragraph (1) that will be most cost-beneficial to the National Flood Mitigation Fund. The Director may approve only mitigation plans that give priority for funding to such properties, or to such subsets of properties, as are in the best interest of the National Flood Insurance Fund.

[(4) PRIORITY FOR MITIGATION ASSISTANCE.—In providing grants under this subsection for mitigation activities, the Director shall give first priority for funding to such properties, or to such subsets of such properties as the Director may establish, that the Director determines are in the best interests of the National Flood Insurance Fund and for which matching amounts under subsection (f) are available.]

(2) REQUIREMENTS OF TECHNICAL FEASIBILITY, COST EFFECTIVENESS, AND INTEREST OF NFIF.—The Administrator may approve only mitigation activities that the Administrator determines are technically feasible and cost-effective and in the interest of, and represent savings to, the National Flood Insurance Fund. In making such determinations, the Administrator shall take into consideration recognized benefits that are difficult to quantify.

(3) PRIORITY FOR MITIGATION ASSISTANCE.—In providing grants under this section for mitigation activities, the Administrator shall give priority for funding to activities that the Administrator determines will result in the greatest savings to the National Flood Insurance Fund, including activities for—

(A) severe repetitive loss structures;

(B) repetitive loss structures; and

(C) other subsets of structures as the Administrator may establish.

[(5) ELIGIBLE ACTIVITIES.—The Director shall determine whether mitigation activities described in a mitigation plan submitted under subsection (d) comply with the requirements under paragraph (1). Such activities may include—]

(4) ELIGIBLE ACTIVITIES.—Eligible activities may include—

(A) * * *

* * * * * * *

(C) acquisition by States and communities of properties (including public properties) located in areas having special flood hazards or other areas of flood risk and properties substantially damaged by flood, for public use, as the [Director] *Administrator* determines is consistent with sound land management and use in such area;

(D) elevation, relocation, and floodproofing of utilities (including equipment that serve structures);

[(D)] *(E)* minor physical mitigation efforts that do not duplicate the flood prevention activities of other Federal agencies and that lessen the frequency or severity of flooding and decrease predicted flood damages, which shall not include major flood control projects such as dikes, levees, seawalls, groins, and jetties unless the [Director] *Administrator* specifically determines in approving a mitigation plan that such activities are the most cost-effective mitigation activities for the National Flood Mitigation Fund;

[(E) beach nourishment activities;]

(F) the development or update of State, local, or Indian tribal mitigation plans which meet the planning criteria established by the Administrator, except that the amount from grants under this section that may be used under this subparagraph may not exceed $50,000 for any mitigation plan of a State or $25,000 for any mitigation plan of a local government or Indian tribe;

[(F)] *(G)* the provision of technical assistance by States to communities and individuals to conduct eligible mitigation activities;

[(G)] *(H)* other activities that the [Director] *Administrator* considers appropriate and specifies in regulation; [and]

[(H) other mitigation activities not described in subparagraphs (A) through (F) or the regulations issued under subparagraph (G), that are described in the mitigation plan of a State or community.]

(I) other mitigation activities not described in subparagraphs (A) through (G) or the regulations issued under subparagraph (H), that are described in the mitigation plan of a State, community, or Indian tribe; and

(J) personnel costs for State staff that provide technical assistance to communities to identify eligible activities, to develop grant applications, and to implement grants awarded under this section, not to exceed $50,000 per State in any Federal fiscal year, so long as the State applied for and was awarded at least $1,000,000 in grants available under this section in the prior Federal fiscal year; the re-

quirements of subsections (d)(1) and (d)(2) shall not apply to the activity under this subparagraph.

(6) ELIGIBILITY OF DEMOLITION AND REBUILDING OF PROPERTIES.—The [Director] *Administrator* shall consider as an eligible activity the demolition and rebuilding of properties to at least base flood levels or higher, if required by the [Director] *Administrator* or if required by any State or local ordinance, and in accordance with project implementation criteria established by the [Director] *Administrator*.

(6) ELIGIBILITY OF DEMOLITION AND REBUILDING OF PROPERTIES.—The Administrator shall consider as an eligible activity the demolition and rebuilding of properties to at least base flood elevation or greater, if required by the Administrator or if required by any State regulation or local ordinance, and in accordance with criteria established by the Administrator.

[(f) LIMITATIONS ON AMOUNT OF ASSISTANCE.—

[(1) AMOUNT.—The sum of the amounts of mitigation assistance provided under this section during any 5-year period may not exceed—

[(A) $10,000,000, to any State; or

[(B) $3,300,000, to any community.

[(2) GEOGRAPHIC.—The sum of the amounts of mitigation assistance provided under this section during any 5-year period to any one State and all communities located in such State may not exceed $20,000,000.

[(3) WAIVER.—The Director may waive the dollar amount limitations under paragraphs (1) and (2) for any State or community for any 5-year period during which a major disaster or emergency declared by the President (pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act) as a result of flood conditions is in effect with respect to areas in the State or community.

[(g) MATCHING REQUIREMENT.—

[(1) IN GENERAL.—The Director may not provide mitigation assistance under this section to a State or community in an amount exceeding 3 times the amount that the State or community certifies, as the Director shall require, that the State or community will contribute from non-Federal funds to develop a mitigation plan under subsection (c) and to carry out mitigation activities under the approved mitigation plan. In no case shall any in-kind contribution by any State or community exceed one-half of the amount of non-Federal funds contributed by the State or community.

[(2) REDUCED COMMUNITY MATCH.—With respect to any 1-year period in which assistance is made available under this section, the Director may adjust the contribution required under paragraph (1) by any State, and for the communities located in that State, to not less than 10 percent of the cost of the activities for each severe repetitive loss property for which grant amounts are provided if, for such year—

[(A) the State has an approved State mitigation plan meeting the requirements for hazard mitigation planning under section 322 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5165) that speci-

fies how the State intends to reduce the number of severe repetitive loss properties; and

[(B) the Director determines, after consultation with the State, that the State has taken actions to reduce the number of such properties.

[(3) NON-FEDERAL FUNDS.—For purposes of this subsection, the term "non-Federal funds" includes State or local agency funds, in-kind contributions, any salary paid to staff to carry out the mitigation activities of the recipient, the value of the time and services contributed by volunteers to carry out such activities (at a rate determined by the Director), and the value of any donated material or building and the value of any lease on a building.

[(h) OVERSIGHT OF MITIGATION PLANS.—The Director shall conduct oversight of recipients of mitigation assistance under this section to ensure that the assistance is used in compliance with the approved mitigation plans of the recipients and that matching funds certified under subsection (g) are used in accordance with such certification.]

(d) MATCHING REQUIREMENT.—The Administrator may provide grants for eligible mitigation activities as follows:

(1) SEVERE REPETITIVE LOSS STRUCTURES.—In the case of mitigation activities to severe repetitive loss structures, in an amount up to 100 percent of all eligible costs.

(2) REPETITIVE LOSS STRUCTURES.—In the case of mitigation activities to repetitive loss structures, in an amount up to 90 percent of all eligible costs.

(3) OTHER MITIGATION ACTIVITIES.— In the case of all other mitigation activities, in an amount up to 75 percent of all eligible costs.

[(i)] *(e)* RECAPTURE.—

(1) NONCOMPLIANCE WITH PLAN.—If the [Director] *Administrator* determines that a State or community that has received mitigation assistance under this section has not carried out the mitigation activities as set forth in the mitigation plan, the [Director] *Administrator* shall recapture any unexpended amounts and deposit the amounts in the National Flood Mitigation Fund under section 1367.

(2) FAILURE TO PROVIDE MATCHING FUNDS.—If the [Director] *Administrator* determines that a State or community that has received mitigation assistance under this section has not provided matching funds in the amount [certified under subsection (g)] *required under subsection (d)*, the [Director] *Administrator* shall recapture any unexpended amounts of mitigation assistance exceeding [3 times the amount] *the amount* of such matching funds actually provided and deposit the amounts in the National Flood Mitigation Fund under section 1367.

[(j)] *(f)* REPORTS.—Not later than 1 year after the date of enactment of the [Riegle Community Development and Regulatory Improvement Act of 1994] *Flood Insurance Reform Act of 2012* and biennially thereafter, the [Director] *Administrator* shall submit a report to the Congress describing the status of mitigation activities carried out with assistance provided under this section.

[(k) DEFINITION OF COMMUNITY.—For purposes of this section, the term "community" means—

[(1) a political subdivision that (A) has zoning and building code jurisdiction over a particular area having special flood hazards, and (B) is participating in the national flood insurance program; or

[(2) a political subdivision of a State, or other authority, that is designated to develop and administer a mitigation plan by political subdivisions, all of which meet the requirements of paragraph (1).

[(m) COORDINATION WITH STATES AND COMMUNITIES.—The Director shall, in consultation and coordination with States and communities take such actions as are appropriate to encourage and improve participation in the national flood insurance program of owners of properties, including owners of properties that are not located in areas having special flood hazards (the 100-year floodplain), but are located within flood prone areas.]

(g) FAILURE TO MAKE GRANT AWARD WITHIN 5 YEARS.—For any application for a grant under this section for which the Administrator fails to make a grant award within 5 years of the date of application, the grant application shall be considered to be denied and any funding amounts allocated for such grant applications shall remain in the National Flood Mitigation Fund under section 1367 of this title and shall be made available for grants under this section.

(h) LIMITATION ON FUNDING FOR MITIGATION ACTIVITIES FOR SEVERE REPETITIVE LOSS STRUCTURES.—The amount used pursuant to section 1310(a)(8) in any fiscal year may not exceed $40,000,000 and shall remain available until expended.

(i) DEFINITIONS.—For purposes of this section, the following definitions shall apply:

(1) COMMUNITY.—The term "community" means—

(A) a political subdivision that—

(i) has zoning and building code jurisdiction over a particular area having special flood hazards, and

(ii) is participating in the national flood insurance program; or

(B) a political subdivision of a State, or other authority, that is designated by political subdivisions, all of which meet the requirements of subparagraph (A), to administer grants for mitigation activities for such political subdivisions.

(2) REPETITIVE LOSS STRUCTURE.—The term "repetitive loss structure" has the meaning given such term in section 1370.

(3) SEVERE REPETITIVE LOSS STRUCTURE.—The term "severe repetitive loss structure" means a structure that—

(A) is covered under a contract for flood insurance made available under this title; and

(B) has incurred flood-related damage—

(i) for which 4 or more separate claims payments have been made under flood insurance coverage under this title, with the amount of each such claim exceeding $15,000, and with the cumulative amount of such claims payments exceeding $60,000; or

(ii) for which at least 2 separate claims payments have been made under such coverage, with the cumulative amount of such claims exceeding the value of the insured structure.

NATIONAL FLOOD MITIGATION FUND

SEC. 1367. (a) ESTABLISHMENT AND AVAILABILITY.—The [Director] *Administrator* shall establish in the Treasury of the United States a fund to be known as the National Flood Mitigation Fund, which shall be credited with amounts described in subsection (b) and shall be available, to the extent provided in appropriation Acts, for providing assistance under section 1366.

(b) CREDITS.—The National Flood Mitigation Fund shall be credited with—

[(1) in each fiscal year, amounts from the National Flood Insurance Fund not exceeding $40,000,000, to remain available until expended;]

(1) in each fiscal year, from the National Flood Insurance Fund in amounts not exceeding $90,000,000 to remain available until expended, of which—

(A) not more than $40,000,000 shall be available pursuant to subsection (a) of this section only for assistance described in section 1366(a)(1);

(B) not more than $40,000,000 shall be available pursuant to subsection (a) of this section only for assistance described in section 1366(a)(2); and

(C) not more than $10,000,000 shall be available pursuant to subsection (a) of this section only for assistance described in section 1366(a)(3).

* * * * * * *

(3) any amounts recaptured under [section 1366(i)] *section 1366(e)*.

(c) ADMINISTRATIVE EXPENSES.—The [Director] *Administrator* may use not more than 5 percent of amounts made available under subsection (b) to cover salaries, expenses, and other administrative costs incurred by the [Director] *Administrator* to make grants and provide assistance under [sections 1366 and 1323] *section 1366*.

(d) PROHIBITION ON OFFSETTING COLLECTIONS.—Notwithstanding any other provision of this title, amounts made available pursuant to this section shall not be subject to offsetting collections through premium rates for flood insurance coverage under this title.

(e) CONTINUED AVAILABILITY AND REALLOCATION.—Any amounts made available pursuant to subparagraph (A), (B), or (C) of subsection (b)(1) that are not used in any fiscal year shall continue to be available for the purposes specified in such subparagraph of subsection (b)(1) pursuant to which such amounts were made available, unless the Administrator determines that reallocation of such unused amounts to meet demonstrated need for other mitigation activities under section 1366 is in the best interest of the National Flood Insurance Fund.

[(d)] *(f)* INVESTMENT.—If the [Director] *Administrator* determines that the amounts in the National Flood Mitigation Fund are in excess of amounts needed under subsection (a), the [Director]

Administrator may invest any excess amounts the [Director] *Administrator* determines advisable in interest-bearing obligations issued or guaranteed by the United States.

[(e)] *(g)* REPORT.—The [Director] *Administrator* shall submit a report to the Congress not later than the expiration of the 1-year period beginning on the date of enactment of this Act and not less than once during each successive 2-year period thereafter. The report shall describe the status of the Fund and any activities carried out with amounts from the Fund.

CHAPTER IV—APPROPRIATIONS AND MISCELLANEOUS PROVISIONS

DEFINITIONS

SEC. 1370. (a) As used in this title—

(1) the term "flood" shall have such meaning as may be prescribed in regulations of the [Director] *Administrator*, and may include inundation from rising waters or from the overflow of streams, rivers, or other bodies of water, or from tidal surges, abnormally high tidal water, tidal waves, tsunamis, hurricanes, or other severe storms or deluge;

* * * * * * *

(3) the terms "insurance company", "other insurer" and "insurance agent or broker" include any organizations and persons authorized to engage in the insurance business under the laws of any State*, is subject to the reporting requirements of the Securities Exchange Act of 1934, pursuant to section 13(a) or 15(d) of such Act (15 U.S.C. 78m(a), 78o(d)), or is authorized by the Administrator to assume reinsurance on risks insured by the flood insurance program*;

* * * * * * *

(6) the term "[Director] *Administrator*" means the [Director] *Administrator* of the Federal Emergency Management Agency;

* * * * * * *

(15) the term "substantially damaged structure" means a structure covered by a contract for flood insurance that has incurred damage for which the cost of repair exceeds an amount specified in any regulation promulgated by the [Director] *Administrator*, or by a community ordinance, whichever is lower.

(b) The term "flood" shall also include inundation from mudslides which are proximately caused by accumulations of water on or under the ground; and all of the provisions of this title shall apply with respect to such mudslides in the same manner and to the same extent as with respect to floods described in subsection (a)(1), subject to and in accordance with such regulations, modifying the provisions of this title (including the provisions relating to land management and use) to the extent necessary to insure that they can be effectively so applied, as the [Director] *Administrator* may prescribe to achieve (with respect to such mudslides) the purposes of this title and the objectives of the program.

(c) The term "flood" shall also include the collapse or subsidence of land along the shore of a lake or other body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels, and all of the provisions of this title shall apply with respect to such collapse or subsidence in the same manner and to the same extent as with respect to floods described in subsection (a)(1), subject to and in accordance with such regulations, modifying the provisions of this title (including the provisions relating to land management and use) to the extent necessary to insure that they can be effectively so applied, as the [Director] *Administrator* may prescribe to achieve (with respect to such collapse or subsidence) the purposes of this title and the objectives of the program.

STUDIES OF OTHER NATURAL DISASTERS

SEC. 1371. (a) The [Director] *Administrator* is authorized to undertake such studies as may be necessary for the purpose of determining the extent to which insurance protection against earthquakes or any other natural disaster perils, other than flood, is not available from public or private sources, and the feasibility of such insurance protection being made available.

(b) Studies under this section shall be carried out, to the maximum extent practicable, with the cooperation of other Federal departments and agencies and State and local agencies, and the [Director] *Administrator* is authorized to consult with, receive information from, and enter into any necessary agreements or other arrangements with such other Federal departments and agencies (on a reimbursement basis) and such State and local agencies.

PAYMENTS

SEC. 1372. Any payments under this title may be made (after necessary adjustment on account of previously made underpayments or overpayments) in advance or by way of reimbursement, and in such installments and on such conditions, as the [Director] *Administrator* may determine.

* * * * * * *

EFFECTIVE DATE

SEC. 1377. This title shall take effect one hundred and twenty days following the date of its enactment, except that the [Director] *Administrator* on the basis of a finding that conditions exist necessitating the prescribing of an additional period, may prescribe a later effective date which in no event shall be more than one hundred and eighty days following such date of enactment.

FLOOD DISASTER PROTECTION ACT OF 1973

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Flood Disaster Protection Act of 1973".

* * * * * * *

DEFINITIONS

SEC. 3. (a) As used in this Act, unless the context otherwise requires, the term—

(1) * * *

* * * * * * *

(6) "[Director] *Administrator*" means the [Director] *Administrator* of the Federal Emergency Management Agency;

* * * * * * *

(b) The [Director] *Administrator* is authorized to define or redefine, by rules and regulations, any scientific or technical term used in this Act, insofar as such definition is not inconsistent with the purposes of this Act.

TITLE I—EXPANSION OF NATIONAL FLOOD INSURANCE PROGRAM

* * * * * * *

FLOOD INSURANCE PURCHASE AND COMPLIANCE REQUIREMENTS AND ESCROW ACCOUNTS

SEC. 102. (a) After the expiration of sixty days following the date of enactment of this Act, no Federal officer or agency shall approve any financial assistance for acquisition or construction purposes for use in any area that has been identified by the [Director] *Administrator* as an area having special flood hazards and in which the sale of flood insurance has been made available under the National Flood Insurance Act of 1968, unless the building or mobile home and any personal property to which such financial assistance relates is covered by flood insurance in an amount at least equal to its development or project cost (less estimated land cost) or to the maximum limit of coverage made available with respect to the particular type of property under the National Flood Insurance Act of 1968, whichever is less: *Provided,* That if the financial assistance provided is in the form of a loan or an insurance or guaranty of a loan, the amount of flood insurance required need not exceed the outstanding principal balance of the loan and need not be required beyond the term of the loan. The requirement of maintaining flood insurance shall apply during the life of the property, regardless of transfer of ownership of such property.

(b) REQUIREMENT FOR MORTGAGE LOANS.—

(1) REGULATED LENDING INSTITUTIONS.—Each Federal entity for lending regulation (after consultation and coordination with the Financial Institutions Examination Council established under the Federal Financial Institutions Examination Council Act of 1974) shall by regulation direct regulated [lending institutions not to make] *lending institutions*—

(A) not to make, increase, extend, or renew any loan secured by improved real estate or a mobile home located or to be located in an area that has been identified by the [Director] *Administrator* as an area having special flood hazards and in which flood insurance has been made available under the National Flood Insurance Act of 1968, unless the building or mobile home and any personal prop-

erty securing such loan is covered for the term of the loan by flood insurance in an amount at least equal to the outstanding principal balance of the loan or the maximum limit of coverage made available under the Act with respect to the particular type of property, whichever is less[.]*; and*

(B) to accept private flood insurance as satisfaction of the flood insurance coverage requirement under subparagraph (A) if the coverage provided by such private flood insurance meets the requirements for coverage under such subparagraph.

(2) FEDERAL AGENCY LENDERS.—A Federal agency lender may not make, increase, extend, or renew any loan secured by improved real estate or a mobile home located or to be located in an area that has been identified by the [Director] *Administrator* as an area having special flood hazards and in which flood insurance has been made available under the National Flood Insurance Act of 1968, unless the building or mobile home and any personal property securing such loan is covered for the term of the loan by flood insurance in the amount provided in paragraph (1). *Each Federal agency lender shall accept private flood insurance as satisfaction of the flood insurance coverage requirement under the preceding sentence if the flood insurance coverage provided by such private flood insurance meets the requirements for coverage under such sentence.* Each Federal agency lender shall issue any regulations necessary to carry out this paragraph. Such regulations shall be consistent with and substantially identical to the regulations issued under paragraph (1).

(3) GOVERNMENT-SPONSORED ENTERPRISES FOR HOUSING.—The Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation shall implement procedures reasonably designed to ensure that, for any loan that is—

(A) secured by improved real estate or a mobile home located in an area that has been identified, at the time of the origination of the loan or at any time during the term of the loan, by the [Director] *Administrator* as an area having special flood hazards and in which flood insurance is available under the National Flood Insurance Act of 1968, and

* * * * * * *

the building or mobile home and any personal property securing the loan is covered for the term of the loan by flood insurance in the amount provided in paragraph (1). *The Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation shall accept private flood insurance as satisfaction of the flood insurance coverage requirement under the preceding sentence if the flood insurance coverage provided by such private flood insurance meets the requirements for coverage under such sentence.*

* * * * * * *

(5) PRIVATE FLOOD INSURANCE DEFINED.—In this subsection, the term "private flood insurance" means a contract for flood insurance coverage allowed for sale under the laws of any State.

(c) EXCEPTIONS TO PURCHASE REQUIREMENTS.—

(1) STATE-OWNED PROPERTY.—Notwithstanding the other provisions of this section, flood insurance shall not be required on any State-owned property that is covered under an adequate State policy of self-insurance satisfactory to the [Director] *Administrator*. The [Director] *Administrator* shall publish and periodically revise the list of States to which this subsection applies.

* * * * * * *

(d) ESCROW OF FLOOD INSURANCE PAYMENTS.—

(1) REGULATED LENDING INSTITUTIONS.—Each Federal entity for lending regulation (after consultation and coordination with the Financial Institutions Examination Council) shall by regulation require that, if a regulated lending institution requires the escrowing of taxes, insurance premiums, fees, or any other charges for a loan secured by residential improved real estate or a mobile home, then all premiums and fees for flood insurance under the National Flood Insurance Act of 1968 for the real estate or mobile home shall be paid to the regulated lending institution or other servicer for the loan in a manner sufficient to make payments as due for the duration of the loan. Upon receipt of the premiums, the regulated lending institution or servicer of the loan shall deposit the premiums in an escrow account on behalf of the borrower. Upon receipt of a notice from the [Director] *Administrator* or the provider of the insurance that insurance premiums are due, the regulated lending institution or servicer shall pay from the escrow account to the provider of the insurance the amount of insurance premiums owed.

* * * * * * *

(e) PLACEMENT OF FLOOD INSURANCE BY LENDER.—

(1) NOTIFICATION TO BORROWER OF LACK OF COVERAGE.—If, at the time of origination or at any time during the term of a loan secured by improved real estate or by a mobile home located in an area that has been identified by the [Director] *Administrator* (at the time of the origination of the loan or at any time during the term of the loan) as an area having special flood hazards and in which flood insurance is available under the National Flood Insurance Act of 1968, the lender or servicer for the loan determines that the building or mobile home and any personal property securing the loan is not covered by flood insurance or is covered by such insurance in an amount less than the amount required for the property pursuant to paragraph (1), (2), or (3) of subsection (b), the lender or servicer shall notify the borrower under the loan that the borrower should obtain, at the borrower's expense, an amount of flood insurance for the building or mobile home and such personal property that is not less than the amount under subsection (b)(1), for the term of the loan.

(2) PURCHASE OF COVERAGE ON BEHALF OF BORROWER.—If the borrower fails to purchase such flood insurance within 45 days after notification under paragraph (1), the lender or servicer for the loan shall purchase the insurance on behalf of the borrower and may charge the borrower for the cost of premiums and fees incurred by the lender or servicer for the loan in purchasing the [insurance.] *insurance, including premiums or fees incurred for coverage beginning on the date on which flood insurance coverage lapsed or did not provide a sufficient coverage amount.*

(3) TERMINATION OF FORCE-PLACED INSURANCE.—Within 30 days of receipt by the lender or servicer of a confirmation of a borrower's existing flood insurance coverage, the lender or servicer shall—

(A) terminate the force-placed insurance; and

(B) refund to the borrower all force-placed insurance premiums paid by the borrower during any period during which the borrower's flood insurance coverage and the force-placed flood insurance coverage were each in effect, and any related fees charged to the borrower with respect to the force-placed insurance during such period.

(4) SUFFICIENCY OF DEMONSTRATION.—For purposes of confirming a borrower's existing flood insurance coverage, a lender or servicer for a loan shall accept from the borrower an insurance policy declarations page that includes the existing flood insurance policy number and the identity of, and contact information for, the insurance company or agent.

[(3)] *(5)* REVIEW OF DETERMINATION REGARDING REQUIRED PURCHASE.—

(A) IN GENERAL.—The borrower and lender for a loan secured by improved real estate or a mobile home may jointly request the [Director] *Administrator* to review a determination of whether the building or mobile home is located in an area having special flood hazards. Such request shall be supported by technical information relating to the improved real estate or mobile home. Not later than 45 days after the [Director] *Administrator* receives the request, the [Director] *Administrator* shall review the determination and provide to the borrower and the lender with a letter stating whether or not the building or mobile home is in an area having special flood hazards. The determination of the [Director] *Administrator* shall be final.

(B) EFFECT OF DETERMINATION.—Any person to whom a borrower provides a letter issued by the [Director] *Administrator* pursuant to subparagraph (A), stating that the building or mobile home securing the loan of the borrower is not in an area having special flood hazards, shall have no obligation under this title to require the purchase of flood insurance for such building or mobile home during the period determined by the [Director] *Administrator*, which shall be specified in the letter and shall begin on the date on which such letter is provided.

(C) EFFECT OF FAILURE TO RESPOND.—If a request under subparagraph (A) is made in connection with the origina-

tion of a loan and the [Director] *Administrator* fails to provide a letter under subparagraph (A) before the later of (i) the expiration of the 45-day period under such subparagraph, or (ii) the closing of the loan, no person shall have an obligation under this title to require the purchase of flood insurance for the building or mobile home securing the loan until such letter is provided.

[(4)] *(6)* APPLICABILITY.—This subsection shall apply to all loans outstanding on or after the date of enactment of the Riegle Community Development and Regulatory Improvement Act of 1994.

* * * * * * *

(h) FEE FOR DETERMINING LOCATION.—Notwithstanding any other Federal or State law, any person who makes a loan secured by improved real estate or a mobile home or any servicer for such a loan may charge a reasonable fee for the costs of determining whether the building or mobile home securing the loan is located in an area having special flood hazards, but only in accordance with the following requirements:

(1) BORROWER FEE.—The borrower under such a loan may be charged the fee, but only if the determination—

(A) * * *

(B) is made pursuant to a revision or updating under section 1360(f) of the floodplain areas and flood-risk zones or publication of a notice or compendia under subsection (h) or (i) of section 1360 that affects the area in which the improved real estate or mobile home securing the loan is located or that, in the determination of the [Director] *Administrator*, may reasonably be considered to require a determination under this subsection; or

* * * * * * *

(i) AUTHORITY TO TEMPORARILY SUSPEND MANDATORY PURCHASE REQUIREMENT.—

(1) FINDING BY ADMINISTRATOR THAT AREA IS AN ELIGIBLE AREA.—For any area, upon a request submitted to the Administrator by a local government authority having jurisdiction over any portion of the area, the Administrator shall make a finding of whether the area is an eligible area under paragraph (3). If the Administrator finds that such area is an eligible area, the Administrator shall, in the discretion of the Administrator, designate a period during which such finding shall be effective, which shall not be longer in duration than 12 months.

(2) SUSPENSION OF MANDATORY PURCHASE REQUIREMENT.—If the Administrator makes a finding under paragraph (1) that an area is an eligible area under paragraph (3), during the period specified in the finding, the designation of such eligible area as an area having special flood hazards shall not be effective for purposes of subsections (a), (b), and (e) of this section, and section 202(a) of this Act. Nothing in this paragraph may be construed to prevent any lender, servicer, regulated lending institution, Federal agency lender, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation, at the discretion of such entity, from requiring the purchase of

flood insurance coverage in connection with the making, increasing, extending, or renewing of a loan secured by improved real estate or a mobile home located or to be located in such eligible area during such period or a lender or servicer from purchasing coverage on behalf of a borrower pursuant to subsection (e).

(3) ELIGIBLE AREAS.—An eligible area under this paragraph is an area that is designated or will, pursuant to any issuance, revision, updating, or other change in flood insurance maps that takes effect on or after the date of the enactment of the Flood Insurance Reform Act of 2012, become designated as an area having special flood hazards and that meets any one of the following 3 requirements:

(A) AREAS WITH NO HISTORY OF SPECIAL FLOOD HAZARDS.—The area does not include any area that has ever previously been designated as an area having special flood hazards.

(B) AREAS WITH FLOOD PROTECTION SYSTEMS UNDER IMPROVEMENTS.—The area was intended to be protected by a flood protection system—

(i) that has been decertified, or is required to be certified, as providing protection for the 100-year frequency flood standard;

(ii) that is being improved, constructed, or reconstructed; and

(iii) for which the Administrator has determined measurable progress toward completion of such improvement, construction, reconstruction is being made and toward securing financial commitments sufficient to fund such completion.

(C) AREAS FOR WHICH APPEAL HAS BEEN FILED.—An area for which a community has appealed designation of the area as having special flood hazards in a timely manner under section 1363.

(4) EXTENSION OF DELAY.—Upon a request submitted by a local government authority having jurisdiction over any portion of the eligible area, the Administrator may extend the period during which a finding under paragraph (1) shall be effective, except that—

(A) each such extension under this paragraph shall not be for a period exceeding 12 months; and

(B) for any area, the cumulative number of such extensions may not exceed 2.

(5) ADDITIONAL EXTENSION FOR COMMUNITIES MAKING MORE THAN ADEQUATE PROGRESS ON FLOOD PROTECTION SYSTEM.—

(A) EXTENSION.—

(i) AUTHORITY.—Except as provided in subparagraph (B), in the case of an eligible area for which the Administrator has, pursuant to paragraph (4), extended the period of effectiveness of the finding under paragraph (1) for the area, upon a request submitted by a local government authority having jurisdiction over any portion of the eligible area, if the Administrator finds that more than adequate progress has been made

on the construction of a flood protection system for such area, as determined in accordance with the last sentence of section 1307(e) of the National Flood Insurance Act of 1968 (42 U.S.C. 4014(e)), the Administrator may, in the discretion of the Administrator, further extend the period during which the finding under paragraph (1) shall be effective for such area for an additional 12 months.

(ii) LIMIT.— For any eligible area, the cumulative number of extensions under this subparagraph may not exceed 2.

(B) EXCLUSION FOR NEW MORTGAGES.—

(i) EXCLUSION.—Any extension under subparagraph (A) of this paragraph of a finding under paragraph (1) shall not be effective with respect to any excluded property after the origination, increase, extension, or renewal of the loan referred to in clause (ii)(II) for the property.

(ii) EXCLUDED PROPERTIES.—For purposes of this subparagraph, the term "excluded property" means any improved real estate or mobile home—

(I) that is located in an eligible area; and

(II) for which, during the period that any extension under subparagraph (A) of this paragraph of a finding under paragraph (1) is otherwise in effect for the eligible area in which such property is located—

(aa) a loan that is secured by the property is originated; or

(bb) any existing loan that is secured by the property is increased, extended, or renewed.

(6) RULE OF CONSTRUCTION.—Nothing in this subsection may be construed to affect the applicability of a designation of any area as an area having special flood hazards for purposes of the availability of flood insurance coverage, criteria for land management and use, notification of flood hazards, eligibility for mitigation assistance, or any other purpose or provision not specifically referred to in paragraph (2).

(7) REPORTS.—The Administrator shall, in each annual report submitted pursuant to section 1320, include information identifying each finding under paragraph (1) by the Administrator during the preceding year that an area is an area having special flood hazards, the basis for each such finding, any extensions pursuant to paragraph (4) of the periods of effectiveness of such findings, and the reasons for such extensions.

TITLE II—DISASTER MITIGATION REQUIREMENTS

NOTIFICATION TO FLOOD-PRONE AREAS

SEC. 201. (a) Not later than six months following the enactment of this title, the **[**Director**]** *Administrator* shall publish information in accordance with subsection 1360(1) of the National Flood Insurance Act of 1968, and shall notify the chief executive officer of each known flood-prone community not already participating in the na-

tional flood insurance program of its tentative identification as a community containing one or more areas having special flood hazards.

(b) After such notification, each tentatively identified community shall either (1) promptly make proper application to participate in the national flood insurance program or (2) within six months submit technical data sufficient to establish to the satisfaction of the [Director] *Administrator* that the community either is not seriously flood prone or that such flood hazards as may have existed have been corrected by floodworks or other flood control methods. The [Director] *Administrator* may, in his discretion, grant a public hearing to any community with respect to which conflicting data exist as to the nature and extent of a flood hazard. If the [Director] *Administrator* decides not to hold a hearing, the community shall be given an opportunity to submit written and documentary evidence. Whether or not such hearing is granted, the [Director's] *Administrator's* final determination as to the existence or extent of a flood hazard area in a particular community shall be deemed conclusive for the purposes of this Act if supported by substantial evidence in the record considered as a whole.

(c) As information becomes available to the [Director] *Administrator*, concerning the existence of flood hazards in communities not known to be flood prone at the time of the initial notification provided for by subsection (a) of this section he shall provide similar notifications to the chief executive officers of such additional communities, which shall then be subject to the requirements of subsection (b) of this section.

* * * * * * *

(e) The [Director] *Administrator* is authorized to establish administrative procedures whereby the identification under this section of one or more areas in the community as having special flood hazards may be appealed to the [Director] *Administrator* by the community or any owner or lessee of real property within the community who believes his property has been inadvertently included in a special flood hazard area by the identification. When, incident to any appeal under this subsection, the owner or lessee of real property or the community, as the case may be, incurs expense in connection with the services of surveyors, engineers, or similar services, but not including legal services, in the effecting of an appeal which is successful in whole or part, the [Director] *Administrator* shall reimburse such individual or community to an extent measured by the ratio of the successful portion of the appeal as compared to the entire appeal and applying such ratio to the reasonable value of all such services, but no reimbursement shall be made by the [Director] *Administrator* in respect to any fee or expense payment, the payment of which was agreed to be contingent upon the result of the appeal. There is authorized to be appropriated for purposes of implementing this subsection not to exceed $250,000.

(f) ANNUAL NOTIFICATION.—The Administrator, in consultation with affected communities, shall establish and carry out a plan to notify residents of areas having special flood hazards, on an annual basis—

(1) that they reside in such an area;

(2) of the geographical boundaries of such area;

(3) of whether section 1308(g) of the National Flood Insurance Act of 1968 applies to properties within such area;

(4) of the provisions of section 102 requiring purchase of flood insurance coverage for properties located in such an area, including the date on which such provisions apply with respect to such area, taking into consideration section 102(i); and

(5) of a general estimate of what similar homeowners in similar areas typically pay for flood insurance coverage, taking into consideration section 1308(g) of the National Flood Insurance Act of 1968.

EFFECT OF NONPARTICIPATION IN FLOOD INSURANCE PROGRAM

SEC. 202. (a) No Federal officer or agency shall approve any financial assistance for acquisition or construction purposes on and after July 1, 1975, for use in any area that has been identified by the [Director] *Administrator* as an area having special flood hazards unless the community in which such area is situated is then participating in the national flood insurance program.

* * * * * * *

AUTHORITY TO ISSUE REGULATIONS

SEC. 205. (a) The [Director] *Administrator* is authorized to issue such regulations as may be necessary to carry out the purpose of this Act.

(b) The head of each Federal agency that administers a program of financial assistance relating to the acquisition, construction, reconstruction, repair, or improvement of publicly or privately owned land or facilities, and each Federal instrumentality responsible for the supervision, approval, regulation, or insuring of banks, savings and loan associations, or similar institutions, shall, in cooperation with the [Director] *Administrator*, issue appropriate rules and regulations to govern the carrying out of the agency's responsibilities under this Act.

CONSULTATION WITH LOCAL OFFICIALS

SEC. 206. In carrying out his responsibilities under the provisions of this title and the National Flood Insurance Act of 1968 which relate to notification to and identification of flood-prone areas and the application of criteria for land management and use, including criteria derived from data reflecting new developments that may indicate the desirability of modifying elevations based on previous flood studies, the [Director] *Administrator* shall establish procedures assuring adequate consultation with the appropriate elected officials of general purpose local governments, including but not limited to those local governments whose prior eligibility under the program has been suspended. Such consultations shall include, but not be limited to, fully informing local officials at the commencement of any flood elevation study or investigation undertaken by any agency on behalf of the [Director] *Administrator* concerning the nature and purpose of the study, the areas involved, the manner in which the study is to be undertaken, the general principles to be applied, and the use to be made of the data obtained. The

[Director] *Administrator* shall encourage local officials to disseminate information concerning such study widely within the community, so that interested persons will have an opportunity to bring all relevant facts and technical data concerning the local flood hazard to the attention of the agency during the course of the study.

* * * * * * *

REAL ESTATE SETTLEMENT PROCEDURES ACT OF 1974

* * * * * * *

SPECIAL INFORMATION BOOKLETS

SEC. 5. (a) * * *

* * * * * * *

(c) Each lender shall include with the booklet a good faith estimate of the amount or range of charges for specific settlement services the borrower is likely to incur in connection with the settlement as prescribed by the Bureau. *Each such good faith estimate shall include the following conspicuous statements and information: (1) that flood insurance coverage for residential real estate is generally available under the national flood insurance program whether or not the real estate is located in an area having special flood hazards and that, to obtain such coverage, a home owner or purchaser should contact the national flood insurance program; (2) a telephone number and a location on the Internet by which a home owner or purchaser can contact the national flood insurance program; and (3) that the escrowing of flood insurance payments is required for many loans under section 102(d) of the Flood Disaster Protection Act of 1973, and may be a convenient and available option with respect to other loans.*

* * * * * * *

HOUSING AND COMMUNITY DEVELOPMENT ACT OF 1974

TITLE I—COMMUNITY DEVELOPMENT

* * * * * * *

ELIGIBLE ACTIVITIES

SEC. 105. (a) Activities assisted under this title may include only—

(1) * * *

* * * * * * *

(24) the construction or improvement of tornado-safe shelters for residents of manufactured housing, and the provision of assistance (including loans and grants) to nonprofit and for-profit entities (including owners of manufactured housing parks) for such construction or improvement, except that—

(A) * * *

* * * * * * *

(D) amounts may not be used for a shelter as provided under this paragraph unless there is located, within the neighborhood in which the shelter is located (or, in the case of a shelter located in a manufactured housing park, within 1,500 feet of such park), a warning siren that is operated in accordance with such local, regional, or national disaster warning programs or systems as the Secretary, after consultation with the Director of the Federal Emergency Management Agency, considers appropriate to ensure adequate notice of occupants of manufactured housing located in such neighborhood or park of a tornado; **[**and**]**

(25) lead-based paint hazard evaluation and reduction, as defined in section 1004 of the Residential Lead-Based Paint Hazard Reduction Act of 1992**[**.**]***;*

(26) supplementing existing State or local funding for administration of building code enforcement by local building code enforcement departments, including for increasing staffing, providing staff training, increasing staff competence and professional qualifications, and supporting individual certification or departmental accreditation, and for capital expenditures specifically dedicated to the administration of the building code enforcement department, except that, to be eligible to use amounts as provided in this paragraph—

(A) a building code enforcement department shall provide matching, non-Federal funds to be used in conjunction with amounts used under this paragraph in an amount—

(i) in the case of a building code enforcement department serving an area with a population of more than 50,000, equal to not less than 50 percent of the total amount of any funds made available under this title that are used under this paragraph;

(ii) in the case of a building code enforcement department serving an area with a population of between 20,001 and 50,000, equal to not less than 25 percent of the total amount of any funds made available under this title that are used under this paragraph; and

(iii) in the case of a building code enforcement department serving an area with a population of less than 20,000, equal to not less than 12.5 percent of the total amount of any funds made available under this title that are used under this paragraph,

except that the Secretary may waive the matching fund requirements under this subparagraph, in whole or in part, based upon the level of economic distress of the jurisdiction in which is located the local building code enforcement department that is using amounts for purposes under this paragraph, and shall waive such matching fund requirements in whole for any recipient jurisdiction that has dedicated all building code permitting fees to the conduct of local building code enforcement; and

(B) any building code enforcement department using funds made available under this title for purposes under this paragraph shall empanel a code administration and enforcement team consisting of at least 1 full-time building

code enforcement officer, a city planner, and a health planner or similar officer; and

(27) provision of assistance to local governmental agencies responsible for floodplain management activities (including such agencies of Indians tribes, as such term is defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)) in communities that participate in the national flood insurance program under the National Flood Insurance Act of 1968 (42 U.S.C. 4001 et seq.), only for carrying out outreach activities to encourage and facilitate the purchase of flood insurance protection under such Act by owners and renters of properties in such communities and to promote educational activities that increase awareness of flood risk reduction; except that—

(A) amounts used as provided under this paragraph shall be used only for activities designed to—

(i) identify owners and renters of properties in communities that participate in the national flood insurance program, including owners of residential and commercial properties;

(ii) notify such owners and renters when their properties become included in, or when they are excluded from, an area having special flood hazards and the effect of such inclusion or exclusion on the applicability of the mandatory flood insurance purchase requirement under section 102 of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4012a) to such properties;

(iii) educate such owners and renters regarding the flood risk and reduction of this risk in their community, including the continued flood risks to areas that are no longer subject to the flood insurance mandatory purchase requirement;

(iv) educate such owners and renters regarding the benefits and costs of maintaining or acquiring flood insurance, including, where applicable, lower-cost preferred risk policies under this title for such properties and the contents of such properties;

(v) encourage such owners and renters to maintain or acquire such coverage;

(vi) notify such owners of where to obtain information regarding how to obtain such coverage, including a telephone number, mailing address, and Internet site of the Administrator of the Federal Emergency Management Agency (in this paragraph referred to as the "Administrator") where such information is available; and

(vii) educate local real estate agents in communities participating in the national flood insurance program regarding the program and the availability of coverage under the program for owners and renters of properties in such communities, and establish coordination and liaisons with such real estate agents to facilitate purchase of coverage under the National Flood Insurance

Act of 1968 and increase awareness of flood risk reduction;

(B) in any fiscal year, a local governmental agency may not use an amount under this paragraph that exceeds 3 times the amount that the agency certifies, as the Secretary, in consultation with the Administrator, shall require, that the agency will contribute from non-Federal funds to be used with such amounts used under this paragraph only for carrying out activities described in subparagraph (A); and for purposes of this subparagraph, the term "non-Federal funds" includes State or local government agency amounts, in-kind contributions, any salary paid to staff to carry out the eligible activities of the local governmental agency involved, the value of the time and services contributed by volunteers to carry out such services (at a rate determined by the Secretary), and the value of any donated material or building and the value of any lease on a building;

(C) a local governmental agency that uses amounts as provided under this paragraph may coordinate or contract with other agencies and entities having particular capacities, specialties, or experience with respect to certain populations or constituencies, including elderly or disabled families or persons, to carry out activities described in subparagraph (A) with respect to such populations or constituencies; and

(D) each local government agency that uses amounts as provided under this paragraph shall submit a report to the Secretary and the Administrator, not later than 12 months after such amounts are first received, which shall include such information as the Secretary and the Administrator jointly consider appropriate to describe the activities conducted using such amounts and the effect of such activities on the retention or acquisition of flood insurance coverage.

* * * * * * *

FEDERAL FLOOD INSURANCE ACT OF 1956

* * * * * * *

FUNDS AND TREASURY BORROWING

SEC. 15. * * *

(e) The [Director] *Administrator* of the Federal Emergency Management Agency is authorized to issue to the Secretary of the Treasury from time to time and have outstanding at any one time, in an amount not exceeding $500,000,000 (or such greater amount as may be approved by the President) notes or other obligations in such forms and denominations bearing such maturities, and subject to such terms and conditions as may be prescribed by the [Director] *Administrator* of the Federal Emergency Management Agency, with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current av-

erage market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of such notes or other obligations. The Secretary of the Treasury is authorized and directed to purchase any notes and other obligations to be issued hereunder and for such purpose he is authorized to use as a public debt transaction the proceeds from the sale of any securities issued under chapter 31 of title 31, United States Code, and the purposes for which securities may be issued under such chapter are extended to include any purchases of such notes and obligations.

The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this section. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States.

* * * * * * *

DISSENTING VIEWS ON BUDGET RECONCILIATION

We are very disappointed by the partisan, non-substantive approach taken by the Republican majority to the important issue of deficit reduction.

The Republicans have simply used the reconciliation vehicle as a means of achieving what they have been unable to do through the regular legislative process, namely repeal the section of the Financial Reform bill—urged on us by Bush administration appointees after their experience with the crisis of 2008—that provide for a way to deal with large financial institutions that have become too indebted to exist. The legislation that was adopted requires that such institutions be put out of existence, with the shareholders wiped out and the officers and directors abolished. The law then mandates that the government—as recommended, we note, by Secretary of the Treasury Paulson—be given the authority to make some payments if necessary to prevent contagion from the unpaid debts of this now defunct institution, but also mandates the Secretary of the Treasury to recover any expenditure so made from large financial institutions. Because of the very specific timeframe Congress has imposed on the CBO, they were required to rule that there would be a $22 billion shortfall, again not because there would not be reimbursement, but because the reimbursement would lag the expenditure as a result of the way the law is written, Thus, CB0 estimates that $22 billion would be owed to the government at the end of the ten year period. It should be noted again that this is not an argument by CBO that the federal government would lose money. It is simply an assertion that at the end of an arbitrary ten year period, money that would eventually be repaid would be owed.

The Democratic response to this scoring quirk was to simply move up the period within which institutions with $50 billion dollars or more would have to pay in the funding. Since CB0 estimated that the cost of this would be $30 billion—$22 billion in reimbursements and an $8 billion tax reduction in consequence for the paying financial institutions—we proposed that $30 billion be collected over a ten year period. The Republicans, expressing great sympathy for the banks which they believe, apparently, to be overtaxed, and thinking that these banks should not have to contribute to paying the cost of the financial crisis they caused, voted this down on a party line vote. Instead they responded by voting to repeal the entire orderly liquidation authority, which would put us back where we were in 2008, when the failure of Lehman Brothers triggered a crisis.

In other words, rather than assess financial institutions at $50 billion dollars in assets and more, a total of $3 billion a year collectively to provide some backup in case we needed to respond to a potential crisis, the Republicans repealed the entire mechanism

that had been set up—and we note again, in response to the requests of Treasury Secretary Paulson, Federal Reserve Chairman Bernanke, and FDIC Chairman Bair—all three of them Bush appointees.

The Republicans further used reconciliation for their ideological purposes by singling out the Consumer Financial Protection Bureau of all banking regulatory agencies to be subject to appropriations, rather than to have its own revenue stream guaranteed. When Democrats argue that if this was to be the model, it should apply also to the Federal Reserve System and the Comptroller of the Currency, the Republicans, with great inconsistency, voted us down. That is, of all the federal regulatory agencies that are not subject to the appropriations process, only the Consumer Financial Protection Bureau was singled out for this treatment, and the Republicans did so noting that if they had their way, they would thus be able to reduce the funding for this important consumer agency by billions of dollars over a ten year period. In addition to refusing to apply this principle to the Comptroller of the Currency or the Federal Reserve, the Republicans also neglected to apply it to the Federal Housing Financing Administration, which governs Fannie Mae and Freddie Mac, and when the Republicans were asked why they were not doing that, the result was an embarassed silence.

Finally, the Republicans seek once again to repeal the HAMP Program which has resulted in the prevention of hundreds of thousands of foreclosures. This is in line with the Republican philosophy that the federal government should do nothing to deal with the crisis in housing, that is not only a terrible problem for individuals, but has a negative effect on the economy as a whole.

The last part of the reconciliation was the adoption in the bill of the bipartisan flood insurance bill that has been worked on equally by Democrats and Republicans and we are supportive of this provision.

BARNEY FRANK.
JOE BACA.
GWEN MOORE.
EMANUEL CLEAVER.
GARY C. PETERS.
WM. LACY CLAY.
CAROLYN B. MALONEY.
ED PERLMUTTER.
MAXINE WATERS.
BRAD MILLER.
MICHAEL E. CAPUANO.
LUIS V. GUTIERREZ.
MELVIN L. WATT.
RUBÉN HINOJOSA.
STEPHEN F. LYNCH.
GARY L. ACKERMAN.
ANDRÉ CARSON.
KEITH ELLISON.
CAROLYN MCCARTHY.

TITLE IV—THE COMMITTEE ON THE JUDICIARY

LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE JUDICIARY,
Washington, DC, April 27, 2012.

Hon. PAUL RYAN,
Chairman, House Committee on the Budget,
Washington, DC.

DEAR CHAIRMAN RYAN: Pursuant to Section 201 of H. Con. Res. 112, I transmit to you the enclosed legislative language and accompanying materials from the Committee on the Judiciary.

Sincerely,

LAMAR SMITH,
Chairman.

CONTENTS

	Page
Summary of the Major Policy Decisions in the Legislation	365
Report Language: Section-by-Section	412
Advisory on Earmarks	413
Committee Oversight Findings	413
Constitutional Authority Statement	413
Committee Votes	413
Changes in Existing Law (Ramseyer Submission)	414
Performance Goals	414
Congressional Budget Office Estimate	415
Dissenting Views	421

SUMMARY OF THE MAJOR POLICY DECISIONS IN THE LEGISLATION

The HEALTH Act is modeled on California's legal reforms, which have been the law in that state for over 35 years. The HEALTH Act's reforms include a $250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge, and authorization for courts to require periodic payments for future damages instead of lump sum awards that prevent bankruptcies in which plaintiffs would receive only pennies on the dollar. Additionally, the HEALTH Act has a provision creating a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault. It also includes reasonable guidelines—but not caps—on the award of punitive damages. The HEALTH Act will accomplish reform without in any way limiting compensation for 100% of plaintiffs' economic losses (anything to which a receipt can be attached), including their medical costs, their lost wages, their future lost wages, rehabilitation costs, and any other economic out of pocket loss suffered as the result of a health care injury. Finally, the HEALTH Act preserves any State law that otherwise caps damages or provides procedural or substantive protections for health care providers and health care organizations.

BACKGROUND AND NEED FOR THE LEGISLATION

The HEALTH Act's reforms are necessary to help improve health care, make it more affordable, and save taxpayer money while reducing the federal deficit.

The HEALTH Act, modeled after California's decades-old and highly successful health care litigation reforms, addresses the current crisis in health care by reigning in unlimited lawsuits and thereby making health care delivery more accessible and cost-effective in the United States. California's Medical Injury Compensation Reform Act ("MICRA"), which was signed into law by Governor Jerry Brown in 1975, has proved immensely successful in increasing access to affordable medical care. Overall, according to data of the National Association of Insurance Commissioners (with the lat-

est data available from 2008), the rate of increase in medical professional liability premiums in California since 1976 has been a relatively modest 387%, whereas the rest of the United States have experienced a 1,089% rate of increase, a rate of increase 281% larger than that experienced in California.

By incorporating MICRA's time-tested reforms at the Federal level, the HEALTH Act will make medical malpractice insurance affordable again, encourage health care practitioners to maintain their practices, and reduce health care costs for patients. Its enactment will particularly help traditionally under-served rural and inner city communities, and women seeking obstetrics care.

MICRA's reforms, which have been the law in California for over 35 years, include a $250,000 cap on noneconomic damages, limits on the contingency fees lawyers can charge, and authorization for courts to require periodic payments for future damages instead of lump sum awards that prevent bankruptcies in which plaintiff's would receive only pennies on the dollar. Additionally, the HEALTH Act has a provision creating a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault. It also includes reasonable guidelines—but not caps—on the award of punitive damages. The HEALTH Act will accomplish reform without in any way limiting compensation for 100% of plaintiffs' economic losses (anything to which a receipt can be attached), including their medical costs, their lost wages, their future lost wages, rehabilitation costs, and any other economic out of pocket loss suffered as the result of a health care injury. Finally, the HEALTH Act preserves any State law that otherwise caps damages or provides greater procedural or substantive protections for health care providers and health care organizations.

Enactment of the HEALTH Act will not result in more medical malpractice cases being brought in Federal court than would be brought in Federal court otherwise. The Supreme Court has held that a "federal standard" does not confer Federal question jurisdiction in the absence of congressional creation of a Federal cause of action.[1]

Finally, many State supreme courts have judicially nullified reasonable litigation management provisions enacted by State legislatures, many of which sought to address the crisis in medical professional liability that reduces patients' access to health care. Consequently, in such States, passage of federal legislation by Congress may be the only means of addressing the State's current crisis in medical professional liability and restoring patients' access to health care. Laws passed by States that have already provided for, or may in the future provide for, different limits on damages in health care lawsuits or greater procedural or substantive protections for health care providers and health care organizations will be preserved under the HEALTH Act.

THE HUGE COSTS OF DEFENSIVE MEDICINE ARE PASSED ON TO TAXPAYERS

The American medical liability system is broken. According to one study, 40 percent of claims are meritless, in that either no in-

[1] See Merrell Down Pharm Inc. v. Thompson, 478 U.S. 804, 813 (1986).

jury or no error occurred in the case. Attorneys' fees and administrative costs eat away 54% of the compensation that should be paid to plaintiffs. And completely meritless claims (which are nonetheless successful approximately one in four times) account for nearly a quarter of total administrative costs.[2]

Under current rules, health care workers seek to avoid these costs to themselves by conducting many additional costly tests and procedures and shifting those costs to taxpayers. As one physician explained, "[j]ust one successful lawsuit against a physician for a missed diagnosis can damage his ability to maintain his credentials, cost him . . . in increased liability insurance, jeopardize his financial assets, and even end his career. Why risk our own money when we can use somebody else's to protect us, even if it costs millions?"[3]

"DEFENSIVE MEDICINE" IS WIDESPREAD, AND THE SOLUTION IS TORT REFORM

"Defensive medicine" is widely practiced. Skyrocketing medical liability insurance rates have distorted the practice of medicine. Costly, but unnecessary, tests have become routine as doctors try to protect themselves from frivolous lawsuits. Indeed, according to a Harvard University research study, 40% of medical malpractice lawsuits filed in the United States lack evidence of medical error or any actual patient injury.[4]

A survey released in 2010 found defensive medicine is an issue for all physicians. The results, published in the Archives of Internal Medicine, found that 91% of the 1,231 doctors who responded to their survey "reported believing that physicians order more tests and procedures than needed to protect themselves from malpractice suits." That view was held by the vast majority of generalists (91%), medical specialists (89%), surgeons (93%) and other specialists (94%). The survey asked two questions: (1) "Do physicians order more tests and procedures than patients need to protect themselves from malpractice suits?"; and, (2) "Are protections against unwarranted malpractice lawsuits needed to decrease the unnecessary use of diagnostic tests?" Overall, 91 percent of doctors surveyed agreed with both statements.[5]

According to a 2008 survey conducted by the Massachusetts Medical Society, 83 percent of physicians reported that they practice defensive medicine.[6] Another study in Pennsylvania put the figure at 93 percent.[7]

Defensive medicine is widespread in specialty medical fields as well. According to another report:

---

[2] "Claims, Errors, and Compensation Payments in Medicald Malpratice Litigation," David Studdert et al., New England Journal of Medicine (May 11, 2006).

[3] Panda Bear, MD, "How I Am Learning to Throw Money Away with Both Hands and a Big Shovel" (February 5, 2008).

[4] Available at http://www.hsph.harvard.edu/facility/articles/litigation.pdf.

[5] *See* Tara F. Bishop, MD, Alex D. Federman, MD, MPH, Salomeh Keyhani, MD, MPH, "Physicians' Views on Defensive Medicine: A National Survey" Arch. Intern. Med. 2010; 170(12): 1081–1083.

[6] "Investigation of Defensive Medicine in Massachusetts," Massachusetts Medical Society (November 2008).

[7] David Studdert et al., "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment," *JAMA* (June 1, 2005) at 2609-2617.

> [A] survey from Emergency Physicians Monthly [concludes] many tests performed in the ER [emergency room] are deemed unnecessary to good patient care. Here's how doctors responded to the following question: "Given that in a typical shift of eight hours you see an average of two patients per hour (16 patients/shift), could you have eliminated any of the following tests and/or treatments without compromising the quality of care? If so, how many of each?" The results of the survey showed how many times ER doctors prescribe which types of tests unnecessarily to avoid unlimited lawsuits:

	None	1	2	3	4	More
Plain Film X-Rays	23%	20%	23%	15%	10%	9%
CT Scans	30%	32%	23%	6%	5%	5%
Lab Tests	17%	8%	19%	14%	15%	27%
Medication Orders	42%	14%	18%	10%	7%	10%
Other	45%	13%	17%	6%	6%	13%

> As you can see, laboratory tests and CT scans comprised the greatest proportion of unnecessary tests.[8]

The same survey found that the HEALTH Act's limit on noneconomic damages is essential to reducing defensive medicine: "The survey also found that non-economic caps are these physicians' preferred choice of malpractice reform, with 84 percent of emergency physicians calling them a 'non-negotiable part of health reform.'"[9]

Another report on defensive medicine in the emergency room summarized emergency room doctors' incentives as follows:

> The fear of missing something weighs heavily on every doctor's mind. But the stakes are highest in the ER, and that fear often leads to extra blood tests and imaging scans for what might be harmless chest pains, run-of-the-mill head bumps and non-threatening stomachaches. Many ER doctors say the No. 1 reason is fear of malpractice lawsuits. "It has everything to do with it," said Dr. Angela Gardner, president of the American College of Emergency Physicians.[10]

As one Newsweek reporter described the personal experience of individual doctors:

When I asked physicians which medical procedures were costly and commonly performed but did not help (at least some) patients, I expected more of them to justify almost everything they do. Some did. But as the Newsweek article on "medicine we can live without" showed, many physicians couldn't get their nominees to me fast enough, so eager were they to spread the word about how much stupid, useless medical care there is.

---

[8] KevinMD.com "How Much Unnecessary Testing Goes On in the ER?" (September 30, 2009).

[9] KevinMD.com "How Much Unnecessary Testing Goes On in the ER?" (September 30, 2009). And in 2003, the Florida Governor's Select Task Force on Health Care Professional Liability Insurance made its official recommendations to Governor Bush. The Task Force concluded as follows: "the most important [recommendation] is a cap on noneconomic damages in the amount of $250,000." Governor's Select Task Force on Healthcare Professional Liability Insurance (January 29, 2003) at xvi (Executive Summary).

[10] Lindsey Tanner, "Fear Can Drive ERs To Do Tests to Excess," Associated Press (June 21, 2010).

The reason for that isn't surprising: doctors hate practicing defensive medicine—that is, ordering tests, surgeries, or other procedures not because the doctor knows it will help the patient but to protect the physician from lawsuits. . . .

[M]ore typical was Angela Gardner, president of the American College of Emergency Physicians, who had a list as long as my arm of procedures ER docs perform, often for no patient benefit. They include following a bedside sonogram (looking for ectopic pregnancy, for instance) with an "official" sonogram (because if something is missed it's easier to defend yourself to a jury if you've ordered the second one); a CT scan for every child who bumped his or her head (to rule out things that can be diagnosed just fine by observation); X-rays that do not guide treatment, such as for a simple broken arm; CTs for suspected appendicitis that has been perfectly well diagnosed without it (ORs won't accept patients for an appendectomy without a CT); and . . . well, there were more. But in short, Gardner told me, "I think there is plenty we could cut out without hurting patients in any way."

So why don't they? Because although doctors may hate practicing defensive medicine, they do it so they don't get sued. We've known that for a long time, but a recent survey of physicians is so replete with horror stories I can't resist sharing them. . . .

Nationwide, physicians estimate that 35 percent of diagnostic tests they ordered were to avoid lawsuits, as were 19 percent of hospitalizations, 14 percent of prescriptions, and 8 percent of surgeries . . . . All told, it adds up to $650 billion in unnecessary care every year.

And now for those horror stories. The ER, said one doc in the Jackson survey, "should have a CT head scanner at the entrance door," since "every patient gets a head CT."

Another ER doc said he "routinely admit[s] low-risk chest pain patients because I know at some point in my career, one of them will go home and die from a heart attack. I will admit hundreds to avoid that one death (and possible lawsuit)." Another said he ordered 52 CT scans in one 12-hour shift: "That's $104K in one day." And another: "Any patient who presents to the ER and mentions the magic words 'chest pain,' unless they are well known by the physician, is guaranteed to undergo multiple blood tests, ECGs, stress tests, perhaps CT scans, and will incur charges of several thousand dollars. A very large percentage of these patients will have very low probability of having ischemic chest pain, yet all patients will undergo testing to prevent 'something from being missed' in the name of defensive medicine."

Like other physicians, this one bemoaned what he has to do to appease patients, such as a "paranoid new mom [who] insists her child needs a head CT after they bumped their head . . . to rule out a head bleed. So to appease the lawyers and hospital administration and everyone else, I have to consciously sedate a perfectly normal 15-month-old and put them at terrible risk just to prove to a mother that children don't get head bleeds from falling over and bumping their heads!" (That "terrible risk" refers to the fact that CTs deliver a lot of radiation and thus increase the risk of cancer.) And an anesthesiologist described how he orders "lab tests, X rays,

cardiac consultations, and stress tests, [as well as] pregnancy tests . . . most often to cover our butts."

Obstetricians really sounded off. One described having to admit to the hospital "pregnant patients with complaints such as stomach pain, cramps, excess vaginal discharge, headache, etc." almost solely for defensive reasons: "You can't afford to give them any reason to point to you if their baby isn't perfect." [11]

And, according to a recent survey of heart doctors:

> A substantial number of heart doctors—about one in four—say they order medical tests that might not be needed out of fear of getting sued, according to a new study . . . [A]bout 24 percent of the doctors said they had recommended the test in the previous year because they were worried about malpractice lawsuits . . . The study was released Tuesday by the journal Circulation: Cardiovascular Quality and Outcomes.[12]

Moreover, according to the Massachusetts Medical Society, and White Coat Notes, a publication of the Boston-area medical community:

> The fear of being sued is driving Massachusetts physicians to order many tests, procedures, referrals to specialists and even hospitalizations for consumers that aren't needed and drive up health costs by more than $1.4 billion a year, according to a new study that is the first of its kind.
>
> The Massachusetts Medical Society surveyed 900 of its members, including family doctors, obstetricians and gynecologists and general surgeons, who reported practicing so-called "defensive medicine."
>
> The report found that 83 percent of physicians surveyed reported practicing defensive medicine and that an average of 18 to 28 percent of tests, procedures and referrals and consultations, and 13 percent of hospitalizations were ordered solely out of fear of being sued.[13]

A recent Gallup survey of American physicians found the fear of lawsuits was the driver behind 21 percent of all the tests and treatments ordered by doctors, which equates to 26 percent of all health care dollars spent. That comes to a staggering $650 billion.[14] According to a study of medical liability costs and the practice of medicine in Health Affairs, overuse of imaging services alone, driven by fear of lawsuits, costs as much as $170 billion a year nationally.[15]

---

[11] Sharon Begley, "Block That CT Scan!—Despite the massive overhaul of health care passed by Congress, many costs will remain high, thanks to doctors' fears of potential lawsuits," Newsweek (March 22, 2010).

[12] Stephanie Nano, "Heart Doctors Admit They Order Unnecessary Tests Out of Fear of Being Sued," Associated Press (April 14, 2010).

[13] Kay Lazar, "Doctors' Practice of 'Defensive Medicine' Widespread, Costly," *White Coat Notes* (November 17, 2008).

[14] "Price: Cutting Medical Costs without Obamacare," *Washington Times*, 3/18/10.

[15] "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Care 11," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2003.

The medical lawsuit crisis affects nurses as well. Nearly half of nurses say they are prohibited or discouraged from providing needed care by rules set up to avoid lawsuits.[16]

DEFENSIVE MEDICINE IS COSTLY

As was recently reported, defensive medicine costs billions of dollars annually:

> The latest estimate of the costs of defensive medicine, from an analysis just published in Health Affairs: $45.6 billion annually (in 2008 dollars), accounting for more than 80% of the $55.6 billion total yearly cost of the medical liability system. The authors from Harvard University and the University of Melbourne explain that their analysis doesn't attempt to estimate social costs or benefits of the malpractice system, such as damage to physicians' reputations or any deterrent effect it may provide . . . .
>
> [Their conclusions] include estimates of defensive medicine costs both for hospitals ($38.8 billion) and for physicians ($6.8 billion), calculated by looking at costs in high- and low-liability environments. The thought is that the difference represents [increased] spending due to fear of being sued—i.e. defensive medicine . . . . The total costs of the medical liability system constitute about 2.4% of total health-care spending, the authors write. That's "not trivial," they write, and because some of these costs "stem from meritless malpractice litigation," flaws in the system are worth addressing.[17]

A study by the Pacific Research Institute estimates that defensive medicine costs $191 billion a year,[18] while a separate study by PricewaterhouseCoopers puts the number even higher—$239 billion.[19] That follows another study by PricewaterhouseCoopers that found, "While the bulk of the premium dollar pays for medical services, those medical services include the cost of medical liability and defensive medicine . . . . Defensive tests and treatment can pose unnecessary medical risks and add unnecessary costs to healthcare."[20]

THE CONSENSUS IS THAT DEFENSIVE MEDICINE CAUSED BY UNLIMITED LAWSUITS IS A REAL PROBLEM

President Obama himself acknowledged the harm caused by defensive medicine, stating "I want to work with the AMA so we can scale back the excessive defensive medicine that reinforces our current system, and shift to a system where we are providing better care, simply—rather than simply more treatment."[21] The President himself weighed in on the issue in more detail, writing in the *New England Journal of Medicine* that "the current tort system does not

---

[16] "Fear of Litigation Study, The Impact on Medicine," Harris Interactive (April 11, 2002).

[17] Katherine Hobson, "How Much Does Defensive Medicine Cost? One Study Says $46 Billion," *Wall Street Journal Health Blog* (September 7, 2010).

[18] Available at http://www.heartland.org/custom/semod—policybot/pdf/26161.pdf.

[19] PricewaterhouseCoopers' Health Research Institute, The Price of Excess: Identifying Waste in Healthcare Spending (New York: PricewaterhouseCoopers 2008), endnote 18, at 18.

[20] "The Price of Excess: Identifying Waste in Healthcare Spending," PricewaterhouseCoopers, 2008.

[21] Text: Obama's AMA Speech on Health Care (CBS News) (June 15, 2010).

promote open communications to improve patient safety. On the contrary, it jeopardizes patient safety by creating an intimidating liability environment."[22] In his 2011 State of the Union Address, President Obama said "I'm willing to look at other ideas to bring down costs, including one that Republicans suggested last year: medical malpractice reform to rein in frivolous lawsuits." Although the Associated Press has written that "Republicans may be forgiven if [the President's] offer makes them feel like Charlie Brown running up to kick the football, only to have it pulled away, again,"[23] the President should fulfill his promise and support time-tested reforms that have proven successful for over three decades in California.

A survey conducted for the bipartisan legal reform organization "Common Good," whose Board of Advisors included Eric Holder, who is now President Obama's Attorney General, found that more than three-fourths of physicians feel that concern about malpractice litigation has hurt their ability to provide quality care in recent years. When physicians were asked, "Generally speaking, how much do you think that fear of liability discourages medical professionals from openly discussing and thinking of ways to reduce medical errors?" an astonishing 59% of physicians replied "a lot."[24]

President Obama's own doctor of over two decades also supports medical tort reform. David Scheiner was President Obama's doctor from 1987 until he entered the White House. As was recently reported in *Forbes* magazine:

> [Dr. Scheiner is] still an enthusiastic Obama supporter, but he worries about whether the health care legislation currently making its way through Congress will actually do any good, particularly for doctors like himself who practice general medicine. "I'm not sure [Obama] really understands what we face in primary care," Scheiner says. . . .
>
> Scheiner is critical of Obama's pick for Health and Human Services secretary—Kansas Gov. Kathleen Sebelius, who used to work as the chief lobbyist for her state's trial lawyers association. . . .
>
> Scheiner says he never thought it was appropriate to talk about health policy with Obama, especially once he became a U.S. Senator. The one exception was medical malpractice reform. "I once briefly talked to him about malpractice, and he took the lawyers' position," he says. . . .
>
> Scheiner, like most others in his profession, thinks that it should be harder to sue doctors and that awards should be capped. He says that he and other doctors must order too many tests and imaging studies just to avoid being sued.[25]

---

[22] "Making Patient Safety the Centerpiece of Medical Liability Reform, " Sen. Barack Obama and Sen. Hillary Clinton, *New England Journal of Medicine* (May 25, 2006).

[23] Associated Press, "Fact Check: Obama and His Imbalanced Ledger" (January 26, 2011).

[24] *See* Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine," Final Report (April 11, 2002) ("Executive Summary") at 30 (Table 17), available at www.ourcommongood.com/news.html.

[25] David Whelan, "Obama's Doctor Knocks ObamaCare," Forbes.com (June 16, 2009).

The National Commission on Fiscal Responsibility and Reform

The National Commission on Fiscal Responsibility and Reform, which was created by President Obama, supports health care litigation reform in its final December 2010 report. As the Commission states in a report that was endorsed by 61% of its members (by a vote of 11–7):

> Most experts agree that the current tort system in the United States leads to an increase in health care costs. This is true both because of direct costs—higher malpractice insurance premiums—and indirect costs in the form of over-utilization of diagnostic and related services (sometimes referred to as "defensive medicine"). The Commission recommends an aggressive set of reforms to the tort system.
>
> Among the policies pursued, the following should be included: (1) Modifying the "collateral source" rule to allow outside sources of income collected as a result of an injury (for example workers' compensation benefits or insurance benefits) to be considered in deciding awards; (2) Imposing a statute of limitations—perhaps one to three years—on medical malpractice lawsuits; (3) Replacing 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; (4) Creating specialized "health courts" for medical malpractice lawsuits; and (5) Allowing "safe haven" rules for providers who follow best practices of care.
>
> Many members of the Commission also believe that we should impose statutory caps on punitive and non-economic damages, and we recommend that Congress consider this approach and evaluate its impact.[26]

Since President Obama signed the health care bill into law, the co-chairs of the Commission, Erskine Bowles and Alan Simpson, recommended that Congress enact a law to "[p]ay lawyers less and reduce the cost of defensive medicine" by "[e]nact[ing] comprehensive medical malpractice liability reform to cap non-economic and punitive damages and make other changes in tort law."[27]

The New York Times

According to the New York Times:

> The fear of lawsuits among doctors does seem to lead to a noticeable amount of wasteful treatment. Amitabh Chandra—a Harvard economist whose research is cited by both the American Medical Association and the trial lawyers' association—says $60 billion a year, or about 3 percent of overall medical spending, is a reasonable upper-end estimate.

---

[26] The National Commission on Fiscal Responsibility and Reform, "The Moment of Truth" (December 2010) at 34–35.

[27] Co-Chair Proposal, at 32, available at http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/CoChair—Draft.pdf.

> Perhaps the best-known study of defensive medicine—by Dr. Mark McClellan, who later ran Medicare in the Bush administration, and Daniel Kessler—compared cardiology treatment in states that had capped malpractice awards in the 1980s and early '90s with those that didn't. In the states without caps, stenting and other treatments were more common, but the outcomes were no better. . . .
>
> [T]he researchers in the field tend to agree about the scale of the problem—and how much malpractice reform might accomplish. . . . Dana Goldman, director of the Schaeffer Center for Health Policy at the University of Southern California, adds: "It is one of the things we need to address if we want to bend the cost curve."[28]

The New York Times also reported that Uwe E. Reinhardt, an economist at Princeton University, has written that the massive costs of lawsuit abuse in the United States distinguishes it from other countries:

> Health-services researchers call the difference between these numbers [the health care spending of different countries], "excess spending." That term [conveys] a difference driven by factors other than G.D.P. per capita. Prominent among these other factors are: . . . higher treatment costs triggered by our uniquely American tort laws, which in the context of medicine can lead to "defensive medicine"—that is, the application of tests and procedures mainly as a defense against possible malpractice litigation, rather than as a clinical imperative.[29]

We know that our medical liability costs are at least twice those in other developed countries[30] and make up 10 percent of all tort cases. That's the macro perspective, but what about the physicians, hospitals or other health care providers on the wrong end of a lawsuit? They can expect to pay an average of $26,000 to defend a case that is dropped before trial and as much as $140,000 if the case actually goes to court, regardless of the merits.[31] So, even when good doctors win their lawsuits, which happens the vast majority of the time, they still lose. They lose valuable patient time, money, and peace of mind while watching their professional reputations impugned.

USA Today

The USA Today editorial board also recently came out supporting tort reform, citing the high cost of defensive medicine:

> A study last month by the Massachusetts Medical Society found that 83% of its doctors practice defensive medicine at a cost of at least $1.4 billion a year. Nationally, the cost is $60 billion-plus, according to the Health and Human Services Department. [And a] 2005 study in the

[28] David Leonhardt, "Medical Malpractice System Breeds More Waste," The New York Times (September 23, 2009).

[29] Uwe E. Reinhardt, "Why Does U.S. Health Care Cost So Much? (Part I)," The New York Times (November 14, 2008).

[30] Manhattan Institute's Center for Legal Policy study (2008).

[31] "Reviving Tort Reform," Investor's Business Daily, 11/15/10.

> Journal of the American Medical Association found 93% of Pennsylvania doctors practice defensive medicine. The liability system is too often a lottery. Excessive compensation is awarded to some patients and little or none to others. As much as 60% of awards are spent on attorneys, expert witnesses and administrative expenses . . . The current system is arbitrary, inefficient and results in years of delay.[32]

The editors of USA Today concluded that "one glaring omission" from the health care law "was significant tort reform, which was opposed by trial lawyers and their Democratic allies. CBO estimates that restricting malpractice suits would save $54 billion over 10 years by curbing tests and procedures that patients don't really need. So why not add it?"[33]

The Director of Pediatric Neurosurgery at Johns Hopkins

One of the nation's top surgeons, with credibility and acclaim the world over for the pioneering surgeries he has and his personal story of overcoming hardship, recently severely criticized the dominant health care legislation before Congress. Benjamin Carson, director of pediatric neurosurgery at the Johns Hopkins Medical Institutions in Baltimore, Maryland, and recipient of numerous awards including the Presidential Medal of Freedom, criticized in a recent interview the approach of the current bills for their mandate, creation of a "public option," and lack of malpractice liability reform. He pointed to excessive litigation, pointing out how much malpractice insurance and other forms of "defensive medicine" to protect against lawsuits add to medical costs. In the interview with a local television station, Carson insisted that tort reform must go "hand in hand" as part of any true health care reform. According to Dr. Carson, "We have to bring a rational approach to medical litigation." "We're the only nation in the world that really has this problem. Why is it that everybody else has been able to solve this problem but us? Simple. Special interest groups like the trial lawyers' association. They don't want a solution."[34]

The Wall Street Journal

As summarized by Kimberly Strassel in the Wall Street Journal:

> Tort reform is a policy no-brainer. Experts on left and right agree that defensive medicine—ordering tests and procedures solely to protect against Joe Lawyer—adds enormously to health costs. The estimated dollar benefits of reform range from a conservative $65 billion a year to perhaps $200 billion. In context, Mr. Obama's plan would cost about $100 billion annually. That the president won't embrace even modest change that would do so much, so quickly, to lower costs, has left Americans suspicious of his real ambitions.

---

[32] USA Today editorial, "Our View on 'Defensive' Medicine: Lawyers' Bills Pile High, Driving Up Health Care Costs," USA Today (December 29, 2008).

[33] USA Today editorial, "Don't try to repeal the new health care law—improve it" (November 18, 2010) at 9A.

[34] John Berlau, "'Gifted Hands' Surgeon Rips Into Obamacare," BogGovernment.com, available at http://biggovernment.com/2009/10/14/gifted-hands-surgeon-rips-into-obamacare/.

> It's also a political no-brainer. Americans are on board. Polls routinely show that between 70% and 80% of Americans believe the country suffers from excess litigation. The entire health community is on board. Republicans and swing-state Democrats are on board. State and local governments, which have struggled to clean up their own civil-justice systems, are on board. In a debate defined by flash points, this is a rare area of agreement. Former Democratic Sen. Bill Bradley, in a New York Times piece, suggested a "grand bipartisan compromise" in which Democrats got universal coverage in return for offering legal reform.

The only folks not on board are a handful of powerful trial lawyers, and a handful of politicians who receive a generous cut of those lawyers' contingency fees. The legal industry was the top contributor to the Democratic Party in the 2008 cycle, stumping up $47 million. The bill is now due, and Democrats are dutifully making a health-care down payment.

During the markup of a bill in the Senate Health Committee, Republicans offered 11 tort amendments that varied in degree from mere pilot projects to measures to ensure more rural obstetricians. On a party line vote, Democrats killed every one.[35]

THE FURTHER HIDDEN COSTS OF DEFENSIVE MEDICINE: MORE RADIATION AND NO ADVICE BY TELEPHONE

Defensive medicine entails additional hidden costs. As was reported recently:

> The result [of defensive medicine] can be extra costs, and potential harm—including side effects from unneeded drugs and increased risk of future cancer from excessive radiation.
>
> No one tells patients after a CT scan that the test "just imparted three years of radiation to your body as well as significant stress on your kidney, and Medicare just got charged lots of money."[36]

As explained by another doctor:

Of course there is far more to defensive medicine than obstetric procedures. Many CT scans are entirely unnecessary, and in fact expose patients to radiation that may contribute to one in fifty cancers. But woe to the emergency room doc who didn't immediately scan the head of a trauma patient.

> Unnecessary blood tests, biopsies, and specialist referrals are all done to "spread the blame" and make lawsuits defensible.
>
> Defensive medicine costs you more than money. When was the last time you asked for telephone advice? Doctors are very, very leery of giving meaningful advice over the phone, because we can't take the risk of this kind of conversation in front of a jury:

[35] Kimberly A. Strassel, "The President's Tort Two-Step," The Wall Street Journal (September 11, 2009).

[36] Lindsey Tanner, "Fear Can Drive ERs To Do Tests to Excess," Associated Press (June 21, 2010).

Attorney: You mean you refilled the medicine without performing another physical exam? If you had seen the patient in person, you would have found the cancer earlier!

Doctor: The medicine had nothing to do with cancer! I was just trying to help the patient! It's expensive to make them come in every month for a refill!

Anytime we tell anyone anything, any kind of advice, doctors must consider the risk of a lawsuit. Everything we say and do is supposed to be documented, too—to defend ourselves. Ever wonder why the doc spends so much time scribbling in the chart, instead of talking to you? It's not because we like writing. It's because every single day we're reminded that the chart is our only defense.

Do you think this hasn't increased health care costs? Do you think it hasn't affected the relationships doctors have with patients?

The current medical malpractice system is a disgrace.[37]

DEFENSIVE MEDICINE CAUSES ALL THOSE HARMS WITHOUT ADDING ANY BENEFITS

Two top economic researchers have concluded: "[P]hysicians from states enacting liability reforms that directly reduce malpractice pressure experience lower growth over time in malpractice claims rates and in real malpractice insurance premiums. [Also], physicians from reforming states report significant relative declines in the perceived impact of malpractice pressure on practice patterns."[38] One of those economists is Mark McClellan, who worked on health policy issues in President Clinton's Treasury Department and who has been described by Senator Ted Kennedy as having "impressive credentials both as a physician and as an economist."[39] These economists conducted two extensive studies using national data on Medicare populations and concluded that patients from states that adopted direct medical care litigation reforms, such as limits on damage awards, incur significantly lower hospital costs while suffering no increase in adverse health outcomes associated with the illness for which they were treated.

In sum, the studies concluded that in states with medical litigation reforms in place, there was an average reduction of 4.3% in hospital costs for patients in managed care programs,[40] and an average reduction of 7.4% in hospital costs for patients in non-managed care programs.[41] They have thereby quantified the cost of "de-

[37] Roy Benaroch, MD, "Health Care Costs: Defensive Medicine," The Pediatric Insider (2010).

[38] See Daniel P. Kessler and Mark B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," 60 Law and Contemporary Problems 1: 81–106 (1997), at 105.

[39] Marc Kaufman, "Bush Adviser Tabbed for FDA," Washington Post (September 25, 2002) at A25.

[40] 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.

[41] Daniel P. Kessler and Mark B. McClellan, "Do Doctors Practice Defensive Medicine?" The Quarterly Journal of Economics (May 1996) at 386 ("Our analysis indicates that reforms that directly limit ability, caps on damage awards ... and collateral source rule reforms—reduce hospital expenditures by 5 to 9 percent within three to five years of adoption. . ."). The researchers in this study analyzed populations in predominantly non-managed care programs in the mid–1980's, and found that, of the populations studied with two different types of illnesses, direct

Continued

fensive medicine," in which doctors perform tests and prescribe medicines that are not necessary for health in order to avoid patients' future claims that they suffered adverse health effects because the doctor didn't do more. Former Senator George McGovern has written that "[l]egal fear drives [doctors] to prescribe medicines and order tests, even invasive procedures, that they feel are unnecessary. Reputable studies estimate that this 'defensive medicine' squanders $50 billion a year, enough to provide medical care to millions of uninsured Americans." [42]

REDUCING UNLIMITED LAWSUITS WILL HELP REDUCE MEDICAL ERRORS

The best evidence about medical injuries comes from two large studies of hospital records, which both concluded that under one percent of hospital charts showed negligent medical injury.[43] Nevertheless, the litigation reforms in the HEALTH Act will reduce the incidence of medical malpractice because the threat of potentially infinite liability in an unregulated tort system prevents doctors from discussing medical errors and looking for ways to improve the delivery of health care.

The HEALTH Act would largely dispel that fear and allow doctors to freely suggest improvements in medical care. The medical journal Annals of Medicine detailed reports of medical errors. As has been reported, "[c]reating a series of articles on [medical] mistakes was the idea of Dr. Robert M. Wachter, associate chairman of the department of medicine at the University of California at San Francisco . . . . The series was inspired in part by a 1999 report by the Institute of Medicine, which found that mistakes in hospitals killed 44,000 to 98,000 patients a year . . . . In an editorial about the new series, Dr. Wachter and his colleagues wrote that the medical profession "for reasons that include liability issues . . . was not harnessing the full power of errors to teach [and thereby reduce errors]." [44]

A survey conducted for the bipartisan legal reform organization "Common Good," whose Board of Advisors included former Senator George McGovern, Eric Holder, and former Senator Paul Simon, found that more than three-fourths of physicians feel that concern about malpractice litigation has hurt their ability to provide quality care in recent years. When physicians were asked, "Generally speaking, how much do you think that fear of liability discourages medical professionals from openly discussing and thinking of ways to reduce medical errors?" an astonishing 59% of physicians replied "a lot." [45]

Indeed, according to an exhaustive study by the RAND Corporation, California's reduction in the number of health care lawsuits

---

health care litigation reforms would reduce hospital expenditures by 5.8% and 8.9% several years after their adoption. Id. at 367, 382.

[42] See George McGovern and Alan Simpson, "We're Reaping What We Sue," Wall Street Journal (April 17, 2002) at A20.

[43] D. Mills, J. Boyden, and D. Rubsamen, "Report on the Medical Insurance Feasibility Study," (San Francisco: Sutter Publications 1977, sponsored jointly by the California Medical Association and California Hospital Association); A. Localio, et al., "Relation Between Malpractice Claims and Adverse Events Due to Negligence," New Engl. J. Med. 325:245–251 (1991).

[44] Denise Grady, "Oops, Wrong Patient: Journal Takes on Medical Mistakes," New York Times (June 18, 2002).

[45] See Harris Interactive, "Common Good Fear of Litigation Study: The Impact of Medicine" Final Report (April 11, 2002) ("Executive Summary") at 30 (Table 17), available at www.ourcommongood.com/news.html.

filed in that state is attributable to improved patient safety at California hospitals. According to the study:

> Our results showed a highly significant correlation between the frequency of adverse events [medical errors] and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims. Likewise, a county that shows an increase of 10 adverse events in a given year would also see, on average, an increase of 3.7 malpractice claims. According to the statistical analysis, nearly three-fourths of the within-county variation in annual malpractice claims could be accounted for by the changes in patient safety outcomes. We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant.[46]

With the passage of health care lawsuit reform in California, doctors, hospitals and other healthcare providers are able to share information needed to create a safer environment, without fear of lawsuits, and focus on their patients instead of worrying about getting sued.

THE CURRENT SYSTEM IS CAUSING A DOCTOR SHORTAGE

Lawsuit abuse drives doctors out of practice. There is a well-documented record of doctors leaving the practice of medicine and hospitals shutting down particular practices that have high liability exposure. This problem has been particularly acute in the fields of ob-gyn and trauma care, as well as in rural areas.[47]

The absence of doctors in vital practice areas is at best an inconvenience; at worst it can have deadly consequences.[48] Hundreds or even thousands of patients may die annually due to lack of doctors.[49]

According to the Massachusetts study, 38 percent of physicians have reduced the number of higher-risk procedures they provide, and 28 percent have reduced the number of higher-risk patients

[46] Michael D. Greenberg, Amelia M. Haviland, J. Scott Ashwood, Regan Main, "Is Better Patient Safety Associated with Less Malpractice Activity?" RAND Institute for Civil Justice (2010) at x.

[47] For an extensive compilation of such instances see "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Care," U.S. Department of Health and Human Services (March 3, 2003).

[48] See Testimony of Leanne Dyess, "Patient Access Crisis: The Role of Medical Litigation," Senate Judiciary Committee (February 11, 2003); Testimony of Dr. Thomas Gleason, "Medical Liability Reform: Stopping the Skyrocketing Price of Health Care," House Small Business Committee (February 17, 2005).

[49] See Testimony of Theodore Frank, "Protecting Main Street from Lawsuit Abuse," Senate Republican Conference (March 16, 2009) ("The effect of the loss of productive doctors and the closing of emergency rooms . . .is in the hundreds of lives a year, and perhaps as high as 1,000 deaths and many exacerbated injuries."); "Tort Reform and Accidental Deaths," Paul Rubin and Joanna Shepherd, Emory Law and Economics Research Paper No. 05–17H (finding tort reforms saved approximately 2,000 lives in the year 2000 and 24,000 over a 20-year period).

they serve, out of fear of liability.[50] The American College of Obstetricians and Gynecologists has concluded that the "current medicolegal environment continues to deprive women of all ages, especially pregnant women, of their most educated and experienced women's health care providers."[51]

As one doctor wrote recently:

> I am what you call a successful neurosurgeon, and I have nothing against "socialized medicine" as such. Everybody deserves good health care. But I am nonetheless worried about President Obama's health care reform, because without tort reform as part of the package, it can't address the labor shortage we face in my specialty. . . .
>
> Only because spinal problems affect nearly 80% of our aging population: It's one of the most common reasons patients visit a primary care physician . . . Baby boomers are about to overwhelm the system with demand for treatment of spinal problems—including surgery—at precisely the moment the supply of neurosurgeons able to treat them is dwindling. . . .
>
> Thus we come to the second reason: The cost of malpractice insurance, which creates a very high cost of entry into this field. Unfortunately, the health care reforms of the Obama administration have done little to curb costs. These costs are imposed by hospital inefficiencies as unpoliced by government-run insurance plans and by the price of malpractice insurance undisciplined by tort reform.
>
> I believe that tort reform is the key to reducing both kinds of cost, because the malignant threat of malpractice haunts the hospitals as well as the physicians. Without such reform, the choice for practicing neurosurgeons like me is between retirement and working 24/7 just to cover my insurance overhead. My premature retirement will reduce the supply of surgeons capable of dealing with the spinal problems of an aging population—and that supply is already short and getting shorter. Meanwhile, a few more board-certified surgeons a year won't meet the growing demand. The lines at your doctor's office could get long.
>
> When Congress returns to consider the problem of health care, it must understand that without tort reform, neurosurgery of the kind I can provide to an aging population will be unavailable.[52]

A new study from Northwestern University's Feinberg School of Medicine polled residents and found that many wish to leave the state to avoid its "hostile" malpractice environment. The study concluded that "[a]pproximately one-half of graduating Illinois residents and fellows are leaving the state to practice. . . . [T]he medical malpractice liability environment is a major consideration for

---

[50] "Defensive Medicine in Massachusetts," pp. 4–5.

[51] "Overview of the 2009 ACOG Survey on Professional Liability."

[52] Dr. Michael Lavyne, "Obamacare Will Fail Without Tort Reforn: Malpractice Insurance Costs Are Crippling Medicine," *New York Daily News* (November 19, 2010).

those that plan to leave Illinois to practice."[53] Without a uniform law to control health care costs, many states will continue to suffer under doctor shortages.

As one local New Jersey official has written:

> Let's say you are a woman over 40 who follows the American Cancer Society guidelines (regardless of the recent controversy about them) and faithfully gets a mammogram each year.
>
> What would you do if you tried to make your 2010 appointment, only to learn this test is no longer available anywhere in the state? Would you take a day off from work to travel to Pennsylvania—or forgo your screening entirely?
>
> Unfortunately, this is a very real possibility for New Jersey women. Eighty-nine percent of radiologists surveyed by the New Jersey Medical Care Availability Task Force said that new doctors in their specialty are unwilling to perform mammography or have asked for limited exposure to it.
>
> Or, imagine getting pregnant and having your obstetrician tell you that you fall into a high-risk category. The good news is that you can be effectively treated by a specialist. The bad news? The closest specialist is in upstate New York. Do you leave your family for days at a time? Do you take a risk and allow your regular physician to do the best she can? This is a decision no woman should have to make, but many may face. Hospitals in New Jersey have reported a serious decline in the number of applicants for specialized obstetrics training—and no new candidates means steadily decreasing access to care.
>
> Even as debate about national health care reform rages across the country, we in New Jersey must confront a homegrown crisis: Our state is losing doctors at an alarming rate. With or without a federal mandate, if there are no doctors to treat New Jersey's patients, the details don't matter.
>
> Why the exodus of physicians? To a significant degree, they are fleeing malpractice insurance premiums and legal exposure so enormous as to make the practice of many medical specialties in our state near untenable. . . .
>
> Medical malpractice liability premiums had already spiraled out of control back in 2002, when huge crowds of physicians donned their white coats and demonstrated at the Statehouse to draw attention to the need for reform. Around the same time, Dr. Dolores Williams, an obstetrician, testified before an Assembly joint committee that her insurance premiums—which had escalated from $30,000 to an estimated $72,000—left her financially unable to continue delivering babies. Her decision to stop, she said, "was based on possibly losing my home, my assets, [and] my ability to fund my children's college tuition."

[53] Northwestern University Feinberg School of Medicine, "Illinois New Physician Workforce Study: Final Report November 2010" at 4.

> Seven years later, these problems have only gotten worse, not only in obstetrics but in a range of other specialties like orthopedics and neonatology.
>
> "The cumulative effect of medical malpractice claims on the health care system in New Jersey is alarming," agrees Marcus Rayner, executive director of the New Jersey Lawsuit Reform Alliance. "Due to skyrocketing medical malpractice insurance premiums and the threat of a lawsuit, hospitals have fewer OB-GYNs willing to work in emergency departments, and fewer specialty physicians willing to work at all."
>
> Five years ago, a survey of New Jersey's neurosurgeons indicated that there were only 63 remaining in the state—to serve a population of more than 8.5 million. Someday it could be your teenager who suffers a head injury in a sports or car accident, and urgently needs the care of a neurosurgeon. What are the odds that one would be available? [54]

It is clear that no doctor is safe from lawsuit abuse, but as studies have shown, some are more vulnerable to abusive litigation than others because of their specialty or the location of their practice. Today, one-third of orthopedists, trauma surgeons, ER doctors and plastic surgeons will probably be sued in any given year.[55] Neurosurgeons face liability lawsuits more often—every two years on average.[56]

OB-GYNs are another favorite target of personal injury lawyers with nearly three out of five OB-GYNs sued at least twice in their careers. The American College of Obstetricians and Gynecologists (ACOG) 2009 Medical Liability Survey found nearly 91 percent of OB-GYNs surveyed had experienced at least one liability claim filed against them and sadly, we know most of the cases are without merit.[57]

Three out of four emergency rooms say they have had to divert ambulances because of a shortage of specialists and more than 25 percent lost specialist coverage due to medical liability issues.[58]

One emergency room physician was quoted as saying, "The lack of on-call specialists affects the numbers of patients referred to tertiary care facilities even for basic specialty related diseases (like orthopedics). This adds to emergency department crowding in some facilities, and it means that patients have to travel across town or greater distances for a relatively simple problem that could have been resolved if the specialist had been on call at the initial facility." [59]

The Association of American Medical Colleges (AAMC) has predicted that once the new health care reform provisions take effect

---

[54] Amy H. Handlin, "Reduce Medical Liability Costs Before More Specialists Flee N.J.," *New Jersey Times* (November 22, 2009).

[55] "Defending the Practice of Medicine," Richard E. Anderson, M.D., *Archives of Internal Medicine,* June 2004.

[56] "Effective Legal Reform and the Malpractice Insurance Crisis," Richard E. Anderson, M.D., *Yale Journal of Health Policy, Law and Ethics,* December 2004.

[57] American College of Obstetrics and Gynecologists Medical Liability Survey, 9/09.

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

[59] "National Report Card on the State of Emergency Medicine," American College of Emergency Physicians, 2009.

in 2015, in just four short years, "the shortage of physicians across all specialties will more than quadruple to almost 63,000."[60] Another group, the American Academy of Family Physicians, has projected the shortfall of family physicians will reach 149,000 by 2020.[61]

AAMC also found the country will need 46,000 more surgeons and other specialists to meet demand in the next decade and that those living in rural or inner city locations will suffer the most severe impact. According to Dr. Atul Grover, of the AAMC, "This will be the first time since the 1930s that the ratio of physicians to the population will start to decline."[62]

DOCTOR SHORTAGE CONSEQUENCES: THE DYESS TRAGEDY

Regardless of the merits of any given case, there are inherent problems with so-called "pain and suffering" or noneconomic damages: they are utterly standardless, unquantifiable, and subject to discriminatory application based of whether or not a particular person happens to be sympathetic or unsympathetic, and even whether or not a particular case has attracted media attention. Tony Dyess's injury did not receive media attention. He was in a car accident in Mississippi. There were no longer any neurosurgeons in the area. They had stopped practicing because they couldn't afford medical professional liability insurance. It took six hours to airlift Tony Dyess to a hospital that could treat his brain injury. It was too late. The "golden hour" had passed, and Tony Dyess has been left permanently brain damaged. As Tony Dyess' wife Leanne has said, "[f]rom my perspective . . . this problem far exceeds any other challenge facing America's health care—even the challenge of the uninsured. My family had insurance when Tony was injured. We had good insurance. What we didn't have was a doctor. And now, no amount of money can relieve our pain and suffering. But knowing that others may not have to go through what we've gone through, could go a long way toward helping us heal." When Leanne Dyess began telling this story, trial lawyers gave her false information about what happened the night her husband was injured, then tried to hire her. She refused.

We all recognize that injured victims should be adequately compensated for their injuries. But too often in this debate we lose sight of the larger health care picture. This country is blessed with the finest health care technology in the world. It is blessed with the finest doctors in the world. People are smuggled into this country for a chance at life and healing, the best chance they have in the world.

The Department of Health and Human Services issued a report recently that included the following amazing statistics.[63] During the past half century, death rates among children and adults up to age 24 were cut in half. Mortality among adults 25–64 years fell nearly as much, and dropped among those 65 years and over by a third. The infant mortality rate—deaths before the first birthday—has plummeted 75 percent since 1950. These are amazing statis-

[60] Association of American Medical Colleges Center for Workforce Studies estimates, 9/30/10.
[61] "Doctor Shortage Looms as Primary Care Loses it Pull," Janice Lloyd, USA Today, 8/18/09.
[62] "Agencies warn of coming doctor shortage," Tammy Worth, Los Angeles times, 6/7/10.
[63] Available at *http://www.cdc.gov/nchs/releases/02news/hus02.htm.*

tics. And they didn't just happen. They happened because America produces the best health care technology and the best health care providers to use it. But now there are fewer and fewer doctors to use that miraculous technology. We have the best brain scanning and brain operation devices in history, and fewer and fewer neurosurgeons to use them. According to the American Board of Neurological Surgery, in 2001 there were fewer active board-certified neurosurgeons (2,936) than there have been in the last decade. Also in 2001, 4.5 times as many board-certified neurosurgeons retired as retired a decade ago (1,400 retired in 2001, only 309 retired in 1990). Only about 100–200 neurosurgeons graduate from residency training programs each year, but it takes about 5 years of post-residency to become "board certified." Unlimited lawsuits are driving doctors out of the healing profession. They are reversing the clock. They are making us all less safe. All in the name of unlimited lawsuits and lawyers' lust for their cut of unlimited awards. But when someone gets sick, or is bringing a child into the world, we can't call our lawyers for help.

WOMEN ARE AT RISK UNDER THE DOCTOR SHORTAGE DRIVEN BY UNLIMITED LAWSUITS

Women pay an especially high price when it comes medical liability and access to care.

According to Albert L. Strunk, M.D., deputy executive vice president of ACOG, "the medical liability situation for ob-gyns remains a chronic crisis and continues to deprive women of all ages—especially pregnant women—of experienced ob-gyns."[64] ACOG's own data proves the point. According to their 2009 survey, 63 percent of OB-GYNs said they had made changes to their practice because of the risk or fear of liability claims. Between seven and eight percent have stopped practicing obstetrics altogether. In fact, ACOG found that the average retirement age of practicing obstetrics was 48. Once upon a time, before the medical lawsuit abuse crisis, that was considered mid-point in a doctor's career.[65]

Looking state by state, the picture is even more alarming. For example in 2007, Hawaiian women faced the harsh reality that 42 percent of the state's OB-GYNs had stopped providing prenatal care.[66] Dr. Francine Sinofsky, an OB-GYN in East Brunswick, N.J., says two of her practice's seven members no longer practice obstetrics due to the cost of medical liability. One who practices gynecology only pays $14,000 a year for liability insurance while another who practices obstetrics as well pays more than $100,000.[67] In 2008, 1,500 counties in America, including eight counties in New York alone, did not have a single obstetrician as liability issues chased good doctors out of obstetrics.[68]

But the negative impact of lawsuit abuse on women's health goes beyond obstetrics. Today, the number of radiologists willing to read mammograms is shrinking, exacerbated by the decreasing number

[64] American College of Obstetricians and Gynecologists (ACOG) news release, 11/3/06.
[65] "Survey on Professional Liability," ACOG, 9/09.
[66] "Doctors Urging Lawmakers to support Tort Reform," KGMB9.com
[67] "The Doctor Drain," Lauren Otis, the New Jersey Monthly, 2/5/08.
[68] "Center for Health Workforce Studies," cited in "no Place to be Born," New York Sun, 8/25/08.

of medical residents choosing radiology as their specialty. The reason is simple. A failure to diagnose properly is the number one allegation in most liability lawsuits.[69] That makes radiologists the number one group of physicians affected.[70] Abuse of the litigation system is putting women at risk.

PROVEN REFORMS

The states have proven that legal reform works. While Democrats in Washington talk about the need to study the problem, states have acted to address it. Several states have limited noneconomic damages—such as those for "pain and suffering"—and dramatically lessened the burden of lawsuits. In states with such limits, premiums are 17 percent lower than they are in states without them.[71]

States also have had success with a variety of other reforms. A comprehensive study of these reforms suggests that attorney-fee limits, such as those in California, are particularly effective.[72] The cumulative effect of all state reforms put together could be as much as a 74 percent reduction in premiums.[73]

PROVEN REFORMS IN CALIFORNIA

California's Medical Injury Compensation Reform Act (called "MICRA") has proved immensely successful in increasing access to affordable medical care in California since it was signed into law in 1975. It has kept California medical malpractice insurance rates consistently much lower than the average in the rest of the country.[74] Some critics claim that a California automobile insurance reform measure called Proposition 103 that required a "rollback" of insurance premiums—and not California's health care litigation reforms—have controlled medical professional liability premiums in that state. However, according to the Orange County Register, "a rollback [under Proposition 103] never took place because the [California Supreme] court amended Prop. 103 to say that insurers could not be forced to implement the 20 percent rollback if it would deprive them of a fair profit."[75] Further, since Proposition 103 went into effect, no medical professional liability insurer has been denied a requested premium increase.

COMMENTS OF SUPPORTERS OF CALIFORNIA'S HEALTH CARE LITIGATION REFORMS (ON WHICH THE HEALTH ACT IS MODELED)

Cruz Reynoso, Democratic Vice Chairman of the U.S. Commission on Civil Rights (appointed by former Senate Majority Leader George Mitchell in 1993), Professor of Law at UCLA, and former Justice of the California Supreme Court:

---

[69] AMA News, 3/20/06.

[70] "Failure to Diagnose: Putting the Pieces Together, A Risk Management Review of Closed Claims in Selected Specialties 2002-2004," Linda Greenwald, Doctors' Insurance Services of New England, 2005.

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

[72] "Tort Law Tally: How State Tort Reforms Affect Tort Losses and Tort Insurance Premiums," Nicole V. Crain, and W. Mark Crain, et al, Pactific Research Institute (2009).

[73] "Tort Law Tally: How State Tort Reforms Affect Tort Losses and Tort Insurance Premiums," Nicole V. Crain, and W. Mark Crain, et al, Pactific Research Institute (2009).

[74] See *http://www.micra.org/about-micra/docs/micra—access—and—affordability.pdf.*

[75] Orange County Register (October 22, 1997).

> Medical insurance has been going up. I think there's no question that what the legislature did and continues to do has had an influence on keeping those expenses down and that's a very important public policy . . . . Publicly-funded medical centers were very supportive of the continued protection of MICRA because if their own insurance rates would go up they would be less able to serve the poor . . . . I personally have favored having as much access to the courts as possible, but at the same time you have to be careful that it doesn't do so in a way that is destructive, for example, in the medical field, destructive of the ability of society to respond to the medical needs of the people.

Nancy Sasaki, President and CEO of Planned Parenthood, Los Angeles:

> If the caps [on non-economic damages] in MICRA were to be increased, you actually would begin to see kind of a domino effect . . . . If insurance costs for the physicians go up they typically will then, as any business would, look at what services are their highest risks, which services are costing them the most, and they may no longer provide that. And that's happened in the past, where physicians have stopped providing obstetric care because of costs.

Donna Stidham, Director of Managed Care and Patient Services, AIDS Health Care Foundation:

> [An] increase in the MICRA cap . . . would increase our premiums phenomenally. In a single clinic setting it could probably increase their premiums maybe twenty or thirty thousand dollars. For multiple physicians, I'd hate to even guess, but it'd be in the hundreds of thousands, which would take away from direct patient care . . . . So it would directly take away from care, from the patients. You'd see us perhaps not being able to admit all types of patients. Right now we can take any kind of patient, whether they have the ability to pay or not.

CALIFORNIA SUPREME COURT STATEMENTS ON THE PURPOSES OF MICRA'S LIMIT ON NONECONOMIC DAMAGES

The California Supreme Court has stated the following purposes of California Civil Code section 3333.2, which limits recovery of noneconomic damages to $250,000:

> One purpose is to provide a more stable base on which to calculate insurance rates by eliminating the "unpredictability of the size of large noneconomic damage awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag which different juries placed on such losses." [76]
>
> Another purpose is to "promote settlements by eliminating 'the unknown possibility of phenomenal awards for

[76] Fein v. Permanent Medical Group, 38 Cal.3d 137, 163 (1985); see also Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital 8 Cal.4th 100, 112 (1984).

pain and suffering that can make litigation worth the gamble.'"[77]

Another purpose is to be fair to medical malpractice plaintiffs by "reduc[ing] only the very large noneconomic damage awards, rather than to diminish the more modest recoveries from pain and suffering and the like in the great bulk of cases."[78]

PROVEN REFORMS IN TEXAS

After Texas adopted a new liability system in 2003, medical liability premiums fell dramatically, and thousands of new doctors flooded into the state.[79] Communities in Texas that once did not have primary or specialty care doctors now have a full complement of physicians.

A 2008 study from the Perryman Group found that perhaps the most visible economic impact of the lawsuit reforms are the benefits experienced by Texans who have better access to high-quality healthcare.[80] Doctors and hospitals are using their liability insurance savings to expand services and initiate innovative programs; those savings have allowed Texas hospitals to expand charity care by 24 percent.[81]

The total impact of tort reforms implemented since 1995 includes gains of $112.5 billion in spending each year as well as almost 499,900 jobs in the state.[82] The fiscal stimulus to the state from judicial reforms is almost a $2.6 billion per year increase in state revenue.[83] In addition, these reforms are responsible for approximately 430,000 individuals having health insurance than would otherwise, and there has been an increase in the number of doctors, particularly in regions which have been facing severe shortages.[84]

As the Wall Street Journal has observed:

Before the reform, Texas was a kind of holy place on the tort bar pilgrimage. Now it's a Mecca for doctors, especially the emergency physicians, obstetricians and surgical specialists who elsewhere can face blue-sky malpractice premiums. Liability rates have fallen by 27.5% on average since 2003. The number of doctors applying to practice in Texas has increased 60%, even as the overall population grew by 14%.

All of this is helping to end an acute Lone Star physicians shortage, especially in rural areas. Twenty-three counties now have their first E.R. doctor, 10 their first OB-GYN. Hospitals are reinvesting the malpractice savings in scarce services like neurosurgery and neonatal units and expanding access to care. This Texas success has opened

[77] Fein v. Permanent Medical Group, 38 Cal.3d 137, 163 (1985).
[78] Id.
[79] "Tort Reform: A Victory for Patient Access," Texas Medical Association (July 5, 2006); "Texas-Style Health Care Reform is Bigger and Better," Sally Pipes, San Francisco Examiner (July 24, 2009).
[80] Peggy Venable, "Tort Reform? We've already Done It," Washington Post (September 16, 2009).
[81] Id.
[82] Id.
[83] Id.
[84] Id.

> eyes in nearby Oklahoma, where even Democrats have been forced to agree to some legal reforms.[85]

BARRIERS TO REFORM

The reason Democrats continue to refuse to add serious medical lawsuit reform to their health care legislation remains purely political, as was recently revealed by former DNC Chair Howard Dean. At a recent health care town hall meeting hosted by Rep. Jim Moran (D-VA), Dean responded to an angry constituent who wondered why a supposedly comprehensive "reform" of the health-care system does not include tort reform to lower costs of malpractice insurance and reduce defensive medicine. Dean responded remarkably candidly, stating:

> "This is the answer from a doctor and a politician," said Dean. "Here is 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, the more enemies you make, right? And the reason why 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 everybody else they were taking on, and that is the plain and simple truth. Now, that's the truth."

Moreover, the Democrats' health care law's offer of HHS "demonstration projects" on tort reform, rings hollow given that the cabinet secretary tasked with implementing this proposal for demonstration projects is Kathleen Sebelius. Before she was governor of Kansas and the insurance commissioner of Kansas, she spent eight years as the head of the Kansas Trial Lawyers Association, now the Kansas "Association for Justice." The KAJ's total opposition to reform is highlighted on its website. And Sebelius is also the state executive who, according to the New York Times, "failed to make significant improvement in health coverage or costs during her two terms as governor."

The top contributor to President Obama's presidential campaign was the legal industry, whose donations came to more than $43 million. More than 80 percent of the money given to Congress by lawyers, mostly from the plaintiffs' bar, went to Democrats—almost $22 million.

When President Obama spoke to the American Medical Association's convention in June of 2009, he told the audience "I'm not advocating caps on malpractice awards."

SUPPORT FOR REFORM: THE AMERICAN PEOPLE

The American people are demanding legal reform. A recent survey found that 83 percent of Americans believe that reforming the legal system needs to be a part of any health care reform plan.[86] As the Associated Press reported:

> Most Americans want Congress to deal with malpractice lawsuits driving up the cost of medical care, says an Associated Press poll. Yet Democrats are reluctant to press for-

[85] Wall Street Journal (editorial), "Loser Pays, Everyone Wins" (December 15, 2010).

[86] "National Voter Survey: Health Care Reform and the Legal System 2009," Clarus Research Group (August 2009).

> ward on an issue that would upset a valuable political constituency—trial lawyers—even if President Barack Obama says he's open to changes. The AP poll found that 54 percent of Americans favor making it harder to sue doctors and hospitals for mistakes taking care of patients, while 32 percent are opposed . . . . Support for limits on malpractice lawsuits cuts across political lines, with 58 percent of independents and 61 percent of Republicans in favor. Democrats are more divided. Still, 47 percent said they favor making it harder to sue, while 37 percent are opposed. The survey was conducted by Stanford University with the nonprofit Robert Wood Johnson Foundation . . . . In the poll, 59 percent said they thought at least half the tests doctors order are unnecessary, ordered only because of fear of lawsuits.[87]

In a poll done by the Health Coalition on Liability and Access (HCLA) in October 2009, 69 percent of Americans said they wanted medical liability reform included in health care reform legislation. Seventy-two percent said that their access to quality medical care is at risk because lawsuit abuse forces good doctors out of the practice of medicine. A Rasmussen poll done at the same time found that 57 percent of people favored limiting jury awards.[88]

The American people clearly understand the issue of liability reform and the motives behind the raft of lawsuits trial lawyers are bringing to stop reform in its tracks. The Health Coalition on Liability and Access poll done in October 2009 found that by a wide margin, 70 percent of Americans support full payment for lost wages and medical expenses and reasonable limits on awards for non-economic "pain and suffering." Sixty-eight percent of those polled also favor a law to limit the fees personal injury attorneys can take from an award or settlement.

BLAMING THE INSURANCE COMPANIES IS OFTEN A RED HERRING

As Dr. Stanley Goldfarb, associate dean of clinical education at the University of Pennsylvania School of Medicine, has written: "The president points to for-profit insurance companies [as the source of the problem], but for-profit insurance companies only make up 25 percent of the system and they are not that profitable, ranking 85th among all U.S. industries. [Insurance] 'Reform' will redistribute the money, not reduce the overall costs. There is much that can be done to make our system more efficient. Tort reform is a great place to start."[89]

The Department of Health and Human Services concluded that the average award in medical malpractice cases has risen 76% in recent years, and that "mega-awards" for "pain and suffering" have occurred in states without any limits on what a plaintiff can re-

[87] Ricardo Alonso-Zaldivar and Trevor Tompson, "AP: Support for Curbs on Malpractice Lawsuits," The Associated Press (November 19, 2009).

[88] Rasmussen Research, 12/2/09.

[89] Stanley Goldfarb, "The Malpractice Problem: We Can't Have Health Care Reform Without Tort Reform," The Weekly Standard (October 27, 2009).

cover.[90] Large numbers of these cases are meritless. The Harvard Medical Practice Study, for example, found that over half of the filed medical professional liability claims they studied were brought by plaintiffs who suffered either no injuries at all, or, if they did, such injuries were not caused by their health care providers, but rather by the underlying disease.[91] These findings have been confirmed.[92] Also, before the 1960s, only one physician in seven had ever been sued in their entire lifetime,[93] whereas today's rate is about one in seven per year.[94]

The medical insurance crisis caused insurers like St. Paul—an insurer of 42,000 doctors, 750 hospitals, 5,800 health care facilities, and 72,000 health care providers such as nurses—to leave the medical professional liability insurance business entirely.[95] In the words of Thomas A. Bradley, chief financial officer of St. Paul, the medical malpractice insurance crisis was "basically another World Trade Center loss for us this year."[96] Other medical malpractice insurers have also left the market,[97] and many others have become insolvent. Licensed carriers' medical professional liability insurance business has, on average, been unprofitable since 1990–2000.[98]

The claim that sharp increases in medical liability insurance rates are due to insurer losses in the stock market is also dubious, as less than 15% of the assets of medical liability insurance companies are stocks.[99] Additionally, 60% of the doctors in the United States are insured by insurance companies that are owned and operated by other doctors and which operate primarily for their benefit.[100]

THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT" (PPACA) IS A TRIAL LAWYERS" BAILOUT BILL

The "Patient Protection and Affordable Care Act" (PPACA) not only fails to contain any of the tort reforms the CBO concluded would save billions in health care costs, but it also contains a pro-

---

[90] Department of Health and Human Services, "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System" (July 24, 2002) at 9–10 ("These mega-awards for non-economic damages have occurred (as would be expected) in states that do not have limitations on the amounts that can be recovered.").

[91] See Harvard Medical Practice Study to the State of New York, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York at 11–5 (1990) ("[T]he tort system imposes the costs of defending claims on [health care] providers who may not even have been involved in an injury, let alone a negligent injury.").

[92] See D. Studdert et al., "Negligent Care and Malpractice Claiming Behavior in Utah and Colorado," 38 Medical Care 3: 250–60, 250 (2000) ("Eighteen patients from out study sample filed claims: 14 were made in the absence of discernable negligence and 10 were made in the absence of any adverse event ... The poor correlation between medical negligence and malpractice claims that was present in New York in 1984 is also present in Utah and Colorado in 1992 . . . [W]hen a physician is sued, there is a high probability that it will be for rendering nonnegligent care.") (emphasis added).

[93] See "Opinion Survey of Medical Professional Liability," JAMA 164:1583–1594 (1957).

[94] See R. Bovbjerg, "Medical Malpractice: Problems & Reforms," The Urban Institute, Intergovernmental Health Policy Project (1995).

[95] See Joseph T. Hallinan, "St. Paul Gradually Will Pull Out Of Malpractice-Insurance Sector," The Wall Street Journal (December 13, 2001) at B2.

[96] "St. Paul to Exit Medical Malpractice, Pose $900 Million Charge," Best's Insurance News (December 12, 2001).

[97] See Meg Green, "Med Malcontent: Top medical malpractice writer St. Paul Cos. Abandons the Unprofitable Business. Who Will Fill the Void?" Best's Review (February 1, 2002) at 12.

[98] See American Medical Association, "Trends Report: Medical Professional Liability Insurance" (April 2002) at 5.

[99] See Physician Insurers Association of America, "Bordering on Malpractice: Serious Errors Found in Consumer Federation of America Report on Medical Liability Insurance" (May 9, 2002).

[100] Physician Insurers Association of America.

vision that explicitly allows trial lawyers to "opt-out" of any alternative liability system. This means that if their frivolous lawsuit is limited by the alternative system, they can simply "opt-out" of the alternative system and file in court like they always have. Section 10607 of the Democrats' bill states that any states' "proposed alternative" must "provide[ ] patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative."[101] So the bill literally prohibits any alternative to litigation, or any new limits on litigation, from being enforced.

Moreover, not only does PPACA prevent non-economic damages caps from being enforced, but the law requires that the Secretary of Health and Human Services provide states with "guidance on [the award] of non-economic damages . . . in determining appropriate payment."[102] Consequently, not only does this legislation prevent states from taking part in the demonstration projects if they seek to enforce the reforms the CBO said would save billions; it also requires the Secretary of Health and Human Services to encourage states to adopt lawsuit damages criteria the CBO has concluded would raise health care costs, not lower them. That's not tort reform. It's tort deform.

Further, because the health care bill signed into law by President Obama calls for the federal government and its regulators to create all manner of new standards and guidelines for medical professionals to follow, it opens up many more opportunities for trial lawyers to sue doctors if they deviate at all from those federal standards and guidelines. The House-passed version of the legislation, H.R. 3962, contained a provision that made clear that the new government guidelines provided for by the bill "shall not be construed to establish the standard of care or duty of care owed by health care providers to their patients in any medical malpractice action or claim."[103] But the bill signed into law by President Obama fails to contain such a provision, which can only be read as an invitation to trial lawyers to sue doctors whenever they deviate one iota from whatever guidelines or standards are handed down from Washington, D.C. That's a step backward for legal reform, and yet another cause of defensive medicine.

THE NEED FOR FEDERAL LAWSUIT REFORM THAT APPROPRIATELY USES CONGRESS' COMMERCE CLAUSE POWER

Over 20 State supreme courts have judicially nullified reasonable litigation management provisions enacted by State legislatures, many of which sought to address the crisis in medical professional liability that reduces patients' access to health care. Consequently, in such States, passage of federal legislation by Congress is the only means of addressing the State's current crisis in medical professional liability and restoring patients' access to health care. Many more may do so unless Congress acts under its Supremacy

[101] 42 U.S.C.A. § 280g–15(c)(2)(g).
[102] 42 U.S.C.A. § 280g–15(f)(2)(A).
[103] See H.R. 3962 (111th Cong. 1st Sess.) (passed November 7, 2009) (SEC. 261. CONSTRUCTION REGARDING STANDARD OF CARE. (a) IN GENERAL.—The development, recognition, or implementation of any guideline or other standard under a provision described in subsection (b) shall not be construed to establish the standard of care or duty of care owed by health care providers to their patients in any medical malpractice action or claim).

Clause and Commerce Clause authority to let doctors treat patients wherever they are, not just where States have enacted legal reforms that can be upheld under their state constitutions.[104]

Furthermore, federal legislation is needed to stem the flow of doctors from one state to another, as they flee states to avoid excessive liability costs. Doctors should feel free to practice medicine wherever they want in this country, and patients everywhere should be able to obtain the medical care they need.

While tort reform is usually adopted at the state level in the first instance, it can also be adopted at the federal level, when the effects of tort law present a threat to state autonomy. Indeed, James Madison described the purpose of the Constitution's Commerce Clause as follows: "A very material object of this power [of Congress] was the relief of the States which import and export through other States, from the improper contributions levied on them by the latter. Were these [States] at liberty to regulate the trade between State and State, it must be foreseen that ways would be found out to load the articles of import and export, during the passage through their jurisdiction, with duties which would fall on the makers of the latter and the consumers of the former. *We may be assured by past experience, that such a practice would be introduced by future contrivances; and both by that and a common knowledge of human affairs, that it would nourish unceasing animosities, and not improbably terminate in serious interruptions of the public tranquility.*"[105] Clearly, Madison predicted that states would see in the future the rise of new forms of rules and regulations that would increase the costs of things nationwide, but which could not be foreseen at the time of the Founding, and that Congress would needs its Commerce Clause authority to counter those cost-increasing influences.[106] Indeed, one modern manifestation of

---

[104] See Rept. 107–693 pt. 1 (107th Cong., 2d Sess.) at 13 and n.14.

[105] The Federalist Papers, Federalist No. 42 at 267–68 (Clinton Rossiter ed., 1961) (emphasis added).

[106] At the time of the Founding and soon thereafter, out-of-control state litigation was kept in check in the states by strict limits on lawyers' fees, which no longer prevail. During the American Colonial period, lawyers were roundly despised and subjected to strict limits on lawsuits. According to one historian, "[i]n every one of the Colonies, practically throughout the Seventeenth Century, a lawyer or attorney was a character of disrepute and of suspicion . . . . In many Colonies, persons acting as attorneys were forbidden to receive any fee. . . . in all, they were subjected to the most rigid restrictions as to fees and procedure." Charles Warren, A History of the American Bar 4 (William S. Hein & Co., Inc. 1913). Early American observer Benjamin Austin wrote, "if we look through the different counties throughout the Commonwealth, we shall find that the troubles of the people arise principally from debts enormously swelled by tedious law-suits." Benjamin Austin, Observations on the Pernicious Practice of the Law 4 (1786). As one historian summarized the situation in early America, "[l]awsuits were often begun or continued for no other purpose than to embarrass an enemy by making him incur legal costs." Anton-Hermann Chroust, The Rise of the Legal Profession in America: The Colonial Experience vol. 1, 82 (U. of Okla. Press 1965). Attorneys were so despised in early America that they often inspired violence. As one historian wrote:

> During Shay's Rebellion, in 1786 people actually demanded that all inferior courts and all lawyers be entirely eliminated . . . In Vermont and New Hampshire vociferous demands were made to suppress the legal profession completely, or at least to reduce the number of lawyers and, incidentally, to cut down substantially the usual legal fees. In Vermont, where the general populace was particularly vehement in its actions and denouncements, courthouses were set afire . . . As early as 1786 the town of Braintree, Massachusetts, passed a resolve "to crush . . . that order of Gentlemen denominated Lawyers . . . whose . . . conduct appears . . . to tend rather to the destruction than the preservation of this Commonwealth."

Anton-Hermann Chroust, The Rise of the Legal Profession in America: The Revolution and the Post-Revolutionary Era vol. 2, 26–27 (U. of Okla. Press 1965) (citing Laws and Resolves of Mass., c. 23, § 2, (1785); John Adams, The Adams Papers: Diary and Autobiography of John

the problem Madison foresaw is that, today, some states' tort law allows unbounded lawsuits that increase the costs of selling products or services (including medical services) that cross into their jurisdictions. There is even a word for this modern phenomenon. It is called the "tort tax," and when it's applied to national industries, it's passed on to consumers everywhere. The result is higher prices, and potentially lost jobs, across multiple states, or nationwide. When that happens, Congress can, and often should, enact federal tort reform to preserve federalism principles. While some argue that businesses can avoid tort liability by simply avoiding states that have oppressive tort laws, James Madison clearly rejected that argument against Congressional action, arguing instead that Congress should have the power to enact rules that allow businesses to enter into a state "jurisdiction" without having to worry that doing so would dramatically increase the price of their products elsewhere. Likewise, Alexander Hamilton wrote in the Federalist Papers that "The government of the Union must be empowered to pass all laws, and to make all regulations which have relation to them. The same must be the case in respect to commerce, and to every other matter to which its jurisdiction is permitted to extend." [107]

James Madison and the Founders clearly supported the power of the People's national representatives in Congress to preserve citizens' access to privately-provided goods and services. Madison said, in the seminal speech he gave defending the Commerce Clause at the Virginia convention called to ratify the Constitution, that "All agree that the general government ought to have power for the reg-

---

Adams vol. 1, 342 (1902); John Quincy Adams, Three Episodes of Massachusetts History 897 (1893)).

Fear that the legal profession would abuse its power to generate lawsuits was also reflected in limits on attorneys' fees. In 1784, Connecticut by statute limited attorneys' fees according to a "Table of Fees." Acts and Laws of the State of Connecticut in America 10–11 (1784). In 1792, Georgia regulated attorneys' fees as follows: for "each cause commenced and tried in the superior or inferior courts," eighteen shillings and eight pence. A Digest of the Laws of the State of Georgia 476 (1800). In 1714, Massachusetts fixed attorneys' fees at twelve shillings "at the superior court of judicature . . . and at the inferior court, ten shillings, and no more." Acts and Laws, of Her Majesties Province of the Massachusetts-Bar in New England 185 (1714). In 1719, Rhode Island attorneys' fees were fixed at a maximum of twelve shillings. Charter Granted by His Majesty King Charles the Second to the Colony of Rhode Island and Providence-Plantations in America 21 (1719). In 1766 these fees were reduced to a maximum of five shillings. Acts and Laws of His Majesty's Colony of Rhode-Island and Providence-Plantations in America 98 (1767). By 1748, the New Jersey Legislature passed a statute establishing an elaborate schedule of lawyer's fees. The Acts of the General Assembly of the Province of New Jersey 167 (Allinson ed. 1776). In 1778, in Virginia, attorneys' fees were fixed by statute in the General Court and the High Court of Chancery depending on the nature of the action. Anton-Hermann Chroust, The Rise of the Legal Profession in America: The Revolution and the Post-Revolutionary Era vol. 2, 261–62 (U. of Okla. Press 1965) (citing 9 Statutes at Large of Virginia 529 (Hening ed. 1823)). In 1795, in Pennsylvania, attorneys' fees in the Court of Common Pleas were set for filing a lawsuit and entering an appearance as follows: "if the suit is ended before or during the sitting of the first court," at $1.67; for every suit "ended after the first court and before judgment," $3.34; and for "every suit prosecuted to judgment," $4.00. 15 Statutes at Large of Pennsylvania, c. 1863, § 1, 360 (1911). In 1801, New York enacted the comprehensive Act Regulating the Fees of Several Officers and Ministers of Justice within the State, which included limits on attorneys' fees. 5 Laws of the State of New York Passed at the Session of the Legislature Held in the Year 1801, c. 190, 553–71 (1871). In 1810, in Maryland, a statute was enacted providing "no attorney of any of the county courts shall be authorized to charge more . . . than the sum of three dollars and thirty-three cents and one third of a cent in any one suit." Laws of Maryland of 1810, c. 126, § 2; 1 The General Public Statutory Law of Maryland 601 (1840). Delaware had its own unique method for reducing litigiousness. In 1793, Delaware passed the Act for Regulating and Establishing Fees providing that for all pleadings in an action subsequent to a declaration, the fee would be one cent for every written line, twelve words to a line. Anton-Hermann Chroust, The Rise of the Legal Profession in America: The Revolution and the Post-Revolutionary Era vol. 2, 256 (U. of Okla. Press 1965).

[107] The Federalist Papers, Federalist No. 23 at 155 (Clinton Rossiter ed., 1961).

ulation of commerce here are regulations in different states which are unfavorable to the inhabitants of other states his will not be the case when uniform regulations will be made" by Congress.[108] Indeed, that's what Congress did when it passed the Protection of Lawful Commerce in Arms Act in 2006, which prohibits lawsuits in either state or federal court against the firearms industry for damages resulting from the unlawful use of firearms by others. That federal tort reform law was upheld as coming within Congress' Commerce Clause authority by the Second Circuit Court of Appeals, which said "We find that Congress has not exceeded its authority in this case, where there can be no question of the interstate character of the industry in question and where Congress rationally perceived a substantial effect on the industry of the litigation that the Act seeks to curtail."[109] The same holds true where there can be no question of the interstate character of the health care industry and where Congress rationally perceives a substantial effect lawsuits have on that industry.[110] Congress has enacted many federal tort reform statutes.[111]

Of note, Congress passed the Partial-Birth Abortion Ban Act of 2003, which prohibited a specific medical procedure that involves a particularly gruesome form of abortion procedure, under its Commerce Clause authority. That Act was upheld by the Supreme Court in Gonzales v. Carhart,[112] in which the Court upheld Congress' "legislative power, exercised in this instance under the Commerce Clause, to regulate the medical profession,"[113] concluding that "Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends."[114]

Also, federal tort reform regarding vaccine liability has been the law for several decades. In the late 1980's, Congress enacted the National Vaccine Injury Compensation Program,[115] a federal pro-

---

[108] James Madison, "Speech in the Virginia Ratifying Convention" in Madison: Writings (1999) at 378–79.

[109] City of New York v. Beretta Corp., 524 F.3d 384, 394 (2008), cert. denied 129 S.Ct. 1579 (2009).

[110] Congress has acted many times to enact federal tort reforms, including the Volunteer Protection Act of 1997, which creates immunity for volunteers to nonprofits or government bodies. 42 U.S.C.A. §§ 14501 et seq. Congress has also passed the Partial-Birth Abortion Ban Act of 2003, which prohibited a specific medical procedure that involves a particularly gruesome form of abortion procedure. That Act was upheld by the Supreme Court in Gonzales v. Carhart, 550 U.S. 124 (2007), in which the Court upheld Congress' "legislative power, exercised in this instance under the Commerce Clause, to regulate the medical profession," id. at 166, concluding that "Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends." Id.

[111] See, e.g., Employers Liability Act of 1908, 35 Stat. 65, c. 149; Price-Anderson Act, 42 U.S.C. § 2210(e); Atomic Testing Liability Act, 42 U.S.C. § 2212; National Childhood Vaccine Injury Compensation Act of 1986 42 U.S.C. §§ 300aa–1–300aa–34; Comprehensive Environmental Response, Compensation, and Liability Act (Superfund); General Aviation Revitalization Act, P.L. 103–298, 49 U.S.C. § 40101 note; Cruise Ship Liability, P.L. 104–324, § 1129; Bill Emerson Good Samaritan Food Donation Act, P.L. 104–210, 42 U.S.C. § 1791; Volunteer Protection Act of 1997, P.L. 105–1, 42 U.S.C. §§ 14501–14505; Amtrak Reform and Accountability Act of 1997, P.L. 105–134, § 161, 49 U.S.C. § 28103; Aviation Medical Assistance Act of 1998, P.L. 105–170 (1998), 49 U.S.C. § 44701 note; Biomaterials Access Assurance Act of 1998, P.L. 105–230, 21 U.S.C. §§ 1601–1606; Y2K Act, P.L. 106–37, 15 U.S.C. §§ 6601–6617; Cardiac Arrest Survival Act of 2000, P.L. 106–505, § 404, 42 U.S.C. § 238q; Air Transportation Safety and System Stabilization Act, P.L. 107–42, § 201(b); September 11th Victim Compensation Fund of 2001, 49 U.S.C. § 40101 note; Paul D. Coverdell Teacher Protection Act of 2001, P.L. 107–110, §§ 2361–2368; Multiparty, Multiforum Trial Jurisdiction Act of 2002, P.L. 107–273, § 11020; Homeland Security Act of 2002, P.L. 107–296, §§ 304, 863, 890, 1201, 1402, and 1714–1717.

[112] 550 U.S. 124 (2007).

[113] Id. at 166.

[114] Id.

[115] 42 U.S.C. § 300aa–10 through −34.

gram that preempts state court tort awards, to protect vaccine manufacturers from bankruptcy in the face of otherwise unlimited state tort jury awards. The Act overrides the state court system, putting compensation decisions in the hands of a congressionally created Office of Special Masters, which currently consists of one Chief Special Master and seven Associate Special Masters who are appointed by the U.S. Court of Federal Claims to serve for four-year terms. To this day, that Act has never been successfully challenged on constitutional grounds. If it were, millions of children could be forced to go without necessary vaccines because manufacturers would refrain from providing them. Note that while the federal vaccine compensation program completely overrides state courts and juries, the HEALTH does not go nearly so far because the HEALTH Act allows state lawsuits to proceed, but with reasonable limits on a narrow category of damages and other process reforms.

The Congressional Research Service has concluded that "enactment of tort reform legislation generally would appear to be within Congress's power to regulate commerce, and would not appear to violate principles of due process or federalism . . . . In concluding that Congress has the authority to enact tort reform 'generally,' we refer to reforms that have been widely implemented at the state level, such as caps on damages and limitations on joint and several liability and on the collateral source rule."[116] Caps on damages and limitations on joint and several liability are precisely the reforms contained in the HEALTH Act.

Moreover, laws passed by States that have already provided for, or may in the future provide for, different limits on damages in health care lawsuits will be preserved under the HEALTH Act, as the HEALTH Act provides that "No provision of this Act shall be construed to preempt . . . any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether or not such monetary amount is greater or lesser than is provided for under this Act . . . ." Some States have limited noneconomic damages in medical malpractice actions, but at levels higher than $250,000. Some States place aggregate limits on medical malpractice awards. Those limits would be preserved under the HEALTH Act. Additionally, the HEALTH Act provides that it "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."

President Ronald Reagan established a special task force to study the need for tort reform. That task force, called the Tort Policy Working Group, consisted of representatives of ten Reagan Administration agencies and the White House. The final report of that task force concluded as follows: "In sum, tort law appears to be a major cause of the insurance availability/affordability crisis which the federal government can and should address in a variety of sensible and appropriate ways." Indeed, the Reagan task force specifi-

[116] Henry Cohen, Legislative Attorney, American Law Division, CRS Report to Congress, Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes (February 26, 2003) at 1.

cally recommended "eliminate joint and several liability,"[117] "provide for periodic payments of future economic damages,"[118] "schedule [limit] contingency fees"[119] of attorneys, and "limit non-economic damages to a fair and reasonable amount."[120] Indeed, regarding the limit on non-economic damages, the report concluded:

> Recommendation No. 4: Limit non-economic damages to a fair and reasonable amount.
>
> Non-economic damages such as pain and suffering, mental anguish and punitive damages are inherently open-ended. They are entirely subjective, and often defy quantification. . . . Moreover, because such damages are essentially subjective, awards for similar injuries can vary immensely from case to case, leading to highly inequitable, lottery-like results. Accordingly, such damages are particularly suitable for a specific limitation."[121]

All of these recommended reforms are part of the HEALTH Act. The report also contains an extensive discussion of the harmful effects tort law has on "medical malpractice" insurance,[122] and a discussion and charts describing the impact of rising malpractice jury awards.[123]

STATE LAWS THAT LIMIT DAMAGES TO SPECIFIC AMOUNTS ARE PRESERVED UNDER THE HEALTH ACT

Laws passed by States that have already provided for, or may in the future provide for, different limits on damages in health care lawsuits are preserved under the HEALTH Act. The HEALTH Act specifically provides that "[n]o provision of this Act shall be construed to preempt . . . any State statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, whether or not such State limit permits the recovery of a specific dollar amount of damages that is greater or lesser than is provided for under this Act. . . ."

The following outlines state law in all fifty States and the District of Columbia regarding specific limits on damages in health care lawsuits.

Alabama—None; $400,000 cap on non-economic damages; $1 million cap on wrongful death damages, overturned by Smith v. Shulte, 671 So.2d 1331 (1991), cert. denied, 517 U.S. 1220 (1996).

Alaska—$250,000 cap on non-economic damages for claims involving personal injury, and a $400,000 cap on non-economic damages for claims involving wrongful death or a severe permanent physical impairment that is more than seventy percent disabling. A single cap applies regardless of the number of health care pro-

[117] Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (February 1986), at 64.
[118] Id. at 69.
[119] Id. at 72.
[120] Id. at 66.
[121] Id. at 66.
[122] Id. at 21–24.
[123] Id. at 36–37, 39–40.

viders against whom the claim is asserted or the number of causes of action filed. (2005).

Arizona—None; Article 2 sec. 31 and Article 18 sec. 6 of Arizona's constitution prohibits limiting recoverable damages.

Arkansas—None; Article 5 sec. 32 of Arkansas' constitution prohibits limiting damages recoverable for injury or death.

California—$250,000 cap on non-economic damages (since 1975); upheld in Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665 (1985).

Colorado—$1 million cap on total damages, including any derivative claim by any other claimant, of which non-economic losses shall not exceed $250,000 (including any derivative claim by any other claimant). Upon good cause shown and if the court determines such limit would be unfair, the court may award damages in excess of the limit. In this case, the court may award the present value of additional future damages only for loss of such excess future earnings or such excess future medical and other health care costs, or both. (1988). Upheld in Scholz v. Metropolitan Pathologists P.C., 851 P.2d 901 (1993). Effective July 1, 2003, the non-economic damages cap was raised to $300,000.

Connecticut—None.

Delaware—None.

District of Columbia—None.

Florida—For providers, $500,000 cap on non-economic damages for causes of action for injury or wrongful death due to medical negligence of physicians and other health care providers. Cap applies per claimant regardless of the number of defendants. Cap increases to $1 million for certain exceptions. For non-providers, $750,000 cap on non-economic damages per claimant for causes of action for injury or wrongful death due to the medical negligence of nonpractitioners, regardless of the number of nonpractitioner defendants. Cap increases to $1.5 million for certain exceptions. (2003) Previous law upheld but subject to rules on voluntary arbitration, Univ. of Miami v. Echarte, 618 So.2d 189 (1993).

Georgia—None; previous reforms included the following but were held unconstitutional in Atlanta Oculoplasty Surgery, P.C. v. Nestlehutt, 691 S.E.2d 219 (Ga. 2010) (statute limiting awards of noneconomic damages in medical malpractice cases to a predetermined amount violated state constitutional right to jury trial): $350,000 cap on non-economic damages awarded against all health care providers and a separate $350,000 cap on non-economic damages awarded against a single medical facility that can increase to $700,000 if more than one facility is involved. No more than $1.05 million can be awarded in a medical liability cause of action. Health Care Providers—Any judgment in a medical liability action, including wrongful death, against a health care provider shall not exceed $350,000 in non-economic damages regardless of the number of defendant health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based. The cap applies to each claimant, however, the term "claimant" is defined as including all persons claiming to have sustained damages as a result of the bodily injury or death of a single person. Medical Facilities—Establishes a separate $350,000 cap on non-economic damages awarded in medical liability actions, includ-

ing wrongful death, against a single medical facility including all persons and entities for which vicarious liability theories may apply, regardless of the number of separate causes of action on which the claim is based. If the lawsuit involves more than one medical facility, the total amount of non-economic damages that can be awarded against the facilities is $700,000 with a single facility not liable for more than $350,000. (2005).

Hawaii—$375,000 cap on non-economic damages, with exceptions for certain types of damages, such as mental anguish. (1986).

Idaho—$250,000 cap on non-economic damages per claimant in personal injury and wrongful death actions. The cap will be adjusted annually beginning July 1, 2004 based on the average annual wage. The limit does not apply to causes of action arising out of willful or reckless misconduct, or felonious actions. (2003) Upheld, Kirkland v. Blaine County Medical Center, 134 Idaho 464, 4 P.3d 1115 (2000).

Illinois—None; reforms struck down in LeBron v. Gottlieb Memorial Hospital, 930 N.E.2d 895 (Ill. 2010) (holding unconstitutional caps on non-economic damages and requirement of periodic payments of damages). Reforms that were struck down included the following: $500,000 cap on non-economic damages for awards in a medical liability cause of action, including wrongful death, against a physician, the physician's business or corporate entity, and personnel or health care professionals. Separate $1 million cap on non-economic damages for awards in a medical liability cause of action, including wrongful death, against a hospital and its personnel or hospital affiliates. Both caps apply to all plaintiffs in any civil action arising out of the care. The caps apply to injuries that occur after the effective date of the act. (2005); previous $500,000 cap on non-economic damages, overturned Best v. Taylor Machine Works, 689 N.E.2d 1057 (Ill. 1997). $500,000 cap on economic and non-economic damages, overturned Wright v. Central DuPage Hospital Assn., 63 Ill.2d 313, 347 N.E.2d 736 (1976).

Indiana—$750,000 cap on total damages for any act of malpractice that occurs after 12/31/89 and before 7/1/99. $1.25 million total cap for any act of malpractice that occurs after 6/30/99. Health care providers are not liable for more than $250,000 for an occurrence of malpractice any amount awarded in excess of $250,000 will be paid through the Patient Compensation Fund. (1975) Upheld, Johnson v. St. Vincent Hospital, 404 N.E. 2d 585 (1980).

Iowa—None.

Kansas—$250,000 cap on non-economic damages. This is the total amount of non-economic damages recoverable by each party from all of the defendants. (1988) Upheld, Samsel v. Wheeler Transport Services, Inc., 246 Kan. 336 (1990); previous law struck down as unconstitutional, Kansas Malpractice Victims Coalition v. Bell, 243 Kan. 333, 757 P.2d 251 (1988).

Kentucky—None. Section 54 of Kentucky's Constitution prohibits cap on damages.

Louisiana—$500,000 cap on total damages, excluding damages recoverable for medical care. A health care provider covered by the Patient's Compensation Fund shall not be liable for more than $100,000. The Patient's Compensation Fund will cover the excess

amount awarded up to the cap. (1975); Upheld caps on total damages, but future medical expenses are excluded from cap, Butler v. Flint Goodrich Hospital of Dillard University, 607 So. 2d 517 (1992); ruled unconstitutional by Louisiana Court of Appeal, Third Circuit in Arrington v. ER Physicians Group, No. 04–1235 (La. Ct. App. Sept. 2006). Vacated and set aside by Louisiana Supreme Court Arrington v. Galen-Med, Inc. (La. 06–2968 Feb. 2007).

Maine—$400,000 cap on non-economic damages in wrongful death actions. (1999).

Maryland—The limit on non-economic damages is frozen at $650,000 until January 1, 2009, after which time the cap will increase annually by $15,000 per year. Cap applies in aggregate to all claims and defendants arising from the same medical injury. (Cap also applies in wrongful death actions if the claim involves only one claimant or beneficiary). In wrongful death actions involving two or more claimants or beneficiaries, then the total cap on non-economic damages is $812,500 (125% of the cap). (2005); previous law upheld as constitutional, Murphy v. Edmunds, 325 MD 342, 601 A.2d 102 (1992).

Massachusetts—$500,000 cap on non-economic damages, with exceptions for proof of substantial disfigurement or permanent loss or impairment, or other special circumstances which warrant a finding that imposition of such limitation would deprive the plaintiff of just compensation for the injuries sustained. (1986).

Michigan—$280,000 cap on non-economic damages, adjusted annually for inflation, except in cases where the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, or where the plaintiff has permanently impaired cognitive capacity rendering him incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal, daily living, or the plaintiff has had permanent loss or damage to a reproductive organ resulting in the inability to procreate, then non-economic damages shall not exceed $500,000. As of 2003 the $280,000 cap is $359,000 and the $500,000 cap is $641,000. (1993) Upheld, Zdrojewski v. Murphy, 202 Mich. App. Lexis 1566 (2002); Upheld Smith v. Botsford General Hospital (6th Cir. 2005).

Minnesota—None.

Mississippi—$500,000 cap on non-economic damages per plaintiff for medical liability causes of action filed against a health care provider. (2004).

Missouri—$350,000 cap on non-economic damages per plaintiff irrespective of the number of defendants. Law specifies that multiple caps cannot apply to a single defendant. The law also specifies that in a personal injury case a spouse who claims loss of consortium shall be considered the same plaintiff as their spouse. In wrongful death cases, all individuals asserting a claim shall be considered a single plaintiff. (2005); previous law upheld, Adams v. Children's Mercy Hospital, 848 S.W. 2d 535 (1993).

Montana—$250,000 cap on non-economic damages per occurrence. If a single incident of malpractice injures multiple, unrelated patients, the $250,000 cap applies to each patient and all claims deriving from injuries to that patient. (1995, 1997).

Nebraska—$1.75 million in total damages. Health care providers who qualify under the Hospital-Medical Liability Act (i.e. carry minimum levels of liability insurance and pay surcharge into excess coverage fund) shall not be liable for more than $500,000 in total damages. Any excess damages shall be paid from the excess coverage fund. (1976, 1984, 1986, 1992, 2003); upheld, Prendergast v. Nelson, 256 N.W.2d 657 (1977); Gourley ex. rel Gourley v. Nebraska Methodist Health System Inc., 265 Neb. 918, 633 N.W.2d 43 (Neb. 2003).

Nevada—$350,000 cap on non-economic damages awarded to each plaintiff from each defendant. (2004).

New Hampshire—None; $875,000 cap on non-economic damages, overturned, Brannigan v. Usitalso, 587 A.2d 1232 (N.H. 1991). $250,000 cap on non-economic damages in medical malpractice, overturned, Carson v. Maurer, 424 A.2d 825 (N.H. 1980).

New Jersey—None.

New Mexico—$600,000 cap on total damages, excluding punitive damages and past and future medical care. Health care providers personal liability shall not exceed $200,000, any award in excess of this amount shall be paid by the patient compensation fund. (1992) Upheld, Fed. Express Corp. v. United States, 228 F. Supp. 2d 1267 (NM 2002).

New York—None.

North Carolina—None.

North Dakota—$500,000 cap on non-economic damages. (1995) Economic damage awards in excess of $250,000 are subject to judicial review for reasonableness. (1987); previous law struck down as unconstitutional. Arneson v. Olson, 270 N.W.2d (N.D. 1978).

Ohio—Establishes a sliding cap on non-economic damages. The cap shall not exceed the greater of $250,000 or three times the plaintiff's economic loss up to a maximum of $350,000 for each plaintiff or $500,000 per occurrence. The maximum cap will increase to $500,000 per plaintiff or $1,000,000 per occurrence for a claim based on either (A) a permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (B) a permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and person life sustaining activities. (2002) Note: The Ohio Legislature's previous attempts to enact a law with a cap on non-economic damages were overturned by the Ohio Supreme Court. For example, $250,000–500,000 sliding scale cap on non-economic damages, overturned, State ex rel. Ohio Academy of Trial Lawyers v. Sheward, 86 Ohio 3d 451, 715 N.E. 2d (1999).

Oklahoma—Two caps, one for obstetric cases and care provided in an emergency room and a separate cap for all other medical liability causes of action. $300,000 cap on non-economic damages for cases involving pregnancy, labor and delivery, care provided immediately post partum. The cap also applies in cases involving emergency-room care or medical services provided as a follow up to such care. The judge may lift the cap if the judge makes a finding, out of the presence of the jury, that there is clear and convincing evidence of negligence. The cap applies regardless of the number of parties against whom the medical negligence action is brought. (2003). $300,000 cap on non-economic damages for all other med-

ical liability causes of action. The cap applies only if the defendant has made an offer of judgment (i.e. offer to settle) and the amount of the verdict awarded to the plaintiff is less than 1‡ times the amount of the final offer of judgment. The cap applies to each medical injury regardless of the number of actions brought and adjusts annually based on any increases in the Consumer Price Index. The cap will not apply if nine or more members of the jury find by clear and convincing evidence that the defendant committed negligence or if nine or more members find by a preponderance of the evidence that the defendant's conduct was willful or wanton. These questions, however, will only be proposed to the jury if the judge makes a threshold finding that there is evidence to support such findings. (2004). Neither cap applies in wrongful death cases because the Oklahoma Constitution specifically limits damage limitations in those types of cases.

Oregon—None; $500,000 cap on non-economic damages, overturned, Lakin v. Senco Products, 987 P.2d 463 (Or. 1999). However, an earlier decision, Greist v. Phillips, 322 Or. 281, 906 P.2d 789 (1995), upheld the cap for wrongful death cases.

Pennsylvania—None. Article III sec. 18 of Pennsylvania's Constitution prohibits limiting damages for personal injuries or death. Punitive damages are capped at 2 times actual damages.

Rhode Island—None.

South Carolina—$350,000 stacked cap on non-economic damages. A claim for non-economic damages in a medical liability action against a single health care provider or single health care institution cannot exceed $350,000. If the award is against more than one health care provider or institution, the total award for non-economic damages cannot exceed $1.05 million, with each defendant not liable for more than $350,000. The cap applies separately to each claimant and adjusts annually for inflation based on the Consumer Price Index. (2005).

South Dakota—$500,000 cap on total general (non-economic) damages. (1985, revived by 1996 court decision). Struck down cap on total damages, revived cap on non-economic damages, Knowles ex. rel. Knowles v. United States, 544 N.W. 2d 183 (SD 1996).

Tennessee—None.

Texas—$250,000 cap on non-economic damages for claims against physicians and other health care providers. The cap applies per claimant regardless of the number of defendants. Also provides a $250,000 cap on non-economic damages awarded against a single health care institution and a $500,000 cap on non-economic damages if a judgment is rendered against two or more health care institutions, with the total amount of non-economic damages for each individual institution, not exceeding $250,000 per claimant, irrespective of the number defendants, causes of action, or vicarious liability theories involved. The total amount of noneconomic damages for health care institutions cannot exceed $500,000. Combining the liability limits for physicians, health care providers, and institutions, the maximum non economic damages that a claimant could recover in a health care liability claim is capped at $750,000. (2003). Proposition 12, a ballot initiative to amend the Texas Constitution to specifically allow the legislature to enact laws that place limits on non-economic damages in health care and medical

liability cases, was approved by the voters on September 13, 2003. $500,000 cap on all civil damages for wrongful death, indexed for inflation since 1977. The cap does not apply to medical, hospital, and custodial care received before judgment or required in the future. In 2002 the cap reached approximately $1.4 million. (1977, limited by 1990 court decision). $500,000 cap on non-economic damages (adjusted annually), overturned as applied to cases other than wrongful death, Rose v. Doctors Hospital, 801 S.W. 2d 841 (Tex. 1990).

Utah—$450,000 cap on non-economic damages.

Vermont—None.

Virginia—$1.5 million cap on total damages for acts occurring on or after Aug. 1, 1999. This cap is increased by $50,000 annually beginning on or after July 1, 2000 until July 1, 2006. On July 1, 2007 and July 1, 2008 the cap is increased by $75,000. The last increase shall be July 1, 2008. (1976, 1977, 1983, 1999, 2001) Upheld, Etheridge, et.al. v. Medical Center Hospitals, 237 Va. 87, 376 S.E.2d 525 (Va. 1989).

Washington—None; sliding cap on non-economic damages, overturned, Sophie v. Fiberboard Corp., 771 P.2d 711 (Wash. 1989).

West Virginia—$250,000 cap on non-economic damages per occurrence, regardless of the number of plaintiffs and number of defendants. The cap increases to $500,000 per occurrence, for the following types of injuries; permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system; or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. The limits only apply to defendants who have at least $1,000,000 per occurrence in medical liability insurance. The limits will be adjusted annually for inflation up to $375,000 per occurrence or $750,000 for injuries that fall within the exception. (2003). Upheld previous cap on non-economic damages, Robinson v. Charleston Area Med. Center, 186 W.Va. 720 (1991); Verba v. Ghaphery 552 S.E. 2d 406 (W.Va. 2001).

Wisconsin—$750,000 cap on non-economic damages. (Enacted 2006). $350,000 cap on non economic medical malpractice damages overturned as unconstitutional. Ferdon v. Wisconsin Patients Compensation Fund, 701 N.W.2d. 440 (Wis. 2005).

Wyoming—None; constitution prohibits caps.

STATES WHOSE COURTS HAVE ABUSED "OPEN COURTS" PROVISIONS TO STRIKE DOWN TORT REFORMS ENACTED BY STATE LEGISLATURES

State constitutions often contain provisions that are very malleable in the hands of activist state judges and provide an opportunity for a judge who perceives the judiciary to be the dominant branch of government to easily forget the appropriate powers of its co-equal branch, the legislature. For example, a number of state constitutions have so-called "open courts" provisions. As a practical matter, they are intended to provide citizens of a state with justice and reasonable access to the courts. Open court provisions, however, can be stretched to suggest that any time a legislature in any way limits any person's rights to sue, it is violative of the "open courts" provision. There is no state constitutional history that sug-

gests this extreme result. Respect for fundamental principles of separation of powers counsels against such an interpretation. Nevertheless, in the area of civil justice reform and judicial nullification of legislative efforts to improve the system of justice, such interpretations have spread.

The following cases are representative of those in which state courts have used a generic state constitutional provision providing that "the courts shall be open" to prohibit state legislatures from enacting tort reform:

Jackson v. Mannesmann Demag Corp., 435 So. 2d 725 (Ala. 1983) (holding statute of repose regarding improvements to real property violated open courts provision of state constitution)

Smith v. Dep't of Ins., 507 So. 2d 1080 (Fla. 1987) (statute setting $450,000 limit on noneconomic damages awards violated access to courts provision of state constitution); Owens-Corning Fiberglass Corp. v. Corcoran, 679 So. 2d 291 (Fla. Dist. Ct. App. 1996) (holding application of former statute of repose to latent asbestos injury violated access to courts provision of state constitution)

Martin v. Richey, 711 N.E.2d 1273 (Ind. 1999) (finding two-year occurrence-based statute of limitations as applied to plaintiff was an unconstitutional violation of the privileges and immunities clause and the open courts provision of the Indiana Constitution); Van Dusen v. Stotts, 712 N.E.2d 491 (Ind. 1999) (holding same); Harris v. Raymond, 715 N.E.2d 388 (Ind. 1999) (holding same)

McCollum v. Sisters of Charity of Nazareth Health Corp., 799 S.W.2d 15 (Ky. 1990) (holding five-year statute of repose for health care liability actions violated open courts provision of state constitution); Perkins v. N.E. Log Homes, 808 S.W.2d 809 (Ky. 1991) (holding that seven-year statute of repose for improvements to real property violated state constitutional prohibition against "special legislation" and, according to the court, any remedial legislation would violate provisions in the state constitution providing for open courts and limits on the power of the legislature)

Strahler v. St. Luke's Hosp., 706 S.W.2d 7 (Mo. 1986) (finding statute of limitations for health care liability actions violated access to courts provision of state constitution insofar as the statute applied to minors)

Sorrell v. Thevenir, 633 N.E.2d 504 (Ohio 1994) (holding statute providing offset of collateral source benefits received by plaintiff violated right to jury trial, due process, equal protection, right to open courts, and right to meaningful recovery provisions of state constitution); Samuels v. Coil Bar Corp., 579 N.E.2d 558 (Ohio 1991) (finding same as applied to wrongful death actions)

Daugaard v. Baltic Coop. Bldg. Supply Ass'n, 349 N.W.2d 419 (S.D. 1984) (holding that six-year statute of repose for improvements to real property violated open courts provision of state constitution)

LIMITS ON ATTORNEYS' FEES MEAN MORE MONEY GOES TO VICTIMS

The HEALTH Act's limits on attorneys' fees—the same as those provided for in California's law—will reduce lawyers' incentives to bring frivolous lawsuits while allowing more money to go directly to injured patients.

Currently, limited resources can either fund lawyers or they can fund patients in our health care system. Under the HEALTH Act, the larger a victim's demonstrable, real-life, quantifiable economic damages are, the more they will receive because lawyers will be allowed to take only 15% of awards over $600,000. Standard attorney contingency fee agreements allow lawyers to take one-third—a full 33.3%—of their client's awards, so victims are left with only 66%. The HEALTH Act would allow victims to keep roughly 75% of awards under $600,000, and 85% of awards over $600,000. Under the HEALTH Act, victims who demonstrate large losses get more, and lawyers get less.

THE HEALTH ACT ALLOWS UNLIMITED ECONOMIC DAMAGES

Nothing in the HEALTH Act denies injured plaintiffs the ability to obtain adequate redress, including compensation for 100% of their economic losses (essentially anything to which a receipt can be attached), including their medical costs, the costs of pain relief medication, their lost wages, their future lost wages, rehabilitation costs, and any other economic out-of-pocket loss suffered as the result of a health care injury. "Economic damages" include anything whose value can be quantified, including lost wages or home services (including lost services provided by stay-at-home mothers), medical costs, the costs of pain reducing drugs and lifetime rehabilitation care, and anything to which a receipt can be attached. Indeed, the terms "noneconomic damages" and "pain and suffering damages" (which the federal legislation limits to $250,000 unless a state law provides for a higher or lower limit) are misnomers: only "economic damages," which the federal legislation does not limit, can be used to pay for drugs and services that actually reduce pain.

Consequently, the HEALTH Act does nothing to hurt women and children. Any lawyer can easily produce charts proving the economic value of a stay-at-home-mom's services. Anything necessary to replace those services are economic damages that the HEALTH Act does not limit one bit. Similarly, the future income lost by an injured child constitutes economic damages that are easily proved and which would be fully available from responsible parties under the HEALTH Act.

The following are some recent, very large awards to victims of medical malpractice under California's legal reforms, which cap non-economic damages at $250,000, but which do not cap quantifiable economic damages. The HEALTH Act is modeled on California's legal reform. These cases show that reasonable legal reforms such as those in the HEALTH Act still allow for very large, multimillion dollar awards to deserving victims. Also, loses due to disfigurement can be economically quantified. The Veterans Adminis-

tration, for example, has a rating schedule that quantifies the economic costs of disfigurement.[124]

August 2010, Contra Costa County—$5,500,000
February 2010, Riverside County—$16,500,000
February 2010, Los Angeles County—$12,000,000
November 2009, Los Angeles County—$5,000,000
October 2009, Sacramento County—$5,750,000
September 2009, Los Angeles County—$7,300,000
January 2009, San Diego County—$16,000,000
September 2008, Los Angeles County—$9,000,000
April 2008, San Francisco County—$5,100,000
July 2007, Los Angeles County—$96,400,000
June 2007, Orange County—$11,700,000
May 2007, San Diego County—$5,700,000

THE KEY TO REDUCING HEALTH CARE COSTS IS A FIRM CAP ON NONECONOMIC DAMAGES

Caps on noneconomic damages are essential to the success of the HEALTH Act's reforms. Indeed, the savings of $54 billion over ten years that CBO concluded would be significantly diminished if the cap were raised over time. The key to the success of the legal reforms in California is its cap on noneconomic damages at $250,000, which is not indexed to inflation. The recent reforms in Texas also do not index the caps to inflation. The California cap has stood the test of time and remains an effective check on medical professional liability rates precisely because it was not indexed to inflation back in 1975. What may have been described by some as an arbitrary figure in 1975 has become the keystone of the only proven, long-term, legislative solution to the current crisis in access to medical care. A 2010 study showed that doubling California's cap on noneconomic damages would cost that state between $1.3 and $2.4 billion in employee and retiree benefits over a 10-year period.[125] If one extrapolates from that number, it becomes clear that linking the HEALTH Act's cap on noneconomic damages to the Consumer Price Index, or similarly linking it to inflation, would cost federal taxpayers around $14 billion or more.

The Consumer Price Index and noneconomic damages are also apples and oranges. "Pain and suffering" cannot be measured and there is no consumer price index for "pain and suffering." However, quantifiable economic damages are not limited by the HEALTH Act, and because those damages can be measured, they can and are adjusted upward in future years to account for inflationary effects on economic goods and services that can be quantified.

---

[124] See L.E. Johnson, Robert D. Ley, and Paul T. Benshoof, "Estimating Economic Loss for a Facially Disfigured Minor: A Case Study," Journal of Legal Economics (July, 1993) (The V.A. rating schedule was obtained from a Veterans Benefits Office at the V.A. Center in St. Paul, Minnesota after being advised that the V.A. disability ratings are for economic loss exclusively. The percentage disability ratings contained in the V.A. S-R-D are based on case study data on economic loss from facial disfigurement. This data was initially collected during World War II by the V.A. and has been updated from that time . . . The first component of economic loss is termed social loss. Social loss refers to the additional cost of job search which results from facial disfigurement. The second component of economic loss is what the V.A. terms industrial loss. Industrial loss refers to lost income because of lost earning capacity.").

[125] C. Paul Wazzan, Ph.D. and Dawn Eash, M.S., "Estimated Increases in State of California Employee and Retiree Costs Caused by Doubling the MICRA Cap" (June 9, 2010) at 3.

CONGRESS SHOULD ENACT A FAIR SHARE RULE

Respect for the law is fostered when it is fair and just and punishments are proportionate to the wrongs committed. As Thomas Jefferson noted, "if the punishment were only proportional to the injury, men would feel that their inclination as well as their duty to see the laws observed."[126]

The rule of joint liability, commonly called joint and several liability, provides that when two or more persons engage in conduct that might subject them to individual liability and their conduct produces a single injury, each defendant will be liable for the total amount of damages.[127] Joint liability is unfair because it puts full responsibility on those who may have been only marginally at fault.[128]

Relevant to the "fair share" rule in the HEALTH Act are Senator Lieberman's observations that

> There is a concept, joint and several liability, started out in the law as a way of proportioning responsibility when an accident was caused by a number of different parties working together in a way that caused negligence, and often it was not clear which one actually caused it. So they said everybody could be held liable regardless of the percentage of negligence. It now has grown to a point where what it really means is that somebody who is not liable, or liable very little, if they happen to have deep pockets, they can be held fully liable. That is the wrong message to send . . . . If you hurt somebody, you have to pay. If you do not, you should not have to pay. What kind of cynicism is developed when somebody who did little or no wrong ends up having to pay the whole bill because somebody else slipped up.[129]

Joint and several liability, although motivated by a desire to insure that plaintiffs are made whole, leads to a search by plaintiffs' attorneys for "deep pockets" and to a proliferation of lawsuits against those minimally liable or not liable at all. The HEALTH Act, by providing for a "fair share" rule that apportions damages in proportion to a defendant's degree of fault, prevents unjust situations in which hospitals can be forced to pay for all damages resulting from an injury even when the hospital is minimally at fault. For example, say a drug dealer staggers into the emergency room with a gunshot wound after a deal goes bad. The surgeon who works on him does the best he can, but it is not perfect. The drug dealer sues.[130] The jury finds the drug dealer responsible for the

---

[126] Thomas Jefferson, A Bill for Proportioning Crimes and Punishments in Cases Heretofore Capital, in 2 The Papers of Thomas Jefferson 492, 493 (Julian P. Boyd ed., 1950).

[127] See Coney v. J.L.G. Indus., Inc., 454 N.E.2d 197 (Ill. 1983).

[128] For example, in Walt Disney World Co. v. Wood, 515 So.2d 198 (Fla. 1987), Disney was required to pay an entire damages award, even though it was found only 1% at fault for the claimant's harm.

[129] Senator Lieberman, floor statement on the Common Sense Product Liability and Legal Reform Act (April 27, 1995).

[130] This hypothetical is not fanciful. See Ray Flanagan, "After Stabbing Son, Mom Sues Doctors," The Scranton Time Tribune (May 29, 2002) ("Mrs. Taylor and her husband, Brian, are suing . . . the obstetricians who treated her in the months before she exploded in violence that left her son, Zachary, with two punctured lungs, a severed jugular vein and scalp wounds on July 14, 2000 . . . They accuse the doctors and their employers of not adequately responding as she became more psychotic, delusional and depressed as the end of her pregnancy neared.").

vast majority of his own injuries, but it also finds the hospital 1% responsible because the physician was fatigued after working too long. Today the hospital can be made to pay 100% of the damages if no other defendant has the means to pay their share of the damages. That is unfair.

The Volunteer Protection Act of 1997[131] abolished joint liability for non-economic damages for volunteers of nonprofit organizations. That law was overwhelmingly supported by a bipartisan majority of Congress.[132] Joint liability also brought about a serious public health crisis that critically threatened the availability of implantable medical devices, such as pacemakers, heart valves, artificial blood vessels, and hip and knee joints. Companies had ceased supplying raw materials and component parts to medical implant manufacturers because they found the costs of responding to litigation far exceeded potential sales revenues, even though courts were not finding the suppliers liable. Congress responded to the crisis and enacted legislation, the Biomaterials Access Assurance Act of 1998,[133] that allows medical device suppliers to obtain early dismissal, without extensive discovery or other legal costs, in certain tort suits involving finished medical implants.

THE HEALTH ACT DOES NOT CAP PUNITIVE DAMAGES, BUT DOES INCLUDE REASONABLE GUIDELINES FOR THEIR USE

The United States Supreme Court has observed that punitive damages have "run wild" in the United States, jeopardizing fundamental constitutional rights.[134] The Supreme Court has also emphasized that "the impact of [a punitive damages award] is unpredictable and potentially substantial."[135]

The HEALTH Act does not cap punitive damages. Rather, it includes reasonable guidelines that would govern their award. Under these guidelines, a punitive damages award could not exceed the greater of $250,000, or two times the amount of economic damages that are awarded (and economic damages under the HEALTH Act are not limited at all). Federal legislation should put reasonable parameters on punitive damages to make the punishment fit the offense.[136] Proportionality has been an important part of the United States Supreme Court's consideration of the validity of criminal punishment.[137] Even serious crimes such as larceny, robbery, and arson have sentences defined with a maximum set forth

[131] Pub. L. No. 105–19, 111 Stat. 218.

[132] See Dan Carney, Volunteer Liability Limit Heads to President, Cong. Q., May 24, 1997, at 1199 ("The measure passed the House on May 21 by a vote of 390–35, and the Senate cleared it by voice vote later that day. An earlier Senate version passed May 1 by a vote of 99–1.") (omitting references to bill numbers).

[133] P.L. No. 105–230, 21 U.S.C. §§ 1601–1606.

[134] Pacific Mutual Life Ins. Co. v. Haslip, 499 U.S. 1, 18 (1991). See also Honda Motor Co., Ltd. v. Oberg, 512 U.S. 415, 432 (1994) (stating that punitive damages "pose an acute danger of arbitrary deprivation of property," raising serious due process concerns).

[135] International Bhd. of Elec. Workers v. Foust, 442 U.S. 42, 50 (1979).

[136] Congress included a cap on punitive damages for individuals and small businesses in the Year 2000 Readiness and Responsibility Act, Pub. L. 106–37, 113 Stat. 135 (1999). The "Y2K Act" established procedures and legal standards for lawsuits stemming from Year 2000 date-related computer failures.

[137] See Solem v. Helm, 463 U.S. 277, 284 (1983) ("The principle that a punishment should be proportionate to the crime is deeply rooted and frequently repeated in common-law jurisprudence"); Weems. v. United States, 217 U.S. 349, 366–67 (1910) (it is "a precept of the fundamental law" as well as "a precept of justice that punishment should be graduated and proportioned to the offense").

in a statute.[138] As former Supreme Court Justice Lewis Powell wrote, "It is long past time to bring the law of punitive damages into conformity with our notions of just punishment."[139] Under the HEALTH Act, the larger the economic losses suffered by the victim, the larger the punishment can be.

At the state level, ten States base punitive damages awards on a similar formula.[140] Academic groups have also recommended limiting punitive damages to prevent excessive punitive damages awards.[141]

Opponents of punitive damages reform argue that changes in the law are not needed because large punitive damages awards are often reduced on appeal. However, the practical reality is that the impact of potentially infinite punitive damages stretches beyond an actual award. As Yale law professor George Priest has observed: "[T]he availability of unlimited punitive damages affects the 95% to 98% of cases that settle out of court prior to trial. It is obvious and indisputable that a punitive damages claim increases the magnitude of the ultimate settlement and, indeed, affects the entire settlement process, increasing the likelihood of litigation."[142]

It has also been argued that unlimited punitive damages are needed to police wrongdoing. However, there is no credible evidence that the behavior of profit-making enterprises is less safe in either those states that have set limits on punitive damages or in the six states—Louisiana, Nebraska, Washington, New Hampshire, Massachusetts, and Michigan—that do not permit punitive damages at all.[143] Furthermore, plaintiffs in these six states have no more difficulty obtaining legal representation than in those states where punitive damages are potentially limitless.

Regarding reasonable guidelines for punitive damages, Senator Lieberman has supported an amendment providing that "punitive damages, which have been much discussed here and are an essential part of the continued bullying and bluffing that goes on in our tort system—be limited to $250,000 or three times economic damages."[144] The HEALTH Act limits punitive damages to two times economic damages.

---

[138] Some examples of federal criminal fines, even for particularly egregious crimes, do not exceed $250,000 and include the following: tampering with consumer products ($250,000 if death results), U.S. Sentencing Guidelines Manual §§ 2N1.1, 5E1.2 (1998); assault on the President ($30,000), U.S. Sentencing Guidelines Manual §§ 2A6.1, 5E1.2 (1998); bank robbery ($75,000), U.S. Sentencing Guidelines Manual §§ 2B3.1, 5E1.2; and sexual exploitation of children ($100,000), U.S. Sentencing Guidelines Manual §§ 2G2, 5E1.2 (1998). See generally Jonathan Kagan, Comment, "Toward a Uniform Application of Punishment: Using the Federal Sentencing Guidelines as a Model for Punitive Damages Reform," 40 UCLA L. Rev. 753 (1993).

[139] Lewis Powell, "The Bizarre Results of Punitive Damages," *Wall Street Journal (March 8, 1995), at A21.*

[140] AL, AK, CO, CT, FL, IN, NJ, NC, ND, TX.

[141] See American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, Punitive Damages: A Constructive Examination (1986) at 64–66 (recommending that punitive damages awards in excess of three-to-one ratio to compensatory damages be considered presumptively "excessive"); American College of Trial Lawyers, Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice 15–16 (1989), at 15 (proposing that punitive damages be awarded up to two times a plaintiff's compensatory damages or $250,000, whichever is greater); American Law Institute, 2 Enterprise Responsibility for Personal Injury—Reporters' Study (1991), at 258–59 (endorsing concept of ratio coupled with alternative monetary ceiling).

[142] George L. Priest, Punitive Damages Reform: The Case of Alabama, 56 La. L. Rev. 825, 830 (1996).

[143] See W. Kip Viscusi, "Punitive Damages: The Social Costs of Punitive Damages Against Corporations In Environmental and Safety Torts," 87 Geo. L.J. 285, 294 (1998).

[144] Senator Lieberman, floor statement on the Common Sense Product Liability and Legal Reform Act (April 27, 1995).

THE "CLEAR AND CONVINCING" RULE IS APPROPRIATELY APPLIED TO CLAIMS FOR QUASI-CRIMINAL PUNITIVE DAMAGES

The HEALTH Act provides that punitive damages may be awarded against a person in a health care lawsuit only if it 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. The "clear and convincing evidence" burden of proof standard is appropriate because it reflects the quasi-criminal nature of punitive damages. Such a standard takes a middle ground between the burden of proof standard ordinarily used in civil cases—that is, proof by a "preponderance of the evidence" —and the criminal law standard—that is, proof "beyond a reasonable doubt."

The "clear and convincing evidence" standard is the law in twenty-nine states and the District of Columbia [145] and it has been recommended by the principal academic groups that have analyzed the law of punitive damages over the past 15 years, including the American Bar Association, the American College of Trial Lawyers, and the National Conference of Commissioners on Uniform State Laws.[146] The Supreme Court has also specifically endorsed the "clear and convincing evidence" standard in punitive damages cases.[147] There is also support for the "clear and convincing evidence" standard at the federal level. The Volunteer Protection Act of 1997,[148] which was enacted with strong bipartisan support, requires "clear and convincing evidence" of punitive damages liability before punitive damages can be imposed against volunteers of nonprofit organizations.

The HEALTH Act also contains a procedural reform called "bifurcation." Under such a procedure, at either party's request, a trial would be divided so that the proceedings on punitive damages would be separate from and subsequent to the proceedings on compensatory damages. This procedure would achieve judicial economy by having the same jury determine both compensatory damages and punitive damages issues.

---

[145] See Ala. Code § 6–11–20; Alaska Stat. § 09.17.020; Cal. Civ. Code § 3294(a); Fla. Stat. ch. 768.73; Ga. Code Ann. § 51–12–5.1; Iowa Code Ann. § 668A.1; Kan. Stat. Ann. § 60–3701(c); Ky. Rev. Stat. Ann. § 411.184(2); Minn. Stat. Ann. § 549.20; Miss. Code Ann. § 11–1–65(1)(a); Mont. Code Ann. § 27–1–221(5); N.J. Stat. Ann. § 2A:15–5.12; Nev. Rev. Stat. Ann. § 42–005(1); N.C. Gen. Stat. 10–15(b); N.D. Cent. Code § 32–03.2–11; Ohio Rev. Code Ann. § 2307.80(A); Okla. Stat. Ann. tit. 23, § 9.1; Or. Rev. Stat. § 18.537; S.C. Code Ann. § 15–33–135; S.D. Codified Laws Ann. § 21–1–4.1; Tex. Civ. Prac. & Rem. Code § 41.003; Utah Code Ann. § 78–18–1; Linthicum v. Nationwide Life Ins. Co., 723 P.2d 675 (Ariz. 1986); Jonathan Woodner, Co. v. Breeden, 665 A.2d 929 (D.C. 1995); Masaki v. General Motors Corp., 780 P.2d 566 (Haw. 1989); Travelers Indem. Co. v. Armstrong, 442 N.E.2d 349 (Ind. 1982); Tuttel v. Raymond, 494 A.2d 1353 (Me. 1985); Owens-Illinois v. Zenobia, 601 A.2d 633 (Md. 1992); Rodriguez v. Suzuki Motor Corp., 936 S.W.2d 104 (Mo. 1996); Hodges v. S.C. Toof & Co., 833 S.W.2d 896 (Tenn. 1992); Wangen v. Ford Motor Co., 294 N.W.2d 437 (Wis. 1980). One state, Colorado, requires proof "beyond a reasonable doubt" in punitive damages cases. See Colo. Rev. Stat. § 13–25–127(2).

[146] See American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, Punitive Damages: A Constructive Examination 19 (1986); American College of Trial Lawyers, Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice 15–16 (1989); National Conference Of Commissioners On Uniform State Laws, Uniform Law Commissioners' Model Punitive Damages Act § 5 (approved on July18, 1996); see also American Law Institute, 2 Enterprise Responsibility for Personal Injury—Reporters' Study 248–49 (1991).

[147] See Pacific Mutual Life Ins. Co. v. Haslip, 499 U.S. 1, 23 n.11 (1991) (stating that ([t]here is much to be said in favor of a state's requiring, as many do . . . a standard of 'clear and convincing evidence'").

[148] Pub. L. No. 105–19, 111 Stat. 218.

Bifurcated trials are fair because they prevent evidence that is highly prejudicial and relevant only to the issue of punishment from being heard by jurors and improperly considered when they are determining underlying liability. For example, plaintiffs' lawyers routinely introduce evidence of a company's net worth. Although a jury is often instructed to ignore such evidence unless it decides to punish the defendant, this is very difficult as a practical matter for jurors to do. The net result may be that jurors overlook key issues regarding whether a defendant is liable for compensatory damages and make an award simply because they believe the defendant can afford to pay it. Bifurcation would help prevent that unfair result because evidence of the defendant's net worth would be inadmissible in the first, compensatory damages phase of the case. Bifurcation also helps jurors compartmentalize a trial, allowing them to more easily separate the burden of proof that is required for compensatory damage awards—that is, proof by a preponderance of the evidence—from a higher burden of proof for punitive damages, that is, proof by clear and convincing evidence.

Bifurcation of punitive damages is supported by the American Bar Association, the American College of Trial Lawyers, and the National Conference of Commissioners on Uniform State Laws, among other well-known organizations.[149]

CONGRESS SHOULD ENACT A SAFE HARBOR FROM PUNITIVE DAMAGES FOR FDA COMPLIANCE

Litigation is threatening the viability of the life-saving drug industry.[150] To help encourage new drug development and contain the costs of life-saving drugs, the HEALTH Act contains a safe harbor from punitive damages for defendants whose drugs or medical products comply with rigorous regulations.

FDA standards and regulations are rigorous. The regulatory objectives of the Food, Drug, and Cosmetics Act ("FDCA") are to ensure that the manufacturer shares all risk information with the FDA so that the agency may make informed risk-benefit judgments about the utility of a pharmaceutical. These judgments occur throughout the life of the drug. The agency determines which drugs

[149] See American Bar Association, Special Committee on Punitive Damages of the American Bar Association, Section on Litigation, Punitive Damages: A Constructive Examination (1986) at 19; American College of Trial Lawyers, Report on Punitive Damages of the Committee on Special Problems in the Administration of Justice (1989) at 18–19; National Conference Of Commissioners On Uniform State Laws, Uniform Law Commissioners' Model Punitive Damages Act § 5 (approved on July 18, 1996) at § 11; American Law Institute, 2 Enterprise Responsibility for Personal Injury—Reporters' Study 248–49 (1991) at 255 n.41.

[150] See Michael Freedman, "The Tort Mess" Forbes (May 13, 2002) ("The pharmaceutical industry has always been a ripe target for suits. The difference nowadays is simply that the dollar amounts have gotten bigger . . . . If a drug saves 100 lives for every one it loses, someone who faces certain death should not hesitate to use it. But what happens if the tort system says every death must be paid for? The average payout on a wrongful death claim increased from $1 million in 1994 to $5.7 million in 2000 (the most recent data point available), according to Jury Verdict Research. To merely break even, the drug's maker would have to charge $57,000 for every dose. It can't get away with that. So a potential wonder drug may never see the light of day. A study in the Journal of the American Medical Association estimates that 100,000 people die each year in the U.S. from drug-related deaths. If the families of each sued and won that average of $5.7 million, total liability would hit $570 billion. That's twice the combined revenues of the top 12 drug companies . . . Steven Garber, a researcher at the Rand Research Institute for Civil Justice, says drug companies are willing to take on the risk of lawsuits in marketing blockbusters like Viagra and Vioxx. But in other cases the chance of liability is too great. Garber says companies once stopped making new products for use during pregnancy because of the high risk of birth defects. Companies also limit research on orphan drugs—those that cure rare, often fatal illnesses—because the potential tort liability outweighs the profit potential.").

reach the market and the labeling for those that do. The receipt of new safety information can lead the agency, after holding a hearing, to withdraw approval for marketing of a drug.[151] The Secretary of Health and Human Services also has the authority to order the withdrawal of marketing approval without a hearing where there appears to be an "imminent hazard to public health."[152]

To obtain FDA approval for marketing a prescription drug, a pharmaceutical applicant must generate substantial pre-marketing safety and efficacy information through human clinical trials. The FDA must ensure that the proposed new drug complies with the FDCA mandate that safety be established and that "substantial evidence" of efficacy be demonstrated for the drug's proposed uses.[153] The FDA review process often takes years of evaluation. Ultimately, approval by the FDA reflects a risk-benefit judgment that the product will enhance public health. The entire process is a lengthy one, typically taking between five and seven years to complete.

The FDCA and its implementing regulations ensure that a manufacturer shares risk information with the FDA even after the product has been marketed.[154] Post-marketing surveillance consists of two primary components: reports of individual adverse experiences and epidemiologic studies. Serious reactions must be reported within fifteen working days of receipt of the information.[155] A comprehensive, post-marketing system of reporting and record-keeping requirements ensures that the manufacturer reports adverse drug experiences discovered in clinical, epidemiological, or surveillance studies, through review of the medical literature, or otherwise.[156] Post–marketing reporting obligations include the disclosure of data regarding adverse reactions outside the United States.

A few states have already specifically focused on pharmaceuticals and punitive damages and statutorily provide an FDA regulatory compliance defense against such damages.[157]

Research has also confirmed that the reason drug prices generally are so high in the United States compared to Canada, for example, is because of the much larger liability risks drugs are exposed to in this country. One researcher, for example, has concluded that

> A large part of the observed variation in the price differential [of drugs in the United States and Canada] is attributable to anticipated liability cost, and liability effects explain virtually all of the very big price differences ob-

---

[151] See 21 U.S.C. § 355(e)(1); 21 C.F.R. § 5.82.

[152] See 21 U.S.C. § 355(e).

[153] See 21 U.S.C. § 355(d) (1988) ("[S]ubstantial evidence" means evidence consisting of adequate and well- controlled investigations, including clinical investigations, by experts qualified . . . to evaluate the effectiveness of the drug involved, on the basis of which it could fairly and responsibly be concluded by such experts that the drug will have the effect it purports or is represented to have under the conditions of use prescribed, recommended, or suggested in the labeling or proposed labeling thereof.").

[154] See 21 C.F.R. § 314.80.

[155] See 21 C.F.R. § 314.80(c)(1).

[156] See 21 C.F.R. §§ 310.303(a), 314.80(c).

[157] The five states that have proscribed punitive damages where the manufacturer has complied with the FDCA are Arizona, Az.Rev.State.Ann. § 12–701; New Jersey, N.J.Sata.Ann. § 2A:58C–5(c); Ohio, Ohio.Rev.Code Ann. § 2307.80(c); Oregon, Or.Rev.Stat. § 30.927; and Utah, Utah Code Ann. § 78–18–2.

> served . . . . [T]his work indicates that liability costs must have a role in any complete explanation of international price differences. The fact that liability risk plays such a vital role in the model implies that any study of international drug pricing which ignores differences in tort law environments across countries is seriously flawed. The size of these effects is simply too large to ignore.[158]

STATUTE OF LIMITATIONS

Statutes of limitation define the time period following an injury in which a suit must be brought, in order to protect defendants from the prejudice of stale claims by requiring trials while the best evidence is still available. The best way to allow every patient her day in court while preventing prejudice to health care providers is to codify a reasonable statute of limitations, which the HEALTH Act does.

The HEALTH Act provides that a medical malpractice lawsuit must be filed no later than one year after a person discovers an injury, or within three years at the latest. The HEALTH Act makes an exception for minors under the age of six, extending the time within which a suit must be filed to the longer of three years or the date on which the minor reaches the age of eight. These provisions are based on California's MICRA law.[159] The HEALTH Act's statute of limitations provisions are designed to protect, for example, OB-GYNS's, who should not have to worry about being sued a decade or more after they have delivered a baby. Also, like the HEALTH Act, California's MICRA law includes no exception for latent injuries.

REPORT LANGUAGE: SECTION-BY-SECTION

The following discussion describes the bill as reported by the Committee.

Section 1. Short title.

Section 2. Provides for a 3-year statute of limitations with certain exceptions for minors, fraud, intentional concealment, and the presence of a foreign body.

Section 3. Provides for a $250,000 cap on noneconomic damages. Additionally, this section provides for a "fair share" rule, by which damages are allocated fairly, in direct proportion to fault.

Section 4. Provides for a sliding scale limits on the contingency fees lawyers can charge.

Section 5. Provides guidelines for the award of punitive damages, including guidelines for punitive damages awards not to exceed the greater of $250,000 or twice economic damages. Also provides a safe harbor from punitive damages for products that meet applicable FDA safety requirements, with exceptions for cases in which information required to be given to the FDA was withheld, in which illegal payments were made to the FDA, and in which the medical product was misbranded or adulterated. Additionally, includes a

[158] Richard Manning, "Products Liability and Prescription Drug Prices in Canada and the United States," 40 Journal of Law and Economics 203, 234 (1997).

[159] See Cal.C.C.P. § 340.5.

provision protecting pharmacists and doctors from being named in lawsuits for forum-shopping purposes.

Section 6. Provides authorization for courts to require periodic payments for future damages.

Section 7. Definitions.

Section 8. Provides that except as provided in the Act nothing in the Act shall affect any federal vaccine-related injury or any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

Section 9. Provides a savings clause that saves from preemption state laws that limit damages to specific amounts or that provide greater procedural or substantive protections than the provisions of this Act.

Section 10. Provides that the Act shall apply to any health care lawsuit brought in a federal or State court that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

ADVISORY ON EARMARKS

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, the HEALTH Act does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(e), 9(f), or 9(g) of rule XXI.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

CONSTITUTIONAL AUTHORITY STATEMENT

The Committee finds authority for this legislation in article I, section 8, clause 3 of the Constitution.

COMMITTEE VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the Committee advises that the following roll call votes occurred during the Committee's consideration of the HEALTH Act:

1. An amendment by Mr. Scott to strike the provision in the bill creating the fair share rule. Defeated 7 to 11.

2. An amendment by Mr. Johnson to specify that nothing in the bill shall preempt any applicable State constitutional provisions. Defeated 10 to 15.

3. An amendment by Ms. Waters to exclude lawsuits involving preexisting conditions, as defined in the Patient Protection and Af-

fordable Care Act, from the HEALTH Act's coverage. Defeated 9 to 15.

4. An amendment by Ms. Waters to exempt claims involving rescission of health insurance from the HEALTH Act's coverage. Defeated 10 to 15.

5. An amendment by Ms. Waters to allow for unlimited non-economic damages in cases that involve catastrophic injury, vegetative state, or death. Defeated 11 to 15.

6. An amendment by Mr. Nadler to increase the $250,000 caps on noneconomic damages and punitive damages to $1,977,500 and index the caps to the Consumer Price Index. Defeated 10 to 15.

7. An amendment by Mr. Nadler to index the $250,000 caps for noneconomic and punitive damages to the Consumer Price Index. Defeated 9 to 14.

8. An amendment by Mr. Nadler to strike the HEALTH Act's provisions related to medical products. Defeated 9 to 13.

9. An amendment by Mr. Nadler to add restrictions on when judges may issue protective orders and the sealing of cases and settlements. Defeated 7 to 9.

10. An amendment by Ms. Jackson Lee to add a section to the HEALTH Act exempting actions by minors from the limits on damages. Defeated 9 to 14.

11. An amendment by Ms. Jackson Lee to modify the HEALTH Act's statute of limitation provision to change the timeframe related to the manifestation or discovery of an injury related to a minor. Defeated 9 to 12.

12. An amendment by Mr. Cohen to exclude from the bill's limits on damages lawsuits related to a foreign object being left inside a patient or performing a procedure on the wrong patient or body part. Defeated 9 to 13.

13. An amendment by Mr. Deutch to apply the bill's provisions to lawsuits brought by health care providers, health care organizations, and pharmaceutical and device manufacturers. Defeated 11 to 16.

14. An amendment by Mr. Deutch and Mr. Quigley to strike the punitive damages exemption for products that comply with FDA Standards. Defeated 10 to 16.

15. An amendment by Mr. Johnson to strike the references in the bill to "State or Federal court or pursuant to an alternative dispute resolution system" and replaces those references with "Federal Court." Defeated 14 to 16.

16. Motion to order the HEALTH Act favorably transmitted to the House Budget Committee. Approved 16 to 14.

CHANGES IN EXISTING LAW

The Committee on the Judiciary advises that existing law will not change as a result of the enactment of this title.

PERFORMANCE GOALS

The Committee states that pursuant to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the HEALTH Act will improve patient access to health care services and provide im-

proved medical care by reducing the excessive burden the liability system places on the health care delivery system.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 26, 2012.

Hon. LAMAR SMITH,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2011.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2011

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 that reconciliation process, the House Committee on the Judiciary has approved legislation that would impose limits on medical malpractice litigation in state and federal courts by capping awards and attorney fees, modifying the statute of limitations, and eliminating joint and several liability.

In total, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would not have any budgetary effect in fiscal year 2012, and would reduce deficits by $0.1 billion over the 2012–2013 period, $13.6 billion over the 2012–2017 period, and $48.6 billion over the 2012–2022 period. (About $1.9 billion of that $48.6 billion total would be off-budget because of effects on revenues from Social Security payroll taxes).

CBO expects that those changes would, on balance, lower costs for health care both directly and indirectly: directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of health care services prescribed by providers when faced with less pressure from potential malpractice suits. Those reductions in costs would, in turn, lead to lower spending in federal health programs and to lower private health insurance premiums.

Because employers would pay less for health insurance for employees, more of their employees' compensation would be in the form of taxable wages and other fringe benefits. As discussed below, the bill would also increase revenues because it would result in lower subsidies for health insurance. In total, CBO and JCT estimate that enacting the legislation would increase federal revenues by about $7 billion over the 2012–2022 period. Enacting the legislation also would reduce direct spending for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits (FEHB) program, subsidies for individuals enrolled in health insurance through health insurance exchanges, and other federal health benefits programs. CBO and JCT

estimate that direct spending would decline by about $41 billion over the 2012–2022 period.

Federal spending for active workers participating in the FEHB program is included in the appropriations for federal agencies, and is therefore discretionary. The legislation would also affect discretionary spending for health care services paid by the Departments of Defense (DoD) and Veterans Affairs (VA). CBO estimates that implementing the legislation would reduce discretionary costs by about $1 billion over the 2012–2022 period, assuming appropriation actions consistent with the legislation.

The legislation contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would preempt state laws that provide less protection for health care providers and organizations from liability, loss, or damages (other than caps on awards for 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 table. The spending effects of this legislation fall within multiple budget functions, primarily functions 550 (health) and 570 (Medicare).

These estimates are based on CBO's assumption that the legislation will be enacted on or near October 1, 2012. Assuming an earlier enactment date would not change CBO's estimate of the budgetary effects of the legislation.

	By Fiscal year, in millions of dollars 2012—												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012–2017	2012–2022
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority	0	−100	−650	−2,250	−3,850	−4,850	−5,200	−5,500	−5,900	−6,300	−6,700	−11,700	−41,300
Estimated Outlays	0	−100	−650	−2,250	−3,850	−4,850	−5,200	−5,500	−5,900	−6,300	−6,700	−11,700	−41,300
CHANGES IN REVENUE													
Estimated Revenues													
On-budget	0	4	54	231	411	651	731	760	802	850	900	1,352	5,394
Off-budget	0	4	29	93	167	231	255	266	280	295	310	524	1,929
Total	0	8	83	324	578	882	985	1,026	1,082	1,145	1,210	1,875	7,323
NET INCREASE OR DECREASE (−) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND RECEIPTS													
Impact on the Deficit:													
On-budget	0	−104	704	−2,481	−4,261	−5,501	−5,931	−6,260	−6,702	−7,150	−7,600	−13,052	−46,694
Off-budget	0	−4	−29	−93	−167	−231	−255	−266	−280	−295	−310	−524	−1,929
Total	0	−108	−733	−2,574	−4,428	−5,732	−6,185	−6,526	−6,982	−7,445	−7,910	−13,575	−48,623
CHANGES IN SPENDING SUBJECT TO APPROPRIATION													
Estimated Authorization Level	0	0	−5	−40	−95	−140	−155	−165	−175	−180	−190	−280	−1,145
Estimated Outlays	0	0	−5	−40	−95	−140	−155	−165	−175	−180	−190	−280	−1,145

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

Over the 2012–2022 period, CBO and the staff of the Joint Committee on Taxation estimate that enacting the legislation would reduce direct spending by about $41 billion and increase federal revenues by about $7 billion. The combined effect of those changes in direct spending and revenues would reduce federal deficits by almost $49 billion over that period, with changes in off-budget revenues accounting for nearly $2 billion of that reduction in deficits.

In addition, CBO estimates that implementing the legislation would reduce discretionary costs for the FEHB program, DoD, and VA by about $1 billion over the 2012–2022 period.

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 the legislation would reduce national health spending by about 0.4 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 0.4 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 0.4 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 ex-

[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.* The estimated effect on national health spending reported in that letter is different from the estimated effect for this legislation because the two proposals would impose different limits on medical malpractice litigation.

changes. (The portion of 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 the legislation 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 $7.3 billion over the 2012–2022 period, according to estimates by JCT. Social Security payroll taxes, which are off-budget, account for $1.9 billion of that increase in revenues.

Direct Spending

CBO estimates that enacting the legislation would reduce direct spending for Medicare, Medicaid, the Children's Health Insurance Program, 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 $41 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 0.4 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 0.5 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]

Spending Subject to Appropriation

CBO estimates that implementing the legislation would reduce federal costs for health insurance for federal employees covered through the FEHB program by about 0.4 percent—in line with the estimated reductions in the private sector—and would reduce costs for health insurance and health care services paid for by the Departments of Defense and Veterans Affairs by lesser amounts. CBO expects that the impact on those agencies would be proportionally smaller than the impact on overall health spending because medical malpractice costs are already lower than average for entities covered by the Federal Tort Claims Act. In CBO's estimation, the cost of health insurance and health care services funded through appropriation acts would be reduced by $1.1 billion over the 2012–2022 period, assuming appropriation actions consistent with the legislation.

Estimated impact on state, local, and tribal governments: The legislation contains an intergovernmental mandate as defined in UMRA because it would preempt state laws that provide less protection for health care providers and organizations from liability,

[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.

loss, or damages (other than caps on awards for 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).

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 March 19, 2012, CBO transmitted a cost estimate for H.R. 5 as posted on the Web site of the House Committee on Rules on March 12, 2012. Title I of that bill was very similar to the reconciliation legislation, and CBO's cost estimates for this legislation and for title I of H.R. 5 are identical.

Estimate prepared by: Federal Costs: Tom Bradley and Kirstin Nelson Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Stuart Hagen.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

[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.

DISSENTING VIEWS

Introduction

Under H. Con. Res. 112, the Committee on the Judiciary is instructed to "submit changes in laws within its jurisdiction sufficient to reduce the deficit" by $100,000,000 for the period of fiscal years 2012 and 2013; by $11,200,000,000 for the period of fiscal years 2012 through 2017; and by $39,700,000,000 for the period of fiscal years 2012 through 2022."[1] I By design, these numbers parallel the reduction in spending projected by the Congressional Budget Office when it last analyzed H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act)."[2]

As a consequence, instead of addressing jobs or the economy—or even the rising cost of healthcare—the Committee has now considered H.R. 5[3] twice in the same Congress. The HEALTH Act, like the "reconciliation" vehicle that carries it, is dead on arrival in the Senate. Nevertheless, the substance of the bill is as dangerous and one-sided as it was when it was first proposed almost two decades ago.[4] The medical malpractice "crisis" it purports to address does not exist—and, if it did exist, H.R. 5 would not solve it.

I. BACKGROUND

A medical malpractice claim is a tort-based legal claim for damages arising out of an injury caused by a health care provider. Tort claims are part of the "common law," or judge-made law, of the United States civil justice system. Traditionally, tort claims have been reserved to the states.[5] All fifty states have considered some version of limited liability for medical malpractice.[6] The National Conference of State Legislatures maintains that "American federalism contemplates diversity among the states in establishing these rules."[7]

The tort system provides various benefits to society. First, it compensates patients who have been injured by the bad acts of others.

---

[1] H.R. Con. Res. 112, 112th Cong. § 201(b)(4) (2012).

[2] U.S. Congressional Budget Office, "Cost Estimate for H.R. 5 as ordered Reported by the House Committee on the Judiciary on February 16, 2011," March 10, 2011, available at *http://cbo.gov/ftpdocs/120xx/doc12095/hr5.pdf*.

[3] Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, H.R. 5, 112th Cong. (2012) (as considered in the H. Comm. on the Judiciary on April 17, 2012) [hereinafter HEALTH Act].

[4] *See* Common Sense Product Liability and Legal Reform Act of 1995, H.R. 956, 104th Cong. (1995).

[5] "Tort law at present is almost exclusively state law rather than federal law." U.S. Congressional Research Service, *Federal Tort Reform Legislation*: *Constitutionality and Summaries of Selected Statutes*, 95–797 (Jan. 28, 2010), at 1.

[6] *See* Michael I Krauss & Robert A. Levy, *Can Tort Reform and Federalism Coexist*? 514 Cato Inst. Pol'y Anaylsis (2004).

[7] National Conference of State Legislatures, *2010–2011 Policies for the Jurisdiction of the Law and Criminal Justice Committee: Medical Malpractice*, http://www.ncsl.org/default.aspx?TabID=773&tabs=855,27,671#Medical__Malpractice (last visited April 24, 2012) [hereinafter *NCSL Policy*].

Second, it deters future misconduct and carelessness that may cause injury and punishes wrongdoers who inflict such injury. Third, it prevents future injury by removing dangerous products and practices from the marketplace. Fourth, it informs an otherwise unknowing public of these harmful products or practices, thereby adding to public health and public safety.[8]

Most medical malpractice claims are based on the tort of "negligence," defined as conduct "which falls below the standard established by law for the protection of others against unreasonable risk and harm."[9] In medical malpractice cases, this legal standard is based on the practices of the medical profession,[10] and is usually determined based on the testimony of expert witnesses.

As with other torts, there are two types of remedy for medical malpractice. Courts may award compensatory damages for economic and noneconomic losses such as medical expenses, lost wages, pain and suffering, reduced life expectancy and diminished quality of life. Courts may also award punitive damages to punish and deter willful and wanton conduct.

Medical malpractice liability reform has historically attracted the attention of Congress during insurance industry "crisis" periods, which occurred during the mid-1970s, the mid-1980s, and the early 2000s.[11] These periods were marked by increases in insurance premiums, reported difficulties in finding malpractice insurance for certain medical specialties, and reports of physicians leaving geographical areas or retiring to avoid insurance difficulties. Currently, the medical liability insurance market does not exhibit crisis symptoms.[12] Moreover, the industry's cycle of "crisis" and "calm" appears to be driven more by the investment practices of insurance companies than by litigation or the legal system.[13]

Still, the federal government has a role to play in encouraging the states to adopt more efficient medical malpractice liability systems. In September 2009, President Obama directed the Department of Health and Human Services to help state governments and health care providers try alternative methods of resolving malpractice allegations.[14] Under this directive, the Agency for Healthcare Research and Quality has already funded seven demonstration and various planning grants, for a total amount of $25 million, and is currently soliciting applications for additional demonstration projects.[15] These grants support evidence-based patient safety and medical liability projects designed to reduce preventable harms, inform injured patients promptly, and promote settlement of cases through alternative dispute resolution.[16]

On March 23, 2010, President Obama signed into law comprehensive health care reform, the Patient Protection and Afford-

---

[8] Joan Claybrook, *Consumers and Tort Law,* 34 Fed. B. News & J. 127 (1987).
[9] Restatment (Second) of Torts § 282 (1965).
[10] David M. Harney, Medical Malpractice 413 (2d ed. 1987).
[11] U.S. Congressional Research Service, *Medical Malpractice: Overview and Legislation in the 112th Congress*, R41693 (March 16, 2012).
[12] *Id.*
[13] *Id.*
[14] *See* The White House, Office of the Press Secretary, *FACT SHEET: Patient Safety and Medical Liability Reform Demonstration* (Sept. 17, 2009), available at http://www.whitehouse.gov/the-press-office/fact-sheet-patient-safety-and-medical-liabilityreform-demonstration.
[15] *See* U.S. Dep't of Health & Human Services, Agency for Health Care Research and Quality, *Medical Liability Reform & Patient Safety Initiative*, http://www.ahrq.gov/qual/liability/.
[16] *Id.*

able Care Act.[17] Among other important reforms, the bill authorizes $50 million for grants to the states to develop, implement, and evaluate alternatives to current tort litigation systems.[18] Preference is given to states that have developed alternatives in consultation with relevant stakeholders to enhance patient safety, reduce medical errors and adverse events, and improve access to medical malpractice liability insurance.[19]

President Obama's FY2012 budget called for "a more aggressive effort to reform our medical malpractice system" and encouraged "Republicans to work constructively with him on medical malpractice as part of an overall effort to restrain health costs."[20] In addition, the President's FY2012 budget requested funding for "250 million in grants to states to reform the way they resolve medical malpractice reform."[21] Although Congress did not fund these grants in FY2012, the President made the same $250 million request in FY2013.[22]

II. Description of the Legislation

H.R. 5 is not "designed brilliantly to cooperate with the States in trying to encourage better practices in medicine," as its supporters maintain.[23] Rather, the bill preempts state law in all fifty states with a rigid, uniform set of rules designed to cut off restitution for victims of medical malpractice.[24]

Although it is often described as a "medical malpractice" bill, H.R. 5 extends far beyond the field of medical malpractice liability. The bill applies to all "health care lawsuits," and defines the term as "any health care liability claim concerning the provision of health care goods or services or any medical product . . . brought in a State or a Federal court or pursuant to an alternative dispute resolution system."[25] Because this definition is so broad, the bill offers new protections to medical device and pharmaceutical manufacturers, nursing homes, hospitals, HMOs, and insurance companies, among others.

This legislation limits the amount of non-economic damages—i.e., damages for pain and suffering—to $250,000. In addition, H.R. 5 eliminates joint and several liability for economic and non-economic loss.[26] Joint and several liability ensures that injured patients are fully compensated for their losses.

---

[17] Pub. L. No. 111–148.

[18] *Id.* § 10607.

[19] *Id.*

[20] The White House Office of Management and Budget, *Fiscal Year 2012 Budget of the United States Government*, at 25, http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/budget.pdf.

[21] *Id.* at 737.

[22] The White House Office of Management and Budget, *Fiscal Year 2013 Budget of the United States Government*, at 231, *http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf*.

[23] *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 16, 2011 (statement of Rep. Trent Franks, Member, House Comm. on the Judiciary).

[24] U.S. Congressional Research Service, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, R41661 (March 28, 2011).

[25] HEALTH Act, 112th Cong. § 7(7).

[26] *Id.* § 3(d). The so-called "Fair Share" rule provides: "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

Continued

The bill dramatically limits a patient's ability to recover punitive damages. First, the bill imposes a heightened standard for the recovery of punitive damages, requiring either clear and convincing evidence that the defendant acted with malicious intent to injure the victim, or that the defendant understood that the defendant understood the victim was substantially certain to suffer unnecessary injury yet deliberately failed to avoid such injury.[27] Even if a patient can meet this burden, the bill limits punitive damages to two times the amount of economic damages or $250,000, whichever is greater.[28]

The second category of punitive damages affected by the bill relates to manufacturers and distributors of drugs and medical devices. Specifically, the bill bans punitive damage liability for: (1) manufacturers of drugs and devices that are approved by the FDA, (2) manufacturers of drugs and devices that are not FDA-approved but are "generally recognized as among qualified experts as safe and effective," and (3) all manufacturers or sellers of drugs with respect to packaging or labeling defects.[29] These changes have the effect of sidestepping federal safety regulations in addition to limiting a patient's ability to recover damages in court.

H.R. 5 sets strict limits on the amount an attorney may receive in contingency fee payments. The total amount of all contingent fees for representing all claimants in a health care lawsuit may not exceed: (1) 40% of the first $50,000 recovered by the claimant(s); (2) 33⅓ % of the next $50,000 recovered by the claimant(s); (3) 25% of the next $500,000 recovered by the claimant(s); and (4) 15% of any amount by which the recovery by the claimant(s) is in excess of $600,000.[30] The bill also gives courts the authority to approve fees lower than those provided for by this formula.

H.R. 5 also imposes a restrictive statute of limitations for medical malpractice actions. A "health care lawsuit may be commenced no later than 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."[31] Although disguised as a three-year statute of limitations, the effect of this provision is that a claimant often has only one year from the date of discovering the injury to file suit. A claimant will, quite often, discover an injury on the same day an injury manifests itself. This provision cuts in the opposite direction for patients whose injuries have long latency periods. A patient might manifest symptoms of HIV or hepatitis long before discovering the cause of the injury, but have no recourse if the three-year deadline has expired.

H.R. 5 further disadvantages patients by requiring judges to permit periodic payments at the request of the defendant.[32] To the ex-

---

in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party." *Id*.

[27] HEALTH Act, 112th Cong. § 5(a).

[28] *Id*. § 5(b)(2).

[29] *Id*. § 7(c)(1).

[30] *Id*. § 4(a).

[31] *Id*. § 2 (emphasis added).

[32] *Id*. § "In any health care lawsuit, if an award of future damages . . . 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." *Id*. (emphasis added).

tent that a patient can successfully negotiate the obstacles set up by the bill, actual payment of damages could take years—assuming the defendant remains solvent.

Finally, the provisions of H.R. 5 is written to be "one-way preemptive"—i.e., with one limited exception, they only supersede state laws that are more favorable to victims. The Congressional Research Service has conducted a fifty-state survey and concluded that H.R. 5 would preempt important patient and consumer protections in all fifty states.[33] Moreover, because the bill applies to all "health care liability claims" regardless of the "theory of liability on which the claim is based," the legislation limits recovery against insurance companies for violations of even the most popular provisions of the Affordable Care Act—such as the prohibition on denying coverage for a pre-existing condition, the lifting of lifetime recovery ceilings, and mandated coverage for adult children under the age of 26.

III. General Concerns

A review of the empirical evidence gathered over the last two decades supports a number of conclusions. First, despite perennial claims to the contrary, the judicial system is not in crisis with respect to medical malpractice liability. Second, no significant savings are likely to be realized through federal "tort reform." Third, medical malpractice is a serious problem in the United States.

Opposition to the HEALTH Act includes, but is not limited to: Alliance for Justice, the Center for Justice and Democracy, the Consumer Federation of America, Consumer Watchdog, the National Consumers League, the National Consumer Voice for Quality Long-Term Care, the National Women's Health Network, and Public Citizen.

A. The Cycle of "Crisis" and "Calm" is Driven by the Investment Practices of Insurance Companies

In past sessions of Congress, supporters of the bill have pointed to a common set of symptoms in the insurance market—most often, "skyrocketing" insurance premiums and difficulties in finding medical malpractice liability coverage.[34] Restricting the ability of patients to recover damages for malpractice, they argued, would reduce the frequency of malpractice lawsuits. This would, in theory, lower medical malpractice premiums, making insurance more available to doctors and doctors more available to patients. This policy assumption—that discouraging litigation mitigates the insurance "crisis"—does not square with the facts.

From a historical perspective, Congress paid closest attention to medical malpractice liability insurance during "crisis" periods in

[33] U.S. Congressional Research Service, *Medical Malpractice Liability Reform: Legal Issues and 50-State Surveys on Tort Reform Proposals*, R41661 (March 28, 2011).

[34] *See, e.g.*, 151 Cong. Rec. H6990 (daily ed. July 28, 2005). "The costs of the tort system continue to take their toll on the Nation's economy. Medical professional liability insurance rates have skyrocketed, causing major insurers to drop coverage or raise premiums to unaffordable levels. We have heard case after case where this last occurred nationwide. . . . The HEALTH Act . . . addresses this crisis by eliminating frivolous lawsuits by making health care more accessible and more affordable." *Id.* (statement of Rep. Steve Chabot).

the mid-1970s, the mid-1980s, and the early 2000s.[35] These periods are punctuated by the same symptoms described by supporters of H.R. 5—increases in malpractice insurance premiums, claims of insurance scarcity, and stories of physicians abandoning specialties or communities because of the high cost of insurance.[36] In each instance, the "crisis" abated when the financial market stabilized.[37]

Experts attribute this cycle of crisis and calm to the investment practices of the insurance industry—not to the frequency of litigation or the size of jury awards. Joanne Doroshow, Executive Director for the Center for Justice and Democracy, testified at a hearing of the Subcommittee on Commercial and Administrative law in the 108th Congress and explained:

> Insurers make their money from investment income. During years of high interest rates and/or insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return. More specifically, insurers engage in severe underpricing to insure very poor risks just to get premium dollars to invest. But when investment income decreases because interest rates drop, the stock market plummets, and/or cumulative price cuts make profits become unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a "liability insurance crisis."[38]

This market-driven cycle repeats itself over and over again.

During the "crisis" of the 1970s, insurance companies increased premiums for medical malpractice insurance by large margins and denied coverage to doctors in certain specialties.[39] In response, the states initiated reforms designed to provide alternative sources of insurance and to reduce the volume and costs of medical malpractice claims. Physician- and hospital-owned insurance companies emerged as an alternative to traditional insurance providers, and, for at least a decade, insurance was accessible and affordable in a market dominated by these companies.

Prior to the "crisis" of the mid-1980s, a favorable investment market allowed the insurance industry to offer stable and affordable premium rates for medical malpractice insurance. When interest rates dropped in 1984, however, insurance providers responded by drastically increasing the cost of medical malpractice insurance.[40] In some instances, insurance rates more than tripled for manufacturers, municipalities, doctors, nurses, midwives, daycare centers, nonprofit groups, and other customers of liability insurance.[41]

---

[35] U.S. Congressional Research Service, *Medical Malpractice: Overview and Legislation in the 112th Congress*, R41693 (March 16, 2012).

[36] *Id.*

[37] *See, e.g.*, U.S. Congressional Research Service, *Medical Malpractice Insurance: An Economic Introduction and Review of Historical Experience*, RL31886 (Oct. 2, 2009).

[38] *Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care? Hearing on H.R. 4600 Before the Subcomm. on Commercial and Admin. Law of the H. Comm. On the Judiciary*, 107th Cong. 15 (2002) (statement of Joanne Doroshow, Executive Director, Center for Justice & Democracy).

[39] U.S. Congress, Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs,* Pub. No. OTA–BP–H–119. at 13 (1993).

[40] *Id.* at 15.

[41] *Id.*

The roots of the most recent "crisis" were described by Raul King, an economist and insurance industry expert with Congressional Research Service, at a forum held by House Democrats in 2003:

> What has happened in the 1990s, after the last medical malpractice in the mid-'80s, is that in the 1990s the markets were up. For an extended period of time, interest rates were relatively low, but the bottom line is that investments were very, very high, and they can continue to price their business in such a way to maximize premium for investment purposes.
>
> Some would argue that, starting in 2000, when not only the medical malpractice area but insurance in general, not just medical malpractice but all P&C, property and casualty insurance, when the market cycle started to turn, investments were not what they expected. Interest rates were low, and across the board rates started firming up.
>
> Incidentally, when the market is considered soft, coverage is readily available. Prices are relatively low. The insurance company will make their products available in the marketplace, and they will aggressively sell as much as they can because they want the business, and it's intensely competitive.
>
> Some would argue that this soft market that went beyond the six years but right close to ten years, and this is what the consumer groups have argued is cash flow underwriting—what Bob Hunter, for example, would argue is cash flow underwriting. They run into a problem. Their investments can't cover their premium losses and underwriting losses.
>
> So what they have to do is increase premiums dramatically. They have to in some cases withdraw from the marketplace, change the amount of insurance they'll make available, in the marketplace. Rather than selling a $500,000 policy, they'll sell only a $250,000 policy, and that's all that's available in a given state.[42]

Once again, when the bottom dropped out on the investment market, premiums increased and availability of coverage declined. Although each crisis "brought about attempts at malpractice reform in many states, it only subsided when the economy fmally recovered and interest rates rose."[43]

Both the American Medical Association and members of the insurance industry acknowledge that these periods of "crisis" are market driven. In a 2003 internal memo, the AMA's Board of Trustees recognized that "the insurance underwriting cycle is now at a point where insurers have both pricing power and a need to increase revenues through premiums as returns on investments are no longer able to subsidize underwriting losses and as insurers

---

[42] Democratic Forum on Malpractice, Feb. 11, 2003, Transcript at 32–33.

[43] Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 Penn. St. L. Rev. 1077 (2004).

have suffered large claim losses in other areas."[44] The memo explains further:

> For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market surged, investments by these historically conservative insurers rose to 10.6% in 1999, up from a more typical 3% in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of $381 million last year, down 30% from the high point in 1998, according to the A.M. Best Company, one of the most comprehensive sources of insurance industry data.[45]

When investment income became scarce, insurance companies increased premiums to turn a profit. This observation has been confumed by the National Conference of State Legislatures.[46] The Physicians Insurers Association of America reported that investment income constituted 47% of insurance company income during the "calm" of 1995, but only 31% during the "crisis" of 2001.[47]

H.R. 5 does nothing to address this boom-and-bust cycle. It does nothing about the investment practices of the insurance industry. It does nothing to repeal the anomalous McCarran-Ferguson antitrust exemption for the insurance industry, which is critical to stabilizing the medical malpractice insurance market.[48] It does nothing to require that premium increases be justified, or to permit health care providers to challenge increases when they occur. Instead, H.R. 5 pretends that a series of restrictions on patients' rights will prevent the next "crisis."

B. NO INSURANCE "CRISIS" EXISTS TODAY

Although supporters of H.R. 5 may suggest otherwise, the evidence shows that there is no insurance "crisis" today. According to the Medical Liability Monitor, premiums for medical malpractice insurance "have eased nationwide."[49] In 2009, 58 percent of premiums stayed level and 36 percent of premiums fell.[50] According to A.M. Best, after reaching an average annual increase of 14.2 percent during the height of the "crisis" in 2003, medical malpractice premiums began to fall—declining by 6.6 percent in 2007, and by an additional 5.3 percent in 2008.[51] Without any of the fed-

---

[44] American Medical Ass'n, Report 35 of the Board of Trustees (A–02) on Liability Reform, at 2.

[45] *Id.*

[46] Peter Eisler, et al., *Hype Outraces Facts in Malpractice Debate*, USA Today, Mar. 5, 2003 *available* at *http://www.usatoday.cominews/nation/2003-03-04-malpractice-cover—x.htm*.

[47] *Id.*

[48] *See Medical Liability Reform—Cutting Costs, Spurring Investment, Creating Jobs, Hearing Before the H. Comm. on the Judiciary*, 112th Cong., Jan. 20, 2011 (statement of Joanne Doroshow, Executive Director, Center for Justice and Democracy).

[49] Amy Lynn Sorrel, *Liability Premiums Stay Stable, but Insurers Warn This Might Not Last*, Am. Med. News (Nov. 23, 2009) *available at http://www.ama-assn.org/amendnews/2009/11/23//pr1121123.htm. http://www.amaassn.org/amendnews/2009/11/23//pr121123.htm. See also* Medical Liability Monitor (Oct. 2008).

[50] *Id.*

[51] U.S. Congressional Research Service, *Medical Malpractice Insurance: An Economic Introduction and Review of Historical Experience*, RL31886 (October 2, 2009) (citing A.M. Best Statistical Study, *Continued Improvement in 2005 Results as Medical Malpractice Premium Growth Subsides* (Aug. 28, 2006), and A.M. Best's Special Report, *U.S. Medical Professional Liability 2008 Market Review* (Apr. 27, 2009).

eral intervention contemplated by H.R. 5, the "crisis" of the mid-2000s appears to have peaked in 2004 and abated by 2006. Premiums have dropped in every state—whether or not court systems have been modified to limit liability for medical malpractice defendants.[52]

Medical malpractice cases are also rare and declining in number. According to the National Center for State Courts, only 4.4 percent of the civil caseload is comprised of tort cases; of these, only 2.8 percent are medical negligence cases.[53] Even that share has declined by fifteen percent over the past ten years.[54] The National Practitioner Databank, which tracks all medical malpractice payments by all physicians in the United States, confirms the same downward trend.[55]

Juries decide against medical malpractice plaintiffs more than three-quarters of the time, and damage awards in medical malpractice cases are generally proportionate to the severity of the injury.[56] In addition, jury awards are stable. An actuarial analysis conducted by J. Robert Hunter, Director of Insurance of the Consumer Federation of America, shows that the average medical malpractice payout hovered at just under $30,000 for an entire decade—from 1990 to 2000—without adjustment for inflation.[57] According to a more recent study by the National Center for State Courts, medical malpractice claims actually declined 15 percent from 1999 to 2008.[58] Insurance industry data shows that claims have dropped 45 percent after adjusting for inflation.[59]

H.R. 5 attempts to contain allegedly "rampant" punitive damages, but the evidence shows that punitive damages are rarely rewarded. According to the Bureau of Justice Statistics, in 1996 only 1.1 percent of medical malpractice plaintiffs who prevailed at trial were awarded punitive damages.[60] Only 1.2 percent of those awards were awarded by juries.[61] In 2005, there were too few medical malpractice cases in which punitive damages were awarded to provide a statistically reliable estimate of the amount of punitive damages in state courts.[62]

C. MEDICAL MALPRACTICE IS THE REAL CRISIS

At best, H.R. 5 is untimely—it is designed to lower premium rates that have already dropped, and curb damages that are rare

---

[52] Americans for Ins. Reform, *True Risk: Medical Liability, Malpracitce Insurance and Health Care* (July 2009) *available at http://insurance-reforrn.orepr/090722.html*.

[53] Nat'l Center for State Courts, *Examining the Work of State Courts: An Analysis of 2008 State Court Caseloads* (2010) *available at http://www.ncsconline.org/d*__researchksp/2008__fi1es/EWSC-2008-Online%20Version%20v2.pdf.

[54] *Id.*

[55] Nat'l Practitioner Databank, *Annual Report* (2006) *available at http://www.npdbhipdb.hrsa.gov/pubs/stats/2006*__NPDB__Annual__Report.pdf.

[56] Nat'l Center for State Courts, *Caseload Highlights: Medical Malpractice Litigation in State Courts* (April 2011) *available at http://www.courtstatistics.org/~*/media/Microsites/Files/CSP/Highlights/18__1__Medical__Malpractice__In__State__Courts.ashx.

[57] Letter from J. Robert Hunter, Director of Insurance, Consumer Federation of America, to Joanne Doroshow, Executive Director, Center for Justice & Democracy (Oct. 13, 2001).

[58] National Center for State Courts, *supra* note 55.

[59] *See* Americans for Ins. Reform, *supra* note 52.

[60] U.S. Dep't of Justice, Bureau of Justice Stat., *Tort Bench and Jury Trials in State Courts, 2005* (Nov. 2009).

[61] *Id.*

[62] *Id.*

and trending downward. In practice, the bill ignores the real medical malpractice crisis in America.

Medical error is the fifth leading cause of death in the United States.[63] In 1999, the Institute of Medicine of the National Academy of Sciences estimated that between 44,000 and 98,000 hospital deaths in the United States each year are attributable to medical mismanagement—at a cost of $29 billion annually.[64] This estimate does not include losses for medical errors at outpatient centers, physician offices, or clinics. During the period of study, the number of deaths due to medical malpractice was greater than the number of people who died due to motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).[65]

The Congressional Budget Office estimated 181,000 severe injuries occurred due to medical negligence in 2003.[66] According to a 2008 report by the Institute for Healthcare Improvement, there are fifteen million incidents of negligent medical harm each year.[67] The Joint Commission Center on Transforming Healthcare reports as many as forty wrong site, wrong side, and wrong patient procedures every week.[68] The Journal of American Medicine reports that there are 1,500 incidents of surgical tools left in patients each year.[69]

Medical malpractice pervades American society. A November 2010 study by the Office of the Inspector General of the Department of Health and Human Services found that approximately one in seven hospital patients experience a medical error, and that these errors cost Medicare $4.4 billion every year."[70] This sum does not include "additional costs required for follow-up care after the sample hospitalizations."[71] Medical errors occur in more than one in ten cases involving children with complex medical problems.[72] Two in five chronically ill patients receive care inconsistent with medical literature.[73] One fifteen-year observational study showed that 45.8 percent of patients experience at least some error while receiving medical treatment.[74]

These figures may even be under-reported. Twenty-three states have no medical error detection programs, and even those with mandatory programs likely miss a majority of the harm.[75] The *New*

---

[63] Centers for Disease Control, Nat'l Center for Health Care Stat., *Deaths/Mortality, 2010, http://www.cdc.gov/nchs/fastats/deaths.htm*.

[64] To Err is Human: Building a Safer Health System, (Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Institute of Medicine, National Academy Press 1999) [hereinafter *IOM Report*].

[65] *Id.*

[66] U.S. Congressional Budget Office, *Key Issues* 150–54 (Dec. 2008).

[67] Institute for Healthcare Improvement, *Campaign—FAQs*, *http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=6*.

[68] American Ass'n for Justice, *Medical Negligence: The Role of America's Civil Justice System in Protecting Patients' Rights* (Feb. 2011) (citing Joint Commission Center for Transforming Healthcare, Wrong Site Surgery Project *http://www.centerfortransforminghealthcare.org/projects/display.aspx?projectid=4)*.

[69] *See* Nagy, et al., *Radio Frequency Identification Systems Technology in the Surgical Setting*, Surgical Innovation, Vol. 13, No. 1 (March 2006).

[70] U.S. Dept't of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (Nov. 2010), at i–ii.

[71] *Id.* at ii–iii.

[72] Eisler et al., *supra* note 46.

[73] Lee Harris, *Tort Reform as Carrot-and-Stick*, 46 HARV. J. ON LEGIS. 163, 169 (2009).

[74] *Id.* (*citing* Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357 (2005)).

[75] Cathleen F. Crowle & Eric Nalder, *Year After Report, Patients Still Face Risks*, Times Union, Sept. 20, 2010.

England Journal of Medicine reports that "Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting."[76] The only national database of malpractice claims, the National Practitioners Databank, remains closed to the public.[77] The American Medical Association goes so far as to offer its members a primer on "How to evade a report to the NPDB."[78]

Changes to court systems that ignore patient safety do little to reverse this trend. After Texas enacted its cap on non-economic damages, complaints against Texas doctors to the state medical board rose from 2,942 to 6,000, more than half of which were focused on poor quality of medical care.[79] And yet, according to a lengthy investigation by the *Houston Chronicle*, "Texas has fumbled attempts to establish a medical error reporting system, often leaving patients to discover errors the hard way—when a mistake costs them their livelihood or the life of a loved one."[80]

The costs of medical malpractice are staggering. CRS has found that "the damage from medical malpractice usually requires additional treatment to repair, sometimes an entire lifetime of medical treatment."[81] In addition to these human costs, the total financial cost of medical malpractice—including lost income, lost household production, disability and health care costs—is estimated by the Centers for Disease Control to be between $17 billion and $29 billion each year.[82]

And yet, there is a profound disconnect between the actual incidence of medical malpractice and the insurance industry. According to one analysis published in the Harvard Journal on Legislation: "Bad doctors are not penalized by insurance companies, which do not normally take into account previous performance when assessing medical malpractice insurance rates."[83] Instead, insurance companies charge premiums based on general factors like physician speciality, without giving an "account for the competence skill, and quality of medical services provided by the physician."[84] The problem is compounded by lax discipline for habitually negligent health care providers. In one study published by N.Y.U., state licensing boards were found to have disciplined less than 17 percent of doctors with five or more medical malpractice payouts on record.[85]

This disconnect between medical malpractice and insurance coverage is the foundation for H.R. 5. By enacting sweeping changes to the court systems in all fifty states, this bill gives all health care providers—all physicians, hospitals, clinics, pharmaceutical manufacturers, device manufacturers, and insurance companies—the

---

[76] Christopher P. Landrigan et al., *Temporal Trends in Rates of Patient Harm Resulting from Medical Care*, 363 N. Engl. J. Med 2124–34 (2010).

[77] American Ass'n for Justice, *supra* note 68, at 9.

[78] AMA webpage on the National Practitioner Databank, *http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/business-management-topics/national-practitioner-data-bank.shtml*.

[79] Terry Langford, *Texas Laws are Vague, Abandoned or Unfunded*, Houston Chronicle, July 30, 2009.

[80] *Id.*

[81] U.S. Congressional Research Service, *supra* note 51.

[82] *See* Centers for Disease Control, *supra* note 63.

[83] Lee Harris, *supra* note 78 at 178.

[84] *Id.* (*citing* Catherine Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps*, 80 N.Y.U.L. REV. 391, 410 (2005) (noting that physicians are not experience-rated and, thus, both "negligent and non-negligent physicians pay similar premiums")).

[85] *Id.*

benefit of additional liability protection in cases of medical malpractice. By forcing the states to cap non-economic damages, the bill disproportionately penalizes members of vulnerable groups, such as women, children, and minorities, all of whom are more likely to realize comparatively substantial non-economic losses. Capping damages "only serves to compel the most grievously injured at the hands of the most clearly negligent and/or reckless to bear the brunt of reform."[86]

Fortunately, there appear to be effective policy solutions for addressing the medical malpractice crisis. For example, the *Wall Street Journal* has found that, by committing to patient safety, anesthesiologists have halved the rate with which they are sued for malpractice, and pay for malpractice insurance at rates lower than the rates they paid twenty years ago.[87]

Along these lines and under the leadership of the Obama Administration, the Affordable Care Act provides fmancial incentives for health care providers to improve care and reduce unnecessary errors. For example, Medicare payments will be reduced for "hospital acquired conditions"[88] and high rates of readmission.[89] The Act also creates the "Hospital Value Based Purchasing Program," which gives health care providers incentives to perform well on a set of quality measures that include efficiency, outcome, and patient experience of care.[90] These reforms are the first steps towards a national plan to address medical malpractice. The Act instructs the Center for Medicare and Medicaid Innovation to develop new concepts for improving patient care and reducing costs.[91]

Unfortunately, H.R. 5 ignores this progress. Instead of encouraging health care providers to make fewer mistakes, the bill cuts off a patient's right to be made whole when mistakes are made. Effective legislation would address the real crisis directly. H.R. 5 addresses a crisis that does not exist.

D. EVEN IF THE CRISIS DID EXIST, H.R. 5 WOULD NOT LOWER MEDICAL MALPRACTICE INSURANCE PREMIUMS

In his pitch for H.R. 5, Chairman Smith argued that, because of a statewide $250,000 cap on noneconomic damages, "the rate of increase in medical professional liability premiums in California since 1976 has been 280% lower than the rate of increase experienced in other states."[92] A closer look at the evidence will show that regulation of the insurance industry, not "tort reform," stabilized the cost of insurance in California.[93]

---

[86] Mitchell J. Nathanson, *supra* note 46 at 1109.

[87] Joseph Hallinan, *Heal Thyself: Once Seen as Risky, One Group of Doctors Changes Its Ways*, WALL ST. J., June 21, 2005, at 1.

[88] Central line infections and surgical site infections are common examples of "hospital acquired conditions." Pub. L. No. 111–148 § 3008.

[89] *Id.* § 3025.

[90] *Id.* § 3001.

[91] *Id.* § 3021.

[92] *Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 9, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

[93] *See Study Finds No Link Between Tort Reforms and Insurance Rates*, Liability Week, July 19, 1999 (quoting Sherman Joyce, President, American Tort Reform Association); Michael Prince, *Tort Reforms Don't Cut Liability Rates, Study Says*, Bus. Ins., July 19, 1999 (quoting Victor Schwartz, General Counsel, American Tort Reform Association); Press Release, *AIA Cites Fatal Flaws in Critic's Reports on Tort Reform*, Am. Ins. Ass'n, Mar. 13, 2002.

The California experience is instructive. H.R. 5 is based largely on California's "Medical Injury Compensation Reform Act" (MICRA).[94] Enacted in 1975, MICRA caps noneconomic damages at $250,000,[95] eliminates joint and several liability for noneconomic damages,[96] limits attorneys' fees on a sliding scale,[97] and imposes a strict statute of limitations on medical malpractice claims.[98] These new protections for defendants had mixed success, at best.

In 1995, a comprehensive study of MICRA's impact found: (1) per capita health care expenditures in California exceeded the national average every year between 1975 and 1993; (2) the rise in the cost of health care in California exceeded the rate of inflation every year between 1975 and 1993; (3) hospital patient costs were higher in California than in almost any other state; and (4) California's medical malpractice liability premiums nearly doubled in the twelve years following the enactment of MICRA.[99] In 1999, the California State Assembly Committee on the Judiciary concluded that medical malpractice premiums had not declined since the enactment of MICRA—California had, at best, experienced a slower rate of premium increase.[100] Further, MICRA altogether failed to decrease the number of malpractice cases filed in California courts.[101]

To the extent that the cost of insurance stabilized in California after 1975, much of the credit is owed to Proposition 103, which became law in 1988. Among other reforms of the insurance industry, Proposition 103 required insurance companies to hold public hearings before increasing premiums more than 15 percent. This requirement effectively froze the cost of medical malpractice liability insurance for many health care providers.[102] Under the rollback provisions of Proposition 103, insurance companies refunded over $1.2 million to policyholders.[103] Within three years, medical malpractice insurance had dropped in cost, on average, by 20.2 percent.[104] Reform of the insurance industry, not of the court system, lowered the cost of insurance.

---

[94] H.R. 5 incorporates "California's time-tested reforms at the Federal level." *Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 9, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

[95] Cal. Civ. Code § 3333.2.

[96] *Id.* § 1431.2.

[97] Cal. Bus. & Prof. Code § 6146.

[98] Cal. Civ. Proc. Code § 340.5.

[99] Proposition 103 Enforcement Project, MICRA: *The Impact on Health Care Costs of California's Experiment with Restrictions on Medical Malpractice Lawsuits*, 1995.

[100] Brian A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 Am. J. L. & Med. 501, 506 (2004).

[101] *Id.*

[102] Testimony of Harvey Rosenfeld, Before the House Comm. on Energy and Commerce, Feb. 10, 2003; *see also* Joseph B. Treaster, *Malpractice Insurance: No Clear or Easy Answers*, N.Y. Times, Mar. 5, 2003.

[103] *Id.*

[104] *Id.*

E. H.R. 5 WILL HAVE NO SUBSTANTIAL EFFECT ON "DEFENSIVE MEDICINE"

Supporters of H.R. 5 frequently invoke "the waste in our health care system caused by so-called 'defensive medicine.'"[105] Defensive medicine occurs, they argue, "when doctors are forced by the threat of lawsuits to conduct tests and prescribe drugs that aren't medically required."[106] The majority's briefing memo for the markup of H.R. 5 cites to a "survey from *Emergency Physicians Monthly*" as proof that "the HEALTH Act's limits on non-economic damages are essential to reducing defensive medicine," mostly because "non-economic caps are . . . physicians'" preferred choice of malpractice reform.'"[107] Although doctors certainly have financial incentives to prefer damage caps, there is little evidence that the practice of defensive medicine exists, and even less to suggest that H.R. 5 would reduce its frequency.

A landmark study by the non-partisan Office of Technology Assessment found that "[c]onventional tort reforms that tinker with the existing process for resolving malpractice claims while retaining the personal liability of the physician are [unlikely to] alter physician behavior."[108] Most defensive medicine studies since have failed to demonstrate any real impact on medical practice arising from higher malpractice premiums.[109]

The reality is that much of "defensive medicine" results, not from threat of litigation, but from financial incentives to order unnecessary tests and procedures. In a fee-for-service health care system, health care providers benefit fmancially by providing additional services.[110] The GAO has criticized the use of "self-serving" defensive medicine surveys—such as the one highlighted by the majority in its briefing memo—citing to low response rates and unscientific questioning, and concluding that "so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by positive (albeit small) benefits to patients."[111]

A June 1, 2009, article in New Yorker magazine framed the issue in more direct terms. Why had the cost of health care risen so high in McAllen, Texas?

> "It's malpractice," a family physician who had practiced here for thirty-three years said. "McAllen is legal hell," the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.
>
> That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suf-

[105] Markup of H.R. 5, *The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 9, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. ont he Judiciary).

[106] Id.

[107] Memorandum from Lamar Smith, Chairman, House Comm. on the Judiciary, to Members of the Committee (Feb. 4, 2011) at 2 (on file with author).

[108] U.S. Congress, Office of Technology Assessment, *supra* note 42, at 92.

[109] Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform,* 80 Tex. L. Rev. 1595 (2002).

[110] *Id.*

[111] U.S. General Accounting Office, *Analysis of Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* GA0–03–836 (Aug. 29, 2003).

> fering awards at two hundred and fifty thousand dollars. Didn't lawsuits go down? "Practically to zero," the cardiologist admitted.
>
> "Come on," the general surgeon finally said. "We all know these arguments are bullshit. There is overutilization here, pure and simple." Doctors, he said, were racking up charges with extra tests, services, and procedures."[112]

Additional studies have shown that doctors' fear of lawsuits is "out of proportion to the risk of being sued," that damage caps have little impact on these perceptions, and that many doctors will, wittingly or unwittingly, "exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems."[113]

That type of overstatement was evident in the Committee's January hearing on medical liability reform, where one Republican witness testified that "the cost of the practice of defensive medicine [is estimated] to be between $70 billion and $126 billion per year."[114] When pressed by Rep. Scott, however, Dr. Hoven had difficulty justifying her claim:

> Mr. SCOTT. And are you suggesting that $70 billion to $126 billion worth of cases, services were rendered that were not medically necessary, were not needed?
>
> Dr. HOVEN. That is not what I said, Congressman.
>
> Mr. SCOTT. Well, what are you saying?
>
> Dr. HOVEN. I am saying that health care delivered in the examining room, in the operating room, is driven by what is based on clinical judgment and based on assurance testing, which is documentation and proving that, in fact, that is what is wrong with a patient.
>
> When we talk about cost control in this country, we are talking about the fact that—and this goes to the whole issue of cost containment, which is, if, in fact, you would recognize my medical judgment and allow me to decide when it is important to do a test or not, then our patients would be better served.
>
> Mr. SCOTT. By not providing the services?
>
> Dr. HOVEN. If, in my judgment, they don't need it.
>
> Mr. SCOTT. And you are not able to—and you charge for services that, in your judgment, are not needed to the tune of $70 billion to $126 billion?
>
> Dr. HOVEN. I do not do that.[115]

Supporters of H.R. 5 can speak about defensive medicine in the abstract, but their expert on the phenomenon was unwilling or unable to discuss specifics.

A nonpartisan analysis confirms that the changes proposed by H.R. 5 will have a negligible impact on the behavior of physicians.

---

[112] Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care,* New Yorker, June 1, 2009.

[113] David Katz, *Physicians Still Fear Malpractice Lawsuits, Despite Tort Reforms,* Health Affairs, Sept. 2010, Vol. 29, Issue 9 available at *http://content.healthaffairs.org/content/29/9.toc.*

[114] *Medical Liability Reform—Cutting Costs, Spurring Investment, Creating Jobs, Hearing Before the H. Comm. on the Judiciary,* 112th Cong., Jan. 20, 2011 (unofficial transcript) (testimony of Dr. Ardis Hoven, Chair, Board of Trustees of the American Medical Association).

[115] *Id.*

The CBO has not found significant evidence that "defensive medicine" exists as a pervasive problem, and projects a scant 0.3 percent savings "from slightly less utilization of health care services" if H.R. 5 were to be enacted.[116] Once again, supporters of H.R. 5 point to a crisis that does not exist, and propose legislation that would not solve the problem if it did.

F. H.R. 5 WILL NOT HAVE A SIGNIFICANT IMPACT ON THE COST OF HEALTH CARE OR ON FEDERAL SPENDING

Although supporters of H.R. 5 argue that limits on medical malpractice liability will help lower the cost of health care, they have targeted a minuscule segment of annual health care spending. According to the National Association of Insurance Commissioners, medical malpractice premiums totaled approximately $11.2 billion in 2008.[117] The overall cost of health care that year totaled $2.6 trillion.[118] In practice, H.R. 5 purports to impact health care spending by taking aim at 0.004 percent of the annual health care budget.

Proponents of H.R. 5 also mention the possibility of federal budget savings, citing to a 2009 CBO study that concludes a proposal like H.R. 5 would result in a $54 billion in budget savings over ten years[119] and a 2012 CBO review of H.R. 5 as it was considered on the House floor.[120] Their use of these CBO reports are troubling for several reasons. First, it is ironic that the same House Republicans who casually dismissed $230 billion in savings identified by the CB) in the Affordable Care Act now apply such importance to asserted savings from H.R. 5. Second, $13 billion of the savings identified by the CBO has nothing to do with federal spending; rather, it results from the increased taxes health professionals will pay if H.R. 5 is enacted.[121]

Third, at least one provision of H.R. 5 is projected to increase costs. The CBO concluded that "reform of joint-and-several liability rules . . . is likely to increase the financial liability of the providers assigned the greatest share of responsibility in malpractice cases—typically physicians."[122] Fourth, "because many states have already implemented some of the changes in the package, a significant fraction of the potential cost savings has already been realized."[123]

Finally, supporters of H.R. 5 miss the narrow scope of the CBO analysis. CBO only concerns itself with the immediate effects of this legislation on the federal budget. It does not account for the full social and financial cost of enacting H.R. 5. The CBO admits as much: "There is less evidence about the effects of tort reform on people's health, however, than about the effects health care spend-

[116] U.S. Congressional Budget Office, Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice ("Tort Reform"), Letter to the Hon. Orrin G. Hatch, Oct. 9, 2009, available at *http://www.cbo.gov/doccfm?index=10641* [hereinafter CBO Letter].

[117] NAIC, *Countrywide Summary of Medical Malpractice Insurance, Calendar Years 1991–2008* (Sept. 1, 2009).

[118] CBO Letter, *supra* note 116.

[119] *Id.*

[120] U.S. Congressional Budget Office, "Cost Estimate for H.R. 5 as ordered Reported by the House Committee on the Judiciary on February 16, 2011," March 10, 2011, *available at http://cbo.gov/flpdocs/120xx/doc12095/hr5.pdf.*

[121] CBO letter, *supra* note 116.

[122] *Id.*

[123] *Id.*

ing—because many studies of malpractice costs do not examine health outcomes."[124]

In the long term, victims of malpractice who are injured but denied full restitution require additional support from Medicare, Medicaid, and other government programs. Moreover, the CBO letter acknowledges that, if the changes contemplated in H.R. 5 are enacted, the U.S. morality rate will increase by as much as 0.2%.[125] That constitutes an additional 4,853 Americans killed every year, or 48,250 Americans over the ten-year period CBO examines.[126] In our judgment, that is too high a price to pay for this legislation. H.R. 5 leaves the families of these patients without full recourse, and leans on the federal government to make up much of the difference.

IV. States' Rights and Federalism Concerns

The majority has sent decidedly mixed messages with respect to states' rights. In the first markup of the bill, supporters of H.R. 5 argued that "bringing a medical liability lawsuit is an activity that substantially affects interstate commerce. There is no federalism concern with this legislation."[127] This claim did not sit well with many members of the majority.[128] Notably, six members of the majority did not support H.R. 5 when it was on the House floor: Reps. Chaffetz and Marino did not vote; Reps. King and Sensenbrenner voted "present"; Reps. Gohmert and Poe voted "no."

Proponents of H.R. 5 conceded at least the existence of a states' rights problem, promising to work on an amendment to address the issue prior to debate on the House floor.[129] No such amendment was ever shared with the Democratic members of the committee, and none was introduced on the House floor. In fact, in both 2011 and 2012, the majority voted down amendments that would have addressed this issue directly.

Simply put, H.R. 5 is a direct attack on states' rights. The Congressional Research Service has concluded that the bill preempts the law in all fifty states. Its so-called "state flexibility" provision does almost nothing to mitigate serious federalism concerns.

A. The States Set the Rules for Their Own Court Systems, and Federalism Permits Diverse Systems to Coexist

Historically, the states have been allowed to set their own rules for their own court systems. The two litigants in a medical mal-

---

[124] *Id.*

[125] CBO letter, *supra* note 116.

[126] Based on 2,436,264 annual deaths, according to the Center for Disease Control and Prevention. Centers for Disease Control, supra note 63.

[127] *Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan,* 112th Cong., Feb. 9, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

[128] "I got problems with that. I think it's a violation of the Tenth Amendment, and I don't believe the Federal Government has any more authority to regulate health care under the Commerce Clause than it does to regulate liability caps in states under the Commerce Clause." *Id.* (statement of Rep. Ted Poe, Member, House Comm. on the Judiciary).

[129] "I want to reassure the gentleman from Georgia and the gentleman from North Carolina, and particularly two gentlemen from Texas on my side, that we are actively working on an amendment for the House floor that would empower States to have control over what aspect of this law would apply to the States or whether the law would apply to those States at all." *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan,* 112th Cong., Feb. 16, 2011 (statement of Rep. Lamar Smith, Chairman, House Comm. on the Judiciary).

practice case are usually an in-state plaintiff and an in-state physician.[130] Except in limited circumstances, malpractice cases can only be filed in state court.[131] Even when malpractice cases can be filed in federal court, those courts apply state malpractice law.

All fifty states have considered some changes to their tort systems, and different states have adopted different approaches to the issue of medical malpractice liability. The National Conference of State Legislatures (NCSL), a bipartisan organization representing the elected legislators and professional staffs of all fifty state legislatures, maintains that "American federalism contemplates diversity among the states in establishing these rules."[132]

All fifty states have statutes of limitations in place with respect to negligence cases.[133] All fifty states have rules of evidence to provide for the full and fair adjudication of lawsuits.[134] Some states—Colorado, Florida, Illinois, Maryland, Michigan, Texas, and West Virginia, among others—have already enacted medical malpractice damage caps of their own.[135] Other states—including Arizona, Connecticut, Iowa, Kentucky, New York, Oregon, Tennessee, and Wyoming—have expressly chosen not to limit medical malpractice damages, in some instances by amendment to the state constitution or popular referendum.[136] Federalism allows each state to choose the rules for medical malpractice cases that best fit the particular needs of its citizens, and permits diverse systems to flourish and to coexist.

B. H.R. 5 PREEMPTS STATE LAW IN ALL FIFTY STATES

H.R. 5 overturns this entire federalist approach to medical malpractice liability reform to impose a uniform set of rules on the states. No state is immune.[137] No state has adopted the bill's precise regime of $250,000 caps on noneconomic damages, $250,000 caps on punitive damages, elimination of joint-and-several liability, and a three-year limited statute of limitations.[138] Moreover, no state 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,"[139] in a law to reform "medical malpractice" liability.

The National Conference of State Legislatures categorically rejects the "one-size-fits-all approach to medical malpractice envisioned in H.R. 5" and has reached the "resounding bipartisan conclusion" that "federal medical malpractice legislation is unneces-

---

[130] *See* Michael I. Krauss & Robert A. Levy, *supra* note 6.

[131] Medical malpractice cases filed in federal court are based on diversity jurisdiction; e.g., where the parties reside in different states.

[132] CSL Policy, *supra* note 7.

[133] *Id.*

[134] *Id.*

[135] Colo. Rev. Stat. § 12–64–302; Fla. Stat. §§ 766.118 and 768.73; 735 Ill. Comp. Stat. § 5/2-1115; Md. Code, Cts. & Jud. Proc 3–2A–09; Mich. Comp. Laws § 600.1483; Tex. Civ. Proc. & Rem. Code § 74.301; W. Va. Code § 55.7B.8.

[136] *See, e.g.,* Ariz. Const., Art. 2, sec. 31. "No law shall be enacted in this state limiting the amount of damages to be recovered for causing the death or injury of any person." *Id. See also* Ark. Const. Art. 5, sec. 32; Ky. Const. Sec. 54; Penn. Const., Art. III, sec. 18.

[137] U.S. Congressional Research Service, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages,* RL31692 (Jan. 18, 2006).

[138] *Id.*

[139] HEALTH Act, 112th Cong. § 7(7).

sary."[140] In a letter to the Chairman and Ranking Member of the Judiciary Committee, NCSL argues further that its opposition to H.R. 5 "will extend to any bill or amendment that directly or indirectly preempts any state law governing the awarding of damages by mandatory, uniform amounts or the awarding of attorney's fees."[141]

With two limited exceptions, H.R. 5 explicitly preempts the states in every area of law it reaches—statutes of limitation, attorney's fees, rules of evidence, suits against pharmaceutical and device manufacturers, and caps on punitive damages.[142]

The first exception exists solely to further disadvantage victims of medical malpractice. H.R. 5 does not preempt any law "that imposes greater procedural or substantive protections for healthcare providers and healthcare organizations."[143] In effect, any state law that goes further than H.R. 5 to favor defendants—e.g., a law that provides for shorter statutes of limitation, imposes lower caps on punitive damages, or removes consumer protections in instances of fraud[144] or bribery[145]—stays on the books.

The second exception to general preemption—the "State Flexibility" provision—is, at best, misnamed. Any state law that "specifies a particular monetary amount of compensatory or punitive damages" avoids preemption by the $250,000 cap on noneconomic damages imposed by H.R. 5.[146] This provision allows existing monetary caps on medical liability damages to stand. But it also forces states without the full range of damage caps contemplated by H.R. 5 to adopt a specific scheme. For example:

> *Arizona.* The Arizona state constitution explicitly prohibits any statutory limit on the amount of damages recoverable by a plaintiff in a medical malpractice suit.[147] H.R. 5 would preempt the state constitution and force Arizona to adopt a $250,000 cap on noneconomic damages in all health care lawsuits. H.R. 5 also preempts similar provisions in the state constitutions of Arkansas, Kentucky, and Pennsylvania.
>
> *Connecticut.* Connecticut imposes several procedural requirements on medical malpractice litigants, but does not include caps on damages.[148] H.R. 5 would preempt state law and force Connecticut to adopt a $250,000 cap on noneconomic damages in all health care lawsuits.
>
> *California.* California caps only noneconomic damages for medical malpractice claims involving licensed medical professionals.[149] Under H.R. 5, it would be forced to cap damages on

---

[140] Letter from Nevada Assemblyman William Horne, Chair, NCSL, and Texas Rep. Jerry Madden, Immediate Past Chair, NCSL, to Rep. Lamar Smith and Rep. John Conyers, Feb. 16, 2011. *See also* Letter from South Dakota Sen. Joni Cutler, Co-Chair, NCSL Committee on Law and Criminal Justice, and Mississippi Rep. Tommy Reynolds, Co-Chair, NCSL Committee on law and Criminal Justice, to Speaker John Boehner and Minority Leader Nancy Pelosi, March 14, 2012.

[141] *Id.*

[142] HEALTH Act, 112th Cong. § 9(a).

[143] *Id.* § 9(b)(2).

[144] *Id.* § 5(c)(4).

[145] *Id.*

[146] *Id.* 9(c).

[147] Ariz. Const., Art. 2, sec. 31.

[148] Conn. Gen. Stat. §§ 51–251c and 52–584.2.

[149] Cal. Civ. Code § 3333.2.

cases involving nursing homes, pharmaceutical companies, and the insurance industry.

Indiana. Indiana caps total compensatory damages at $1,250,000 overall and $250,000 per health care provider, with no limit for wrongful death claims.[150] Under H.R. 5, it would be forced to cap damages in wrongful death suits, as well as in cases involving nursing homes, pharmaceutical manufacturers, and insurance companies.

Texas. Texas caps noneconomic damages in cases involving medical professionals and health care institutions, but not in cases involving the drug and device industry.[151] Under H.R. 5, it would be forced adopt a $250,000 cap in such cases.

In sum, no state will go unaffected by the H.R. 5. The "state flexibility" provision provides for very little actual flexibility.

C. THE MAJORITY SENDS MIXED MESSAGES ON STATES' RIGHTS AND H.R. 5

The federal government has an important role to play in controlling the costs of health care. Supporters of H.R. 5 have invoked a broad "effect on interstate commerce" as constitutional justification for the bill.[152] Specifically, they find that "the health care insurance 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."[153] Because the health care and insurance industries have a massive impact on the national economy, Congress has the authority and reason to act where the individual states are unable to address the issue separately.

For the past two years, supporters of H.R. 5 have argued precisely the opposite with respect to the Affordable Care Act.[154]

In fact, the majority has argued both sides of the states' rights question on the same day. On the morning of February 16, 2011, in a full committee hearing on "The Constitutionality of the Patient Individual Mandate," Republican members described the Affordable Care Act as a massive overreach of the federal government and a clear violation of the Tenth Amendment.[155] Chairman Smith argued further that "if the individual mandate is upheld" by the Supreme Court, "it would be the end of federalism.[156] Later that afternoon, in the continued markup of H.R. 5, Republican members of the committee voted twice—by party line both times—to reject

---

[150] Ind. Code § 34–18–4–3.

[151] Tex. Civ. Proc. & Rem. Code § 74.301.

[152] Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, H.R. 5, 112th Cong. (2011) (as considered in the H. Comm. on the Judiciary on Feb. 9, 2011; the findings section was struck in the version considered this year), § 2(a)(2).

[153] *Id.*

[154] *See, e.g.,* Rep. Lamar Smith, *Updated Health Care Frequently Asked Questions (FAQ) available at http://lamarsmith.house.gov/Issues/Issue/?IssueID=13970* ("I co-sponsored legislation that increases funding for state-based programs providing health insurance to individuals unable to obtain affordable insurance from private insurers. This bill passed by Congress is a massive overreach of government control.").

[155] "I think that [the Affordable Care Act] expanded the Commerce Clause beyond the intentions of the Founding Fathers and the concepts that we basically hold today. . . . [I]f Obamacare is upheld as constitutional . . . then what could be constrained by the Commerce Clause?" *The Constitutionality of the Patient Individual Mandate: Hearing Before the H. Comm. on the Judiciary,* 112th Cong. (Feb. 16, 2011) (statement of Rep. Steve King, member, H. Comm. on the Judiciary).

[156] *Id.* (statement of Rep. Lamar Smith, chairman, H. Comm. on the Judiciary).

amendments to the bill that would have allowed existing state laws to stand.[157]

The majority's position on states' rights took an even stranger turn when the committee considered an amendment to "repair certain provisions in the McCarran-Ferguson Act which currently exempt medical malpractice insurers from Federal antitrust laws."[158] In opposition to the amendment, the majority argued:

> Under our current system, Mr. Chairman, State regulation of health insurance, State regulators have authority to prevent rates that are excessive, inadequate, or unfairly discriminatory . . . . By letting Department of Justice and FTC second guess State insurance regulator's competition policies, this amendment would disrupt subtle law in nearly every State in the Union.[159]

The majority opposed this amendment because it would have preempted state law. To summarize: the majority was in favor of states' rights in the morning and opposed to states' rights in the afternoon—except while debating this amendment, when the majority favored states' rights again.

To their credit, some members of the majority have made public comments pointing out this inconsistency.[160] Others are content to repeat the fiction that H.R. 5 "specifically exempts state laws and does not change what states have already adopted."[161]

V. Specific Concerns with the Legislation

H.R. 5 imposes new restrictions on medical malpractice cases. It applies these restrictions across the board—no matter how much merit a case may have, regardless of the negligence at issue or the severity of the injury. The provisions of H.R. 5 are unjust and unfair. The following are just a few of the most pressing problems with the bill.

A. THE $250,000 CAP ON NONECONOMIC DAMAGES IS UNFAIR AND DISCRIMINATORY.

The $250,000 cap on noneconomic damages is manifestly unfair. It discriminates against women, children, and other vulnerable members of society and does account for the effects of inflation. The

---

[157] *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan,* 112th Cong., Feb. 16, 2011. Amendments introduced by Rep. Hank Johnson would have struck preemption language in H.R. 5 and permitted existing state medical malpractice liability laws (or, in the alternative, relevant provisions of state constitutions) to remain in effect. At least two members of the majority were "noticeably absent from the room" when these amendments were rejected. Brett Coughlin, *House Judiciary Approves Tort Reform,* Politico, Feb. 16, 2011 *available at http://www.politico.cominews/stories/0211/49703.html.*

[158] *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan,* 112th Cong., Feb. 16, 2011 (statement of Rep. Maxine Waters, member, H. Comm. on the Judiciary).

[159] *Id.* (statement of Rep. Trent Franks, member, H. Comm. on the Judiciary).

[160] Comparing the Affordable Care Act to H.R. 5, Rep. Ted Poe remarked: "to be consistent, they're both not covered under the Interstate Commerce [Clause]. I don't think the Constitution gives the Federal government any authority in either one of those areas." *Markup of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan,* 112th Cong., Feb. 9, 2011 (statement of Rep. Ted Poe, member, H. Comm. on the Judiciary). Notably, Rep. Poe voted against final passage of H.R. 5 on the House floor on March 22, 2012.

[161] *Id.* (statement of Rep. Lamar Smith, Chairman, H. Comm. on the Judiciary).

bill's sweeping definition of "health care lawsuit" gives the cap a particularly insidious reach.

H.R. 5 imposes an arbitrarily low cap on noneconomic damages in every case, regardless of the negligence or the extent of injury involved. This one-size-fits-all approach objectifies patients and gives the courts little room to restore any loss that does not come with a price tag. The cap does nothing but stop the most severely injured patients from receiving adequate compensation.[162] It is patently unfair.

Some malpractice cases clearly call for damages that exceed $250,000. At a forum hosted by Democratic members in 2003, Kathy Olsen described her son's injuries.[163] When Steve Olsen was two-years-old, he fell on a stick in the woods. His infection was severe enough that the Olsens asked for a CAT scan, but Steve's doctor administered a steroid injection and sent him home without further treatment. The next day, Steve returned to the hospital in a coma, permanently blind and brain damaged from a growing brain abscess. At trial, a jury concluded that the doctor had committed malpractice. Given the magnitude of the injury—Steve had no lost wages, but he would never play sports, work, or enjoy normal relationships with his peers—the jury awarded the Olsens $7.1 million in "noneconomic" damages. Because the case was subject to California's medical malpractice cap, the judge was forced to reduce the award to $250,000.

Mrs. Olsen testified: "California's malpractice law has failed innocent patients, consumers, and taxpayers. Under this law people are victimized twice, once by the wrongdoer and again by the laws that deny them the right to hold the wrongdoer accountable."[164] As to the cap on damages, Mrs. Olsen observed that the "law is regressive by hurting the most seriously injured victims, those who are permanently and catastrophically injured by medical negligence. . . . In California, and now proposed nationwide, no matter how old you are or how disabled you become or how catastrophic your injuries are, there is a one size fits all limit on your pain and suffering."[165]

The $250,000 cap is a particular burden on women, children, seniors, and the poor. Proportionally, these patients have more trouble demonstrating lost wages and other economic losses. Studies of medical malpractice cases show that women recover economic damages in lower amounts because they receive lower overall wages.[166] Women are three times more likely than men to receive noneconomic damages.[167] Women are far more likely to suffer severe noneconomic loss (e.g., loss of fertility or disfigurement) or to be a victim of the type of conduct that leads to punitive damages (e.g., sexual assault, fraud, false imprisonment, and extreme violation of

---

[162] A survey by the RAND Corporation found that the "most significant impact" of California's $250,000 cap "falls on patients and families who are severely injured or killed as a result of medical negligence or mistakes." ConstunerWatchDog.com, RAND Study: California Patients Killed or Maimed by Malpractice Lose Most Under Damage Caps, *http://www.consumerwatchdog.org/newsrelease/rand-study-california-patients-killed-or-maimed-malpractice-lose-most-under-damage-caps.*

[163] Democratic Forum on Malpractice, Feb. 11, 2003, Transcript at 60.

[164] *Id.* at 62.

[165] *Id.*

[166] *See* Thomas Koenig & Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise,* 70 Wash. L. Rev. 1 (1995).

[167] *Id.* at 84.

medical standards).[168] With the cap on noneconomic damages in place, a woman without a salary is limited to $250,000 to compensate for these injuries.

These effects are more than theoretical. After undergoing a double mastectomy, Linda McDougal was told that she had never had breast cancer—a pathologist had mixed up her charts with those of another patient.[169] Although she recovered $8,000 in lost wages and $48,000 in medical bills, her actual losses were profound:

> My scars are not only physical, but emotional as well . . . . My disfigurement from medical negligence is almost entirely noneconomic . . . . I could never have predicted or imagined in my worst nightmare that I would end up having both of my breasts removed needlessly because of a medical error. No one plans on being a victim of medical malpractice, but it happened.[170]

The cap on non-economic damages puts a price tag on the worst types of physical and psychological trauma. Under H.R. 5, Mrs. McDougal would be entitled to $250,000 for her permanent disfigurement, nothing more.

On May 29, 2010, Connie Spears went to a San Antonio hospital reporting excruciating leg pain. Mrs. Spears had experienced blood clots before, so frequently and some so severe that doctors had installed a filter in one of her heart's main veins. In the San Antonio emergency room, however, the doctor on call diagnosed Mrs. Spears with "bilateral leg pain" and told her to follow up with her primary care physician. Three days later, in immense pain and with her legs a burgundy color, Spears called 911 and was transported by ambulance to a different hospital. This time, doctors determined that the 54–year-old's vein filter was severely clotted and had led to tissue death in her legs and kidney failure. When Mrs. Spears regained consciousness weeks later, she learned that doctors had amputated both of her legs to save her life.[171] "'Do you know what it's like not to have any legs?' Mrs. Spears asked tearfully, trembling as she lifted her dress to reveal the thick pink scars stretched like pillow seams across her thighs. 'It's ruined all of our lives.'"[172] Under H.R. 5, Mrs. Spears would be limited to $250,000 as compensation for the trauma of losing her legs.

The $250,000 cap in H.R. 5 is pegged to the amount adopted by California in 1975, at a time when noneconomic damages rarely exceeded $250,000. More than thirty years later, inflation has taken its to11.[173] Translated into 2011 dollars, the $250,000 cap imposed in 1975 is worth about $61,000 today. If adjusted to reflect inflation in medical care value, the cap would be worth almost $2 million today.

Many states have adopted some form of cap on medical malpractice damages, but no state has capped damages in all "health

---

[168] *Id.*

[169] Democratic Forum on Malpractice, February 11, 2003, Transcript at 48.

[170] *Id.* at 50–51.

[171] Emily Ramshaw, *State's Tort Reform Makes Lawyers Wary of Taking on Patients,* N.Y. Times, Dec. 19, 2010, at A39.

[172] *Id.*

[173] *See* U.S. Congressional Research Service, *Medical Malpractice Liability Reform: Legal Issues and 50–State Surveys on Tort Reform Proposals,* R41661 (March 28, 2011).

care lawsuits," as H.R. 5 defines the term.[174] H.R. 5 reaches all suits "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."[175] The bill is an unprecedented experiment in limiting the rights of patients as they face insurance companies, HMOs, pharmaceutical and device manufacturers, and other entities that have nothing to do with traditional medical malpractice.

Because of the uncertain interaction between the bill's definition of "economic damages" and existing state law, caps on noneconomic damages have a particularly harmful effect on children. In the 2011 markup, Rep. Debbie Wasserman Schultz offered an amendment to exempt minors from the $250,000 cap on noneconomic damages. She reasoned: "the basis of the amendment is just common sense. Children don't work. Like women and the elderly who tend to be in lower wage jobs, children are even more disproportionately impacted by these noneconomic damage."[176] In response, supporters of H.R. 5 argued that "the reality is that the economic damages accrue to the parents, and the parents certainly have the right to sue on behalf of economic damages in a limitless capacity."[177] Although the majority was unable to name a single malpractice case in which parents recovered economic damages on behalf of an injured child, they defeated the amendment along party lines.[178]

H.R. 5 defines "economic damages" as "objectively verifiable monetary losses . . . such as past and future medical expense, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities."[179] On its face, this provision appears to be of limited use to children, who do not work, and the elderly, who may not have significant future earnings.

These limits on recovery have real consequences. In 2008, 17–year-old Olivia Cull was in the process of finishing her senior year at the Archer School for Girls, where she was an accomplished scholar, actress, and musician. She had been accepted early into Smith College and planned to major in Classical Studies and Ancient Arts and Languages. That year, Olivia underwent a routine cardiac catheterization to assess a congenital heart condition. The procedure was without incident, but later, while Olivia was still under general anesthesia, a cardiology fellow-in-training pulled the catheter lines and caused Olivia's heart rate, pulse, and blood pressure to drop rapidly. Basic cardiopulmonary resuscitation was not started for more than ten minutes. Olivia suffered severe and extensive brain damage, never regained consciousness, and died on

---

[174] *Id.*

[175] HEALTH Act, 112th Cong. § 7(7).

[176] *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan*, 112th Cong., Feb. 16, 2011 (statement of Rep. Debbie Wasserman Schultz, member, H. Comm. on the Judiciary).

[177] *Id.* (statement of Rep. Trent Franks, member, H. Comm. on the Judiciary).

[178] Rep. Jackson-Lee offered these amendments again on April 17, 2012. They were again defeated on party lines. *Full Committee Markup of: Committee Print of Material to be Transmitted to the Committee on the Budget Pursuant to Section 201 of H. Con. Res. 112*, 112th Cong. April 17, 2012.

[179] HEALTH Act, 112th Cong. § 7(6).

January 20, 2009.[180] It is difficult to put a price tag on the loss caused to Olivia's parents, but it cannot be measured by "objectively verifiable monetary losses" and should not be capped at $250,000.

B. THE ABOLITION OF JOINT AND SEVERAL LIABILITY CREATES AN UNFAIR STANDARD FOR THE PATIENT (SECTION 3(D))

Joint and several liability has been part of American common law for centuries.[181] The doctrine provides that all tortfeasors who are responsible for an injury are "jointly and severally" liable for the claimant's damages. A patient can sue all responsible defendants and recover from each one in proportion to degree of fault, or sue any one defendant and recover the total amount of damages. A defendant who pays more than his or her share is then entitled, under the doctrine of contribution, to seek compensation from other responsible parties based on their degree of fault.[182] The doctrine is designed to ensure that patients of wrongful conduct are able to fully recover damages for their injuries, especially when one or more of the defendants is insolvent.

H.R. 5 replaces this doctrine with its so-called "Fair Share" rule, which provides: "each party shall be liable for that party's share of any damages only and not for the share of any other person. . . . A separate judgment shall be rendered against each party for the amount allocated to such party."[183] In practice, H.R. 5 would require a patient to demonstrate each defendant's proportional responsibility for an injury.

This burden is unfair. Plaintiffs would be required to bring a separate case against each defendant, "each requiring a fmding of duty of care, a breach of that duty, proximate cause, fmding damages, and a determination of what part of total damages are attributed to which malpractice. Each case requires an expert witness, depositions, and the full expense of complicated litigation."[184] The rule is also unnecessary. As Rep. Scott argued in the 2011 markup: "Health care providers already can agree, in advance, how to apportion responsibility and they provide insurance and all pay premiums and set fees for services accordingly."[185] Although H.R. 5 is based on California's medical malpractice law, not even California eliminates joint and several liability for economic damages. The CBO notes that this particular proposal will actually increase the overall cost of health care.[186]

Rather than engage in debate on the facts, supporters of H.R. 5 turned to a tired anecdote to support this provision:

Say a drug dealer staggers into an emergency room with a gunshot wound after a deal dealing drugs goes bad. The surgeon works

---

[180] American Ass'n for Justice, *The Real Victims of HR. 5* (Feb. 2011).

[181] *See, e.g.,* Michael L. Rustad & Thomas H. Koenig, *Taming the Tort Monster: The American Civil Justice System As A Battleground of Social Theory,* 68 BROOK L. REV. 1 (Fall 2002); Matthew W. Light, *Who's the Boss?: Statutory Damage Caps, Courts, and State Constitutional Law,* 58 Wash. & Lee L. Rev. 315 (Winter, 2001).

[182] Restatement (Third) of Torts § 23 (1999).

[183] HEALTH Act, 112th Cong. § 3(d).

[184] *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan,* 112th Cong., Feb. 16, 2011 (statement of Rep. Robert Scott, member, H. Comm. on the Judiciary).

[185] *Id.*

[186] CBO letter, *supra* note 116. *http://www.cbo.govicloc.cfm?index=10641.*

on him, does the best he possibly can, but it is not perfect, and drug dealer sues him. The jury finds the drug dealer 99 percent responsible for his own injuries. But it also fmds the hospital 1 percent responsible because the physician was fatigued after working too long. But today, the hospital can be made to pay 100 percent of the damages because the drug dealer is without means.[187]

First, this story is borrowed from past debates. It has been used by the majority to defend this proposal nearly every time H.R. 5 has been considered by the committee.[188] Second, its premise is factually incorrect. All fifty states have adopted some form of contributory negligence or comparative negligence standard that bars plaintiffs from recovering for damages for which they are substantially responsible.[189] Even if the "drug dealer" could somehow bring a colorable malpractice claim against the "hospital," he would not be entitled to recover damages if he were "99 percent" responsible. Third, it goes to show how little consideration has been given to the effect of preempting state law in all fifty states. Supporters of H.R. 5 appear to be unaware of how state law applies in instances of joint and several liability, let alone prepared for the unintended consequences of wiping out centuries of jurisprudence in the United States.

C. PUNITIVE DAMAGES CAPS PROTECT THE MOST EGREGIOUS INSTANCES OF MALPRACTICE (SECTIONS 5(A) AND (B))

The bill's limits on punitive damages are problematic for two reasons. First, the heightened standard is practically impossible for patients to prove. Second, the $250,000 cap is inadequate in cases extreme enough to warrant punitive damages.

Under H.R. 5, punitive damages are only available if a plaintiff can prove by "clear and convincing evidence" that a defendant "acted with malicious intent to injure the claimant" or "deliberately failed to avoid unnecessary injury" that he or she was "substantially certain" the patient would suffer.[190] Because proving state of mind in this manner is virtually impossible, perpetrators of the most extreme forms of malpractice will now go unpunished.

Even if a patient is somehow able to show malicious intent, recovery of punitive damages is limited at $250,000 or two times the amount of economic damages awarded.[191] This cap eliminates much of the deterrent effect of punitive damages—$250,000 for grossly negligent conduct would merely be the price of doing business for many hospitals, pharmaceutical manufacturers, insurance companies, and other wealthy health care providers. Worse, the cap applies in the most outrageous instances of medical malpractice, including cases involving drug abuse, alcohol abuse, and sexual as-

---

[187] *Continued Consideration of H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011 and the Committee's Oversight Plan,* 112th Cong., Feb. 16, 2011 (statement of Rep. Trent Franks, member, H. Comm. on the Judiciary).

[188] *See, e.g., Markup of Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2002,* 107th Cong. (statement of Rep. Bachus, member, H. Comm. on the Judiciary).

[189] *See, e.g., Board of County Comm 'r of Garret County v. Bell Atlantic,* 695 A.2d 171 (Md. 1997) (outlining a standard of pure contributory negligence in Maryland); *Liv v. Yellow Cab,* 119 Cal. Rptr. 858 (1975) (outlining a standard of pure comparative fault in California); 0.C.G.A. § 51–11–7 (codifying a 50 percent bar rule in Georgia); and Tex. Civ. Prac. & Rem. Code §§ 33.001–33.017 (codifying a 51 percent bar rule in Texas).

[190] HEALTH Act, 112th Cong. § 5(a).

[191] *Id.* § 5(b)(2).

sault.[192] Under H.R. 5, the patients in this case—children, some as young as three months old, with no economic damages to prove—would be entitled seek no more than $250,000 in punitive damages.

D. SHIELDING DRUG AND DEVICE MANUFACTURERS FROM PUNITIVE DAMAGES PLACES CONSUMERS AT GRAVE RISK (SECTION 5(C))

H.R. 5 provides blanket immunity from punitive damages to the manufacturers of drugs and devices that have been approved by the Federal Drug Administration.[193] This provision alone would be troubling enough. Simply because a product has been approved by the FDA does not mean that a company should be immunized from punitive liability when that product causes sever harm to a consumer. Medical devices cause approximately 53 deaths and more than 1,000 serious injuries every year, with a cost of more than $26 billion annually.[194] Government safety standards, at their best, establish only a minimum level of protection for the public. At their worst, they are outdated, under-protective, and under-enforced.

Moreover, the bill completely insulates manufacturers and distributors of drugs and devices from defects arising during the manufacturing process, which occurs *after* the FDA has given its approval of the device. This means that a drug company distributing an FDA-approved product that is manufactured in a flawed manner and harms consumers would be insulated from punitive damages, even if the flawed manufacture was intentional or reckless.

H.R. 5 goes even further, extending this immunity to manufacturers and distributors of drugs and devices that are "generally recognized among qualified experts as safe and effective," whether or not FDA approval has been sought.[195] In these cases, so long as a defendant can find an expert witness to vouch for its product, federal safety standards are sidestepped altogether. Unless the defendant company has withheld or misrepresented information from the FDA or attempted to bribe an FDA officia1,[196] punitive damages are not available, no matter how flagrant the harm.

E. LIMITS ON CONTINGENCY FEES DENY PATIENTS ACCESS TO THE JUSTICE SYSTEM

Contingency fee arrangements—where attorneys forgo immediate payment in exchange for a share of the damages if a plaintiff prevails in court—serve a useful and essential function in the legal system.[197] Because contingency fee agreements require little or no money up front, injured plaintiffs who could not otherwise afford legal representation have access to counsel. And because attorneys who take losing cases are paid little or nothing for their efforts,

---

[192] Public Citizen found that "47.7% of doctors [found to have been disciplined for sexual abuse or misconduct by a disciplinary board] were allowed to continue practicing, their behavior probably unknown to most if not all of their patients." Sidney Wolfe et al., 20,125 Questionable Doctors (2000).

[193] HEALTH Act, 112th Cong. § 5(c)(1)(A)(i).

[194] *See* Robert Cohen & J. Scott Orr, *Faulty Medical Implants Enter Market Through Flawed System,* Newhouse News Service, 2002.

[195] HEALTH Act, 112th Cong. § 7(c)(1)(A)(ii).

[196] *Id.* § 7(c)(4).

[197] *See* Herbert M. Kritzer, *Lawyer Fees and Lawyer Behavior in Litigation: What does the Empirical Literature Really Say?,* 80 TEX. L. REV. 1943 (2002); and Herbert M. Kritzer, *Economic Policy Litigation Conference Seven Dogged Myths Concerning Contingency Fees,* 80 WASH. U.L.Q. 739 (Fall 2002).

contingency fees also serve as a screening mechanism for "frivolous" cases.[198] Lawyers will not incur the risk of taking a contingency fee case with little merit.

In an unusual position for the traditionally free-market majority, supporters of H.R. 5 prefer that state and federal courts to step into attorney-client agreements and "supervise the arrangements for payment of damages."[199] The bill requires that all contingency fee arrangements adhere to a specific formula: "(1) Forty percent of the first $500,000 recovered by the claimant(s). (2) Thirty-three percent and one-third percent of the next $500,000 recovered by the claimant(s). (3) Twenty-five percent of the next $500,000 recovered by the claimant(s). (4) Fifteen percent of the next $500,000 recovered by the claimant."[200]

This provision purports to limit conflict of interest "in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome,"[201] but the contingency fees formula will have the effect of making it more difficult for poor patients to secure legal representation in medical malpractice cases. Although the stated purpose of this bill is curb the costs of lawsuits and lower insurance premiums, contingency fees do not change the size of a jury award or an insurance company's obligation to pay damages on behalf of a health care provider. Moreover, the one-sided formula does nothing to limit conflicts of interest on the other side of the case. Defense counsels are paid by the hour and have direct financial incentive to engage in unnecessary litigation and drive up costs. The bill's stated concern about legal ethics notwithstanding, this proposal is a naked attempt to prevent plaintiffs from accessing the courts.

F. PERIODIC PAYMENTS SHIFT THE RISKS OF BANKRUPTCY TO INDIVIDUAL PATIENTS

If H.R. 5 passes, courts will no longer have discretion in structuring payment of damages over time. At the request of a defendant found to have committed malpractice, "the court *shall* . . . enter a judgment ordering that future damages be paid by periodic payments."[202] As with the other defendant-friendly provisions of this bill, this requirement harms patients and protects proven bad actors.

Periodic payment plans allow a negligent party to stall while the patient assumes the risk. The defendant (or the defendant's insurance company) can invest and earn interest on compensation owed to the patient. If a defendant files for bankruptcy—or simply refuses to pay—it is the patient's responsibility to retain counsel and press the matter in court. There may be instances where a court, in its discretion, finds good reason to structure payment of damages over time. H.R. 5 removes that discretion, however, and the one-sidedness of this provision is unjustifiable.

---

[198] *Id.*
[199] HEALTH Act, 112th Cong. § 4.
[200] *Id.*
[201] *Id.*
[202] *Id.* § 6(a) (emphasis added).

G. A STRICT STATUTE OF LIMITATIONS DENIES PATIENTS A CHANCE TO BE HEARD IN COURT

H.R. 5 requires that a health care lawsuit commence "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."[203] The bill provides an oddly limited exception for minors under the age of six.[204]

In most cases, this three-year statute of limitations is, in effect, a one-year statute of limitations in disguise. Because most patients will discover an injury when it manifests itself, the one-year statute of limitations will begin to run immediately. In other cases, the three-year statute of limitations alone cuts off patients from bringing legitimate claims—particularly in cases that involve diseases with long latency periods. For example, a child infected with HIV from a tainted blood infusion may manifest symptoms long before a diagnosis is sought. If the child is at least six and more than three years have passed since the symptoms first began to manifest, H.R. 5 cuts off all legal recourse. These patients deserve their day in court.

CONCLUSION

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 fifty states, with little regard for the consequences. This legislation was designed more than twenty 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 that Congress should reject this bill.

JOHN CONYERS, Jr.
HOWARD BERMAN.
JERROLD NADLER.
ROBERT C. SCOTT.
MELVIN L. WATT.
SHEILA JACKSON-LEE.
MAXINE WATERS.
STEVE COHEN.
HENRY C. "HANK" JOHNSON.
MIKE QUIGLEY.
TED DEUTCH.
JARED POLIS.

---

[203] *Id.* § 2.

[204] "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 six years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday." *Id.*

TITLE V—THE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC, April 27, 2012.

Hon. PAUL RYAN,
Chairman, Committee on the Budget,
Washington, DC.

DEAR CHAIRMAN RYAN: On behalf of the Committee on Oversight and Government Reform, I am transmitting the recommendations required by section 201 of H. Con. Res. 112, the Concurrent Resolution on the Budget for Fiscal Year 2013.

Sincerely,

DARRELL ISSA,
Chairman.

Enclosure.

TITLE V—COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

SUMMARY OF THE MAJOR POLICY DECISIONS IN THE LEGISLATION

The President's National Commission on Fiscal Responsibility and Reform (Simpson-Bowles) found that federal civilian employee pensions were out of line with pension benefits available to the average private sector worker. It therefore recommended that Congress change the federal employee pension system to bring it more in line with private sector practice. Simpson-Bowles recommended that the employee and his employing agency make equal contributions toward pension costs. In his *Plan for Economic Growth and Deficit Reduction: Living Within Our Means* and his FY2013 Budget, the President called on federal employees to contribute an additional percentage of salary toward their defined benefit pension, and proposed eliminating the FERS minimum supplement for new hires not subject to mandatory retirement.

Building on these recommendations, Title V increases federal employees' contribution to their defined benefit pension by 5 percent of salary over five years. Members of Congress and their staff enrolled in the Civil Service Retirement System (CSRS) will pay an additional 8.5 percent of salary over five years. Members of Congress enrolled in the Federal Employee Retirement System (FERS) will pay an additional 8.5 percent of salary, and congressional employees will pay an additional 7.5 percent of salary over five years. For new hires in the executive branch, the employee contribution rate is set at 5.8 percent; 6.3 percent for special occupational groups such as law enforcement. At the end of the phase in period, the contribution rate for existing FERS employees will equal the contribution rate for new hires. The increased contributions bring the employee contribution rate to approximately 50 percent of the normal pension cost, and will help reduce the CSRS shortfall covered by the taxpayer.

Under current law federal employees receive a special benefit not available to those in the private sector. Federal employees who voluntarily early retire before age 62 receive a special benefit on top of their retirement until they reach Social Security retirement age. Consistent with the President's FY2013 Budget, the legislation eliminates the FERS supplemental payment for federal employees and Members of Congress entering service after December 31, 2012 who voluntarily retire before age 62.

To better align federal employee benefits with the private sector, the legislation allows retiring federal employees to deposit lump-sum payments for unused annual leave into their Thrift Savings Plan accounts. These contributions would be subject to the existing Internal Revenue Service (IRS) annual contribution limits. In September 2009, the IRS issued regulations allowing employees to de-

posit any cash payment they received from their employer for accumulated leave into their 401(k) plans.

SECTION-BY-SECTION

Section 501. Retirement contributions

Section 501(a) increases the employee contribution to the Civil Service Retirement System (CSRS) by 5 percent of salary over five years, beginning in calendar year 2013. In 2013, CSRS employees will pay 8.5 percent of salary, an increase of 1.5 percent over the current contribution rate. CSRS employees will pay an additional 0.5 percent in 2014, and it will increase by an additional 1 percent each year, for calendar years 2015–2017.

Section 501(b) increases the employee contribution to the Federal Employee Retirement System (FERS) by 5 percent of salary over five years, beginning in calendar year 2013. In 2013, FERS employees will pay 2.3 percent of salary, an increase of 1.5 percent over the current contribution rate. FERS employees will pay an additional 0.5 percent in 2014, and an additional 1 percent in calendar years 2015–2017.

Members of Congress will pay an additional 8.5 percent of salary over five years. CSRS congressional employees will contribute an additional 8.5 percent of salary over five years, and FERS congressional employees will contribute an additional 7.5 percent of salary over five years. The rate increases for Members of Congress and congressional employees reflect the higher normal pension cost for these occupational groups.

Section 501(b) also revises the employee contribution rate for federal employees and Members of Congress entering service after December 31, 2012, who have less than 5 years of creditable service for retirement purposes. The employee contribution rate will equal 5.8 percent for most federal employees and 6.3 percent for special occupational groups such as law enforcement (who receive a more generous defined benefit pension).

Section 502. Annuity supplement

Section 502 eliminates the supplemental payment to FERS employees hired on or after January 1, 2013 who voluntarily retire before the age of eligibility for social security. Individuals subject to mandatory retirement include law enforcement officers, fire fighters, air traffic controllers, and nuclear materials couriers. These special occupational groups will remain eligible for the FERS minimum supplement.

Section 503. Contributions to Thrift Savings Fund of Payments for Accrued or Accumulated Leave

Section 503 allows retiring federal employees and Members of Congress to deposit any lump-sum payment for unused annual leave into their Thrift Savings Plan account.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of Rule XIII and clause (2)(b)(1) of Rule X of the Rules of the House of Representatives, the Com-

mittee's oversight findings and recommendations are reflected in the descriptive portions of this report.

COMMITTEE VOTES

The following votes occurred during the consideration of the committee print:

1. Mr. Chaffetz and Mr. Lynch offered an amendment to the committee print to allow retiring federal employees and Members of Congress to deposit payments for accrued and annual leave in their Thrift Savings Plan accounts. The amendment was agreed to by voice vote.

2. The committee print, as amended, was ordered transmitted to the Budget Committee, a quorum being present, by a recorded vote of 19 Ayes to 15 Nays.

Ayes: Issa, Burton, Turner, Chaffetz, Mack, Walberg, Lankford, Amash, Buerkle, Gosar, Labrador, Meehan, DesJarlais, Walsh, Gowdy, Ross, Guinta, Farenthold, Kelly.

Nays: Cummings, Towns, Norton, Kucinich, Tierney, Clay, Lynch, Cooper, Connolly, Quigley, Davis, Welch, Yarmuth, Murphy, Speier.

PERFORMANCE GOALS

In accordance with clause 3(c)(4) of Rule XIII of the Rules of the House of Representatives, the Committee's performance goals and objectives are reflected in the descriptive portions of this report.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

APRIL 27, 2012.

Hon. DARRELL ISSA,
Chairman, Committee on Oversight and Government Reform,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the House Committee on Oversight and Government Reform.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Amber G. Marcellino, who can be reached at 226–2880.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

Reconciliation Recommendations of the House Committee on Oversight and Government Reform

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 Oversight and Government Reform was instructed to recommend changes to current law that would reduce the deficit by $78.9 billion for fiscal years 2012 through 2022.

The proposal by the House Committee on Oversight and Government Reform would make several changes to the current federal employee retirement program. Specifically, the legislation would increase the percentage of salary that federal employees in the Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) are required to pay towards their retirement and eliminate the FERS retirement supplement that would be paid under current law to certain future retirees under the age of 62. The proposal also would allow federal employees to contribute to their Thrift Savings Plan (TSP) accounts any payment received at retirement for accumulated and accrued annual leave.

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that this proposal would have no impact in 2012, and would reduce deficits by $2.3 billion in 2013 and by $83.3 billion over the 2013–2022 period. Those estimates are relative to CBO's March baseline projections and assume enactment on or near October 1, 2012. The reduction is achieved mostly through an increase in estimated revenues—$2.4 billion in 2013 and $87.8 billion over the 10-year period—partially offset by higher direct spending ($0.2 billion in 2013 and nearly $4.5 billion over the 2013–2022 period). The estimate of budgetary effects would be the same whether enactment is assumed to occur by July 1, 2012, or around October 1, 2012, because the retirement proposals would not take effect until January 1, 2013, while the TSP proposal would not take effect until one year after enactment.

The legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local or tribal governments.

Estimated Cost to the Federal Government: The estimated budgetary impact of the proposal is shown in the following table. The costs of this legislation fall within nearly all functions of 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 REVENUES [a]													
Estimated Revenues	0	2,426	4,505	6,625	8,633	10,514	10,671	10,849	11,009	11,212	11,350	32,704	87,794
CHANGES IN ON-BUDGET DIRECT SPENDING													
Estimated Budget Authority	0	313	565	800	998	1,161	1,117	1,077	1,030	987	938	3,838	8,987
Estimated Outlays	0	313	565	800	998	1,161	1,117	1,077	1,030	987	938	3,838	8,987
CHANGES IN OFF-BUDGET DIRECT SPENDING													
Estimated Budget Authority	0	−157	−283	−400	−499	−581	−559	−539	−515	−494	−469	−1,919	−4,493
Estimated Outlays	0	−157	−283	−400	−499	−581	−559	−539	−515	−494	−469	−1,919	−4,493
NET INCREASE OR DECREASE (−) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND RECEIPTS													
Impact on Deficits	0	−2,269	−4,223	−6,225	−8,134	−9,933	−10,112	−10,310	−10,494	−10,718	−10,881	−30,785	−83,301
CHANGES IN SPENDING SUBJECT TO APPROPRIATION													
Estimated Authorization Level	0	−1,887	−3,633	−5,439	−7,191	−8,882	−9,149	−9,446	−9,722	−10,026	−10,265	−27,032	−75,641
Estimated Outlays	0	−1,887	−3,633	−5,439	−7,191	−8,882	−9,149	−9,446	−9,722	−10,026	−10,265	−27,032	−75,641
Memorandum:													
Reduction in Offsetting Receipts Resulting from Lower Employer Contributions [b]	0	1,887	3,633	5,439	7,191	8,882	9,149	9,446	9,722	10,026	10,265	27,032	75,641

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: The estimate of budgetary effects in the table above would apply whether the enactment date is assumed to be July 1, 2012, or around October 1, 2012.

[a] For revenues, positive numbers indicate a decrease in the deficit.

[b] Employer contributions are intragovernmental transactions that do not affect the deficit; positive numbers indicate a decrease in such intragovernmental receipts. The receipts shown in the memorandum result from federal employer contributions financed by future appropriations; such receipts are not considered to be an offset to direct spending because they are contingent on future appropriations.

Basis of Estimate: CBO estimates that the proposal would increase revenues by nearly $88 billion over the 10-year period because of changes to the retirement contribution rates for federal employees ($88 billion), offset slightly by lower revenues ($355 million) from a proposal to allow employees to contribute any payment received for accumulated and accrued annual leave to their TSP accounts.

Proposed reductions in the rates that the U.S. Postal Service pays into the Civil Service Retirement and Disability Fund (CSRDF) on behalf of its employees subject to FERS would increase direct spending by a net of roughly $4 billion over the 2013–2022 period, CBO estimates. That increase results from additional on-budget outlays of nearly $9 billion (because of fewer receipts into the CSRDF), partially offset by more than $4 billion in off-budget savings (because of lower Postal Service agency contributions).

Similar reductions in the rates that agencies other than the Postal Service would pay into the CSRDF on behalf of their FERS employees would reduce spending subject to appropriation by $76 billion over the 2013–2022 period, CBO estimates. Those lower payments from agencies would also reduce the amount of offsetting receipts received by the CSRDF; together, those changes would offset each other.

Changes in employee and agency contributions

The proposal would increase the required contribution rates paid by federal employees and Members of Congress (in both CSRS and FERS), phased in over five years, beginning in January 2013. Under current law, most CSRS employees contribute 7 percent of their salary towards retirement, and most FERS employees contribute 0.8 percent.

The proposed annual increases in employee contribution rates would be as follows:

	2013	2014	2015	2016	2017
CSRS	1.5%	0.5%	1.0%	1.0%	1.0%
CSRS Members of Congress	2.5%	1.5%	1.5%	1.5%	1.5%
CSRS Congressional staff	2.5%	1.5%	1.5%	1.5%	1.5%
FERS	1.5%	0.5%	1.0%	1.0%	1.0%
FERS Members of Congress	2.5%	1.5%	1.5%	1.5%	1.5%
FERS Congressional staff	1.5%	1.5%	1.5%	1.5%	1.5%

By the end of the phase-in period, most CSRS employees would contribute 12 percent of salary, and most FERS employees would contribute 5.8 percent. (Employees hired on January 1, 2013, or later with less than five years of federal service would immediately begin contributing at a rate of 5.8 percent.) The rate paid by Members of Congress in CSRS would increase from 8.0 percent to 16.5 percent, while the rate paid by Members of Congress in FERS would increase from 1.3 percent to 9.8 percent.

Contributions by federal employees for their retirement are shown as revenues to the federal government; CBO estimates that the proposed increase in the contribution rates would boost revenues by $88 billion over the 2013–2022 period.

Federal agencies are also required to make contributions toward their employees' retirement. For each of the proposed rate in-

creases for FERS employees and Members described above, the proposal would make a corresponding reduction in the rate required to be paid by the employing agencies. (Rate reductions are not proposed for CSRS; agencies would continue to pay the rate in current law on behalf of their CSRS employees.) Reducing the employer contribution rates for FERS employees in agencies other than the Postal Service would lower spending subject to appropriation by $76 billion over the 2013–2022 period, CBO estimates. Such a reduction in employer retirement payments would lower the intragovernmental offsetting receipts of the CSRDF by an equal amount, but because that budgetary action is contingent on future appropriations, the drop in offsetting receipts is not considered an offset to direct spending.

Under the legislation, the total amount of retirement contributions (employee plus agency shares) paid into the CSRDF for FERS employees would remain the same as under current law. That is, the legislation would replace some of the payments by agencies with payments by federal employees. Budgetary savings would be attributed to the proposal because of the different budgetary classification of the employee share (revenues) versus the agency share (an intragovernmental transfer subject to future appropriation action).

CBO estimates that reducing the Postal Service's contribution rate for its employees subject to FERS would lower its required payments by nearly $9 billion over the 2013–2022 period. However, CBO expects that lower retirement expenses would lead the agency to modify its ongoing efforts under current law to reduce spending by doing so less aggressively; CBO estimates that the resulting increase in Postal Service outlays over the 10-year period would be about half of the total estimated reduction in retirement payments. Because the activities of the Postal Service are considered mandatory spending and classified as off-budget, such outlay reductions would result in a total savings of more than $4 billion in off-budget direct spending. In addition, reducing the payments made by the Postal Service on behalf of their FERS employees would result in correspondingly fewer receipts to the CSRDF, which CBO estimates would increase on-budget direct spending by nearly $9 billion over the 2013–2022 period.

Eliminate the FERS annuity supplement

Under current law, certain FERS employees who retire before the age of 62 receive a supplement to their annuity that is intended to equal what they would receive from the Social Security Administration if they were eligible for Social Security benefits at the time of retirement. The supplement ends when the retiree turns 62 or becomes eligible to receive actual Social Security benefits. The proposal would eliminate that supplement for all FERS employees other than law enforcement officers, fire fighters, air traffic controllers and nuclear materials couriers who enter into federal service after December 31, 2012. That provision would have no impact over the next 10 years (employees hired in 2013 or later would not be eligible to receive the supplement under current law until at least 2033), but would reduce direct spending in later years.

Leave payout contributions to the Thrift Savings Plan

The legislation would allow any employee of the federal government who is eligible to make contributions to the TSP to contribute to it any payment received for accumulated and accrued annual leave. Such contributions would be subject to the annual limits that otherwise apply—annual contributions are currently limited to $17,000 for individuals ages 49 or younger and $22,500 for individuals ages 50 or older.

Because income taxes are deferred on contributions to regular (non-Roth) TSP accounts, and earnings within the accounts would not be taxable, the anticipated increase in contributions would initially result in lower revenues from income taxes. JCT estimates that the legislation would reduce revenues by $355 million over the 2013–2022 period.

Intergovernmental and private-sector impact: The legislation contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal costs: Amber G. Marcellino; Impact on state, local, and tribal governments: Elizabeth Cove Delisle; Impact on the private sector: Paige Piper/Bach.

Estimate approved by: Theresa Gullo, Deputy Assistant Director for Budget Analysis.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 5, UNITED STATES CODE

* * * * * * *

PART III—EMPLOYEES

* * * * * * *

SUBPART G—INSURANCE AND ANNUITIES

* * * * * * *

CHAPTER 83—RETIREMENT

* * * * * * *

SUBCHAPTER III—CIVIL SERVICE RETIREMENT

* * * * * * *

§ 8334. Deductions, contributions, and deposits

(a)(1)(A) * * *

(B)(i) [Except as provided in clause (ii),] *Except as provided in clause (ii) or (iii),* an equal amount shall be contributed from the

appropriation or fund used to pay the employee or, in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment. When an employee in the legislative branch is paid by the Chief Administrative Officer of the House of Representatives, the Chief Administrative Officer may pay from the applicable accounts of the House of Representatives the contribution that otherwise would be contributed from the appropriation or fund used to pay the employee.

* * * * * * *

(iii) The amount to be contributed under clause (i) shall, with respect to a period in any year beginning after December 31, 2012, be equal to—

(I) the amount which would otherwise apply under clause (i) with respect to such period, reduced by

(II) the amount by which, with respect to such period, the withholding under subparagraph (A) exceeds the amount which would otherwise have been withheld from the basic pay of the employee or elected official involved under subparagraph (A) based on the percentage applicable under subsection (c) for calendar year 2012.

* * * * * * *

[(c) Each**]** *(c)(1) Each* employee or Member credited with civilian service after July 31, 1920, for which retirement deductions or deposits have not been made, may deposit with interest an amount equal to the following percentages of his basic pay received for that service:

	Percentage of basic pay	Service period
Employee	2 1/2	August 1, 1920, to June 30, 1926.
	3 1/2	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6 1/2	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to December 31, 1998.
	7.25	January 1, 1999, to December 31, 1999.
	7.4	January 1, 2000, to December 31, 2000.
	7	After December 31, 2000.
* *	* * *	* *

(2) Notwithstanding any other provision of this subsection, the applicable percentage of basic pay under this subsection shall—

(A) except as provided in subparagraph (B) or (C), for purposes of computing an amount—

(i) for a period in calendar year 2013, be equal to the applicable percentage under this subsection for calendar year 2012, plus an additional 1.5 percentage points;

(ii) for a period in calendar year 2014, be equal to the applicable percentage under this subsection for calendar year 2013 (as determined under clause (i)), plus an additional 0.5 percentage point;

(iii) for a period in calendar year 2015, 2016, or 2017, be equal to the applicable percentage under this subsection for the preceding calendar year (as determined under clause (ii) or this clause, as the case may be), plus an additional 1.0 percentage point; and

(iv) for a period in any calendar year after 2017, be equal to the applicable percentage under this subsection for calendar year 2017 (as determined under clause (iii));

(B) for purposes of computing an amount with respect to a Member for Member service—

(i) for a period in calendar year 2013, be equal to the applicable percentage under this subsection for calendar year 2012, plus an additional 2.5 percentage points;

(ii) for a period in calendar year 2014, 2015, 2016, or 2017, be equal to the applicable percentage under this subsection for the preceding calendar year (as determined under clause (i) or this clause, as the case may be), plus an additional 1.5 percentage points; and

(iii) for a period in any calendar year after 2017, be equal to the applicable percentage under this subsection for calendar year 2017 (as determined under clause (ii)); and

(C) for purposes of computing an amount with respect to a Member or employee for Congressional employee service—

(i) for a period in calendar year 2013, be equal to the applicable percentage under this subsection for calendar year 2012, plus an additional 2.5 percentage points;

(ii) for a period in calendar year 2014, 2015, 2016, or 2017, be equal to the applicable percentage under this subsection for the preceding calendar year (as determined under clause (i) or this clause, as the case may be), plus an additional 1.5 percentage points; and

(iii) for a period in any calendar year after 2017, be equal to the applicable percentage under this subsection for calendar year 2017 (as determined under clause (ii)).

* * * * * * *

§ 8351. Participation in the Thrift Savings Plan

(a) * * *

(b)(1) * * *

[(2)(A) An employee or Member may contribute to the Thrift Savings Fund in any pay period any amount not exceeding the maximum percentage of such employee's or Member's basic pay for such pay period allowable under subparagraph (B).

[(B) The maximum percentage allowable under this subparagraph shall be determined in accordance with the following table:

[In the case of a pay period beginning in fiscal year:	The maximum percentage allowable is:
2001	6
2002	7
2003	8
2004	9
2005	10

[In the case of a pay period beginning in fiscal year:	The maximum percentage allowable is:
2006 or thereafter	100.]

(2)(A) An employee or Member may contribute to the Thrift Savings Fund in any pay period any amount of such employee's or Member's basic pay for such pay period, and may contribute (by direct transfer to the Fund) any part of any payment that the employee or Member receives for accumulated and accrued annual or vacation leave under section 5551 or 5552. Notwithstanding section 2105(e), in this paragraph the term "employee" includes an employee of the United States Postal Service or of the Postal Regulatory Commission.

[(C)] *(B)* Notwithstanding any limitation under this paragraph, an eligible participant (as defined by section 414(v) of the Internal Revenue Code of 1986) may make such additional contributions to the Thrift Savings Fund as are permitted by such section 414(v) and regulations of the Executive Director consistent therewith.

* * * * * * *

CHAPTER 84—FEDERAL EMPLOYEES' RETIREMENT SYSTEM

* * * * * * *

SUBCHAPTER II—BASIC ANNUITY

* * * * * * *

§ 8421. Annuity supplement

(a)(1) Subject to [paragraph (3)] *paragraphs (3) and (4)*, an individual shall, if and while entitled to an annuity under subsection (a), (b), (d), or (e) of section 8412, or under section 8414(c), also be entitled to an annuity supplement under this section.

(2) Subject to [paragraph (3)] *paragraphs (3) and (4)*, an individual shall, if and while entitled to an annuity under section 8412(f), or under subsection (a) or (b) of section 8414, also be entitled to an annuity supplement under this section if such individual is at least the applicable minimum retirement age under section 8412(h).

* * * * * * *

(4)(A) Except as provided in subparagraph (B), no annuity supplement under this section shall be payable in the case of an individual who first becomes subject to this chapter after December 31, 2012.

(B) Nothing in this paragraph applies in the case of an individual separating under subsection (d) or (e) of section 8412.

* * * * * * *

§ 8422. Deductions from pay; contributions for other service; deposits

(a)(1) * * *

* * * * * * *

(3)(A) * * *

(B) Notwithstanding any other provision of this paragraph, the applicable percentage under this paragraph shall—

(i) except as provided in clause (ii) or (iii), for purposes of computing an amount—

(I) for a period in calendar year 2013, be equal to the applicable percentage under this paragraph for calendar year 2012, plus an additional 1.5 percentage points;

(II) for a period in calendar year 2014, be equal to the applicable percentage under this paragraph for calendar year 2013 (as determined under subclause (I)), plus an additional 0.5 percentage point;

(III) for a period in calendar year 2015, 2016, or 2017, be equal to the applicable percentage under this paragraph for the preceding calendar year (as determined under subclause (II) or this subclause, as the case may be), plus an additional 1.0 percentage point; and

(IV) for a period in any calendar year after 2017, be equal to the applicable percentage under this paragraph for calendar year 2017 (as determined under subclause (III));

(ii) for purposes of computing an amount with respect to a Member—

(I) for a period in calendar year 2013, be equal to the applicable percentage under this paragraph for calendar year 2012, plus an additional 2.5 percentage points;

(II) for a period in calendar year 2014, 2015, 2016, or 2017, be equal to the applicable percentage under this paragraph for the preceding calendar year (as determined under subclause (I) or this subclause, as the case may be), plus an additional 1.5 percentage points; and

(III) for a period in any calendar year after 2017, be equal to the applicable percentage under this paragraph for calendar year 2017 (as determined under subclause (II)); and

(iii) for purposes of computing an amount with respect to a Congressional employee—

(I) for a period in calendar year 2013, 2014, 2015, 2016, or 2017, be equal to the applicable percentage under this paragraph for the preceding calendar year (including as increased under this subclause, if applicable), plus an additional 1.5 percentage points; and

(II) for a period in any calendar year after 2017, be equal to the applicable percentage under this paragraph for calendar year 2017 (as determined under subclause (I)).

[(B)**]** *(C)* The applicable percentage under this paragraph for civilian service by revised annuity employees shall be as follows:

Employee	[9.3] *12*	After December 31, 2012.
Congressional employee	[9.3] *12*	After December 31, 2012.
Member	[9.3] *12*	After December 31, 2012.
Law enforcement officer, firefighter, member of the Capitol Police, member of the Supreme Court Police, or air traffic controller	[9.8] *12.5*	After December 31, 2012.
Nuclear materials courier	[9.8] *12.5*	After December 31, 2012.
Customs and border protection officer	[9.8] *12.5*	After December 31, 2012.

* * * * * * *

SUBCHAPTER III—THRIFT SAVINGS PLAN

* * * * * * *

§ 8432. Contributions

[(a)(1) An employee or Member may contribute to the Thrift Savings Fund in any pay period, pursuant to an election under subsection (b), an amount not to exceed the maximum percentage of such employee's or Member's basic pay for such pay period allowable under paragraph (2). Contributions under this subsection pursuant to such an election shall, with respect to each pay period for which such election remains in effect, be made in accordance with a program of regular contributions provided in regulations prescribed by the Executive Director.

[(2) The maximum percentage allowable under this paragraph shall be determined in accordance with the following table:

[In the case of a pay period beginning in fiscal year:	The maximum percentage allowable is:
2001	11
2002	12
2003	13
2004	14
2005	15
2006 or thereafter	100.]

(a)(1) An employee or Member—

(A) may contribute to the Thrift Savings Fund in any pay period, pursuant to an election under subsection (b), any amount of such employee's or Member's basic pay for such pay period; and

(B) may contribute (by direct transfer to the Fund) any part of any payment that the employee or Member receives for accumulated and accrued annual or vacation leave under section 5551 or 5552.

(2) Contributions made under paragraph (1)(A) pursuant to an election under subsection (b) shall, with respect to each pay period for which such election remains in effect, be made in accordance

with a program of regular contributions provided in regulations prescribed by the Executive Director.

* * * * * * *

(4) Notwithstanding section 2105(e), in this subsection the term "employee" includes an employee of the United States Postal Service or of the Postal Regulatory Commission.

* * * * * * *

DISSENTING VIEWS ON THE MAJORITY'S RECONCILIATION RECOMMENDATIONS

Committee Democrats strongly oppose the Majority's Reconciliation Recommendations, as ordered reported by the Committee on April 27, 2012.

The House Republican Budget directed the Oversight Committee to identify mandatory savings of $78.9 billion over ten years. Despite our limited budgetary jurisdiction, this Committee has been assigned to identify more cuts than the Ways and Means Committee, which has authority over the entire federal tax code, and to make deeper cuts than the Financial Services and Judiciary Committees combined.

This $80 billion mandate is a continuation of the Majority's relentless attacks on the federal workforce. The measure adopted by the Committee would require federal employees to contribute an additional 5% of their annual salaries toward their retirement benefits, effectively resulting in a 5% cut in the take-home pay of three million middle-class American workers. In addition, the legislation would eliminate the FERS annuity supplement for new workers who retire before they are eligible for Social Security at age 62, except those who are subject to mandatory retirement. This would result in the reduction of retirement benefits for these new employees by as much as $700 per month, according to the Office of Personnel Management.

These dedicated public servants have already sacrificed $75 billion toward deficit reduction and other priorities, more than their fair share, and they are still subject to a two-year federal pay freeze. Nevertheless, the Majority continues to view middle-income federal workers as an endless source of government offsets; first to fund the federal budget deficit, then to pay for the extension of the payroll tax cut and unemployment benefits, and now to pay for extending tax cuts for the rich.

Federal employees dedicate their lives day in and day out to public service by protecting our borders, supporting our troops, caring for our wounded veterans, ensuring the safety of our food and water, and providing services to millions of Americans. If this measure is enacted into law, however, these three million middle-class federal employees will have sacrificed a staggering total of $155 billion.

The Majority argues that this measure is necessary in order to reduce our nation's deficit. However, House Republicans have consistently refused to ask the wealthiest Americans to contribute even one additional penny to help address our nation's fiscal challenges. Even more astounding, House Republicans would go even further by rewarding the rich with additional tax breaks even beyond those passed during the Bush Administration.

On April 12, 2012, the nonpartisan Center on Budget and Policy Priorities issued a report examining how much more money the House Republican Budget would give in additional tax breaks to the richest Americans. The report concludes that those earning over $1 million a year would receive an additional *$265,000 in new tax breaks* every year. The report also states that the Republican budget "would enact new tax cuts that would provide huge windfalls to households at the top of the income scale." It also states that these new tax breaks will "disproportionately harm lower-income Americans . . . disproportionately help those at the top of the income scale . . . significantly worsen inequality . . . and increase poverty and hardship." [1]

House Republicans claim that they care about the deficit, yet these new tax breaks would make it worse. It is not shared sacrifice when Republicans keep coming back to the same group of middle-class workers to fund deficit reduction, other government programs, and, in this case, additional tax breaks for the wealthy.

Committee Democrats reject the premise that we need to take an additional $80 billion out of the pockets of millions of middle-class American families across the country. We take a stand supporting these families and opposing more new tax breaks for millionaires and billionaires. Ranking Member Cummings offered an Amendment in the Nature of a Substitute that would have protected middle-class federal workers and called for no new tax breaks for the wealthiest Americans, but Republicans argued that the amendment was not "germane" to the debate.

House Republicans have taken a similar approach in other committees. Last week, the Agriculture Committee slashed the food stamp program by $33 billion as part of this reconciliation exercise. They reduced assistance to every single household receiving benefits under the Supplemental Nutrition Assistance Program, which serves 46 million people. They totally eliminated food assistance for 1.8 million people across the country, and nearly three hundred thousand children will lose their meals at school, on top of losing their food stamp benefits at home.

The Ways and Means Committee eliminated the Social Services Block Grant, which helps 23 million children, seniors, and people with disabilities. It also provides Meals on Wheels and other services for 1.7 million seniors, child protective services for 1.8 million children at risk, and child care and other assistance for 4.4 million children.

Oversight Committee Democrats are committed to reducing the deficit. However, we believe that it needs to be done using a balanced approach that asks for shared sacrifice from everyone. Congress cannot lavish ridiculous new tax breaks on the rich while slashing programs and benefits for poor and middle-class families.

ELIJAH E. CUMMINGS.

---

[1] Center on Budget and Policy Priorities, *New Tax Cuts in Ryan Budget Would Give Millionaires $265,000 on Top of Bush Tax Cuts* (Apr. 12, 2012).

TITLE VI—THE COMMITTEE ON WAYS AND MEANS

LETTER OF TRANSMITTAL

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, April 27, 2012.

Hon. PAUL RYAN,
Chairman, Committee on the Budget,
Washington, DC.

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 Ways and Means, and the appropriate materials including dissenting views, to the House Committee on the Budget. This submission is in order to comply with reconciliation directives included inH. 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,

DAVE CAMP,
Chairman.

SUBTITLE A—RECAPTURE OF OVERPAYMENTS RESULTING FROM CERTAIN FEDERALLY-SUBSIDIZED HEALTH INSURANCE

CONTENTS

	Page
Summary and Background	475
Explanation of Provision	476
Votes of the Committee	479
Budget Effects of the Provisions	480
Other Matters To Be Discussed Under the Rules of the House	486
Changes in Existing Law Made by the Budget Reconciliation Legislative Recommendation as Transmitted	487
Dissenting Views	489

SUMMARY AND BACKGROUND

In partial fulfillment of the reconciliation instructions included in section 201(b)(6) of the Concurrent Resolution on the Budget for Fiscal Year 2013 (H. Con. Res. 112), the Committee on Ways and Means, by voice vote and without amendment (with a quorum being present), favorably transmitted the Budget Reconciliation Legislative Recommendations Relating to Recapture of Federally-Subsidized Health Insurance Overpayments. The Committee recommends a full repeal of the repayment limits on certain federally subsidized insurance premium tax credit overpayments. The Patient Protection and Affordable Care Act of 2010 (PPACA), Pub. L. No. 111–148 (March 23, 2010) provided for refundable tax credits for certain federally subsidized health insurance policies and capped the amount of credit overpayments that can be recouped. The Committee's recommendation repeals section 36B(f)(2)(B) of the Internal Revenue Code of 1986, as added by PPACA and subsequently amended by Pub. L. No. 111–309 and Pub. L. No. 112–9.

Given the Federal government's current fiscal situation and growing financial commitment to health care services, it is imperative that Congress scrutinize the Federal budget to identify potential improper payments resulting from waste, fraud, and abuse. Once identified, it is incumbent on Congress to amend statutes and address programs that fail to fully protect taxpayer dollars. PPACA's design of advanceable and refundable tax credits for the purchase of certain government-approved health insurance creates the potential for such waste, fraud, and abuse. The combination of income determination rules, limits on the amount of subsidy overpayments that can be recouped, and the large amount of federal funds (over $800 billion between 2014 and 2022) being expended make the program particularly susceptible to overpayments. Accordingly, the bill seeks to reduce waste, fraud, and abuse by repealing the limit on the amount of overpayments the government can recoup.

LEGISLATIVE HISTORY

Budget resolution

On March 29, 2012, the House of Representatives approved H. Con. Res. 112, the budget resolution for fiscal year 2013. Pursuant to section 201(b)(6) of H. Con. Res. 112, the Committee on Ways and Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of the Committee on Ways and Means sufficient to reduce the deficit by $1,200,000,000 for the period of fiscal years 2012 and 2013; by $23,000,000,000 for the period of fiscal years 2012 through 2017; and by $53,000,000,000 for the period of fiscal years 2012 through 2022.

Committee action

On April 18, 2012, in partial fulfillment of its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative recommendation relating to recapture of overpayments resulting from certain Federally-subsidized health insurance and ordered the legislative recommendation favorably transmitted.

Committee hearings

The Committee on Ways and Means held hearings regarding the President's Fiscal Year 2012 budget submission on February 15, 2011, and February 16, 2011, with Secretary of the Treasury Timothy F. Geithner and Secretary of Health and Human Services Kathleen Sebelius, respectively, in which implementation of PPACA and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152 (March 30, 2010) was a focal point. The Committee on Ways and Means held hearings regarding the President's Fiscal Year 2013 budget submission on February 15, 2012, and February 28, 2012, with Secretary of the Treasury Timothy F. Geithner and Secretary of Health and Human Services Kathleen Sebelius, respectively, in which projected increases in PPACA's subsidy expenditures and management of the law's implementation, particularly at the Internal Revenue Service, were discussed.

EXPLANATION OF PROVISION

RECAPTURE OF OVERPAYMENTS RESULTING FROM CERTAIN FEDERALLY-SUBSIDIZED HEALTH INSURANCE

Present Law

Premium assistance credit

For taxable years ending after December 31, 2013, section 36B provides a refundable tax credit (the "premium assistance credit") for eligible individuals and families who purchase health insurance through an American Health Benefit Exchange. The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an American Health Benefit Exchange.

The premium assistance credit is available for individuals (single or joint filers) with household incomes between 100 and 400 per-

cent of the Federal poverty level ("FPL") for the family size involved who do not receive health insurance through an employer or a spouse's employer.[1] Household income is defined as the sum of: (1) the taxpayer's modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining that taxpayer's family size (but only if such individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded by section 911 (the exclusion from gross income for citizens or residents living abroad), (2) any tax-exempt interest received or accrued during the tax year, and (3) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) that is excluded from income under section 86 (that is, the amount of the taxpayer's Social Security benefits that are excluded from gross income).[2] To be eligible for the premium assistance credit, taxpayers who are married (within the meaning of section 7703) must file a joint return. Individuals who are listed as dependents on a return are ineligible for the premium assistance credit.

As described in Table 1 below, premium assistance credits are available on a sliding scale basis for individuals and families with household incomes between 100 and 400 percent of FPL to help subsidize the cost of private health insurance premiums. The premium assistance credit amount is determined based on the percentage of income the cost of premiums represents, rising from two percent of income for those at 100 percent of FPL for the family size involved to 9.5 percent of income for those at 400 percent of FPL for the family size involved. After 2014, the percentages of income are indexed to the excess of premium growth over income growth for the preceding calendar year. After 2018, if the aggregate amount of premium assistance credits and cost-sharing reductions[3] exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year. For purposes of calculating family size, individuals who are in the country illegally are not included.

TABLE 1.—THE PREMIUM ASSISTANCE CREDIT PHASE-OUT

Household income (expressed as a percent of FPL)	Initial premium (percentage)	Final premium (percentage)
100% up to 133%	2.0	2.0
133% up to 150%	3.0	4.0
150% up to 200%	4.0	6.3
200% up to 250%	6.3	8.05

[1] Individuals who are lawfully present in the United States but are not eligible for Medicaid because of their immigration status are treated as having a household income equal to 100 percent of FPL (and thus eligible for the premium assistance credit) as long as their household income does not actually exceed 100 percent of FPL.

[2] The definition of modified adjusted gross income used in section 36B is incorporated by reference for purposes of determining eligibility to participate in certain other healthcare-related programs, such as reduced cost-sharing (section 1402 of the Patient Protection and Affordable Care Act, Pub. L. No.111–148 ("PPACA")), Medicaid for the nonelderly (section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) as modified by section 2002(a) of PPACA) and the Children's Health Insurance Program (section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) as modified by section 2101(d) of PPACA).

[3] As described in section 1402 of PPACA.

TABLE 1.—THE PREMIUM ASSISTANCE CREDIT PHASE-OUT—Continued

Household income (expressed as a percent of FPL)	Initial premium (percentage)	Final premium (percentage)
250% up to 300%	8.05	9.5
300% up to 400%	9.5	9.5

Minimum essential coverage and employer offer of health insurance coverage

Generally, if an employee is offered minimum essential coverage [4] in the group market, including employer-provided health insurance coverage, the individual is ineligible for the premium assistance credit for health insurance purchased through an American Health Benefit Exchange.

If an employee's share of the premium for self-only coverage exceeds 9.5 percent of an employee's household income or the plan's share of total allowed cost of provided benefits is less than 60 percent of such costs, the employee can be eligible for the premium assistance credit. Premium assistance tax credit eligibility requires that an employee decline enrollment in employer-offered coverage and satisfy the conditions for receiving a premium assistance tax credit through an American Health Benefit Exchange.

Reconciliation

If the premium assistance credit received through advance payment exceeds the amount of premium assistance credit to which the taxpayer is entitled for the taxable year, the liability for the overpayment must be reflected on the taxpayer's income tax return for the taxable year subject to a limitation on the amount of such liability. For persons with household income below 400 percent of FPL, the liability for the overpayment for a taxable year is limited to a specific dollar amount (the "applicable dollar amount") as shown in Table 2 below (one-half of the applicable dollar amount shown in Table 2 for unmarried individuals who are not surviving spouses or filing as heads of households).[5]

TABLE 2.—RECONCILIATION

Household income (expressed as a percent of FPL)	Applicable dollar amount
Less than 200%	$600
At least 200% but less than 300%	$1,500
At least 300% but less than 400%	$2,500

If the premium assistance credit for a taxable year received through advance payment is less than the amount of the credit to which the taxpayer is entitled for the year, the shortfall in the credit is also reflected on the taxpayer's tax return for the year.

[4] As defined in section 5000A(f).

[5] Section 36B(f)(2), as amended by section208 of the Medicare and Medicaid Extenders Act of 2010, Pub. L. No.111–309, and section 4 of the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, P.L. 112–9.

Reasons for change

The Committee believes that overpayments resulting from certain Federally subsidized health insurance programs should be fully recouped and that failure to do so will result in the mismanagement of taxpayer funds. The Committee believes that it is appropriate to align repayment requirements for this program with those of similar tax credits, like the earned income tax credit. Given that, in the case of an exchange subsidy underpayment, the Federal government is required to pay the filer the additional appropriate amount of funds, the Committee believes it is appropriate for the government to be able to recoup overpayments. Thus, the Committee believes that recipients should be required to repay the full amount of any overpayment of the advance premium assistance credit.

Explanation of provision

The legislative recommendation repeals the present-law provision under which, in the case of an individual with household income below 400 percent of FPL, liability for an overpayment resulting from excess advance payments is limited to the applicable dollar amount. Thus, under the legislative recommendation, an individual would be required to repay the full amount of the overpayment.

Effective date

The legislative recommendation is effective for taxable years ending after December 31, 2013.

VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of "Budget Reconciliation Legislative Recommendations Relating to Recapture of Federally-Subsidized Health Insurance Overpayments."

Motion to transmit recommendation

The budget reconciliation legislative recommendation was ordered favorably transmitted without amendment by a voice vote (with a quorum being present).

Votes on amendments

Roll call votes were conducted on the following amendments to the budget reconciliation legislative recommendation.

An amendment by Mr. Stark, which would preclude the application of the proposal for a taxable year with respect to which the Department of the Treasury makes a specified certification, was not agreed to by roll call vote of 22 nays to 14 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Camp		X		Mr. Levin	X		
Mr. Herger		X		Mr. Rangel			
Mr. Johnson		X		Mr. Stark	X		
Mr. Brady		X		Mr. McDermott	X		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Ryan		X		Mr. Lewis	X		
Mr. Nunes		X		Mr. Neal	X		
Mr. Tiberi		X		Mr. Becerra	X		
Mr. Davis		X		Mr. Doggett	X		
Mr. Reichert		X		Mr. Thompson	X		
Mr. Boustany		X		Mr. Larson	X		
Mr. Roskam		X		Mr. Blumenauer	X		
Mr. Gerlach		X		Mr. Kind	X		
Mr. Price		X		Mr. Pascrell	X		
Mr. Buchanan		X		Ms. Berkley	X		
Mr. Smith		X		Mr. Crowley	X		
Mr. Schock		X					
Ms. Jenkins		X					
Mr. Paulsen		X					
Mr. Marchant		X					
Mr. Berg		X					
Ms. Black		X					
Mr. Reed		X					

An amendment by Mr. Crowley, which would preclude the application of the proposal for a taxable year with respect to which the Department of the Treasury makes a specified certification, was not agreed to by roll call vote of 22 nays to 14 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Camp		X		Mr. Levin	X		
Mr. Herger		X		Mr. Rangel			
Mr. Johnson		X		Mr. Stark	X		
Mr. Brady		X		Mr. McDermott	X		
Mr. Ryan		X		Mr. Lewis	X		
Mr. Nunes		X		Mr. Neal	X		
Mr. Tiberi		X		Mr. Becerra	X		
Mr. Davis		X		Mr. Doggett	X		
Mr. Reichert		X		Mr. Thompson	X		
Mr. Boustany		X		Mr. Larson	X		
Mr. Roskam		X		Mr. Blumenauer	X		
Mr. Gerlach		X		Mr. Kind	X		
Mr. Price		X		Mr. Pascrell	X		
Mr. Buchanan		X		Ms. Berkley	X		
Mr. Smith		X		Mr. Crowley	X		
Mr. Schock		X					
Ms. Jenkins		X					
Mr. Paulsen		X					
Mr. Marchant		X					
Mr. Berg		X					
Ms. Black		X					
Mr. Reed		X					

BUDGET EFFECTS OF THE PROVISIONS

Committee estimate of budgetary effects

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the "Budget Reconciliation Legislative Recommendations Relating to Recapture of Federally-Subsidized Health Insurance Overpayments," as transmitted.

The budget reconciliation legislative recommendation, as transmitted, is estimated to have the following effects on budget receipts for fiscal years 2013–2022:

FISCAL YEARS

[Billions of Dollars]

Item	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013–17	2013–22
Recapture of Overpayments Resulting from Certain Federally-Subsidized Health Insurance[1]	.....	1.1	2.6	4.1	5.0	5.5	5.9	6.1	6.6	6.9	12.9	43.9

NOTE: Details do not add to totals due to rounding.

[1] Estimate includes the following effects:

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013–17	2013–22
Off-budget effects	[2]	[2]	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.2	−0.6
Outlay effects	.....	−0.9	−1.9	−3.0	−3.6	−4.0	−4.2	−4.4	−4.8	−5.1	−9.3	−31.9

[2] Loss of less than $50 million.

Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendation involves no new or increased budget authority. The Committee states further that the budget reconciliation legislative recommendation involves no new or increased tax expenditures.

Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by the CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 24, 2012.

Hon. DAVE CAMP,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the committee's reconciliation recommendation related to the Recapture of Overpayments Resulting From Certain Federally Subsidized Health Insurance, as approved on April 18, 2012.

If you wish further details on this estimate, we will be pleased to provide them. The staff contact is Sarah Anders, who can be reached at 226–9010.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

Recapture of Overpayments Resulting From Certain Federally Subsidized Health Insurance

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 that reconciliation process, the House Committee on Ways and Means has approved three separate provisions as reconciliation recommendations. The following analysis presents estimated budgetary effects for one of those three provisions.

The legislation would require collections of certain overpayments of health insurance subsidies. The staff of the Joint Committee on Taxation (JCT) and CBO estimate that this proposal would have no impact in 2012 or 2013, and would reduce the deficit by $12.9 billion over the 2013–2017 period and $43.9 billion over the 2013–2022 period. This reduction would come from net increases in revenue as well as decreases in direct spending. The estimate of budgetary effects would be the same for any assumed enactment date this year because those effects would not begin until 2014.

JCT has determined that the provision contains no intergovernmental mandates and one private-sector mandate as defined in the Unfunded Mandates Reform Act (UMRA). Based on information provided by JCT, the cost of the provision's private-sector mandate would exceed the annual threshold established in UMRA for private-sector mandates ($146 million in 2012, adjusted annually for inflation) beginning in 2014.

Estimated cost to the Federal Government: The estimated budgetary effects of the proposal are shown in the following table. The spending effects of this proposal fall within budget function 550 (health).

	By fiscal year, in billions of dollars—												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012–2017	2012–2022
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority	0	0	−0.9	−1.9	−3.0	−3.6	−4.0	−4.2	−4.4	−4.8	−5.1	−9.4	−31.9
Estimated Outlays	0	0	−0.9	−1.9	−3.0	−3.6	−4.0	−4.2	−4.4	−4.8	−5.1	−9.4	−31.9
CHANGES IN REVENUES													
Estimated Revenues	0	0	0.2	0.7	1.1	1.4	1.5	1.7	1.7	1.7	1.9	3.5	12.0
On-budget	0	0	0.3	0.7	1.2	1.5	1.6	1.7	1.8	1.8	2.0	3.6	12.6
Off-budget [a]	0	0	*	*	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.2	−0.6
NET INCREASE OR DECREASE (−) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES													
Impact on Deficits	0	0	−1.1	−2.6	−4.1	−5.0	−5.5	−5.9	−6.1	−6.6	−6.9	−12.9	−43.9
On-budget	0	0	−1.1	−2.6	−4.2	−5.1	−5.6	−6.0	−6.2	−6.6	−7.0	−13.0	−44.4
Off-budget [a]	0	0	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6

Source: Staff of the Joint Committee on Taxation.
Notes: Numbers may not sum to totals because of rounding.
* = decrease in revenues of less than $50 million.
a. All off-budget effects would come from changes in revenues. (Payroll taxes for Social Security are classified as "off-budget.")

Basis of estimate: Under current law, starting in 2014, qualified taxpayers will become eligible to receive refundable tax credits to assist in the purchase of health insurance through the health insurance exchanges established by the Affordable Care Act. The amount of those premium assistance credits will be based on family size and income, and the advance payments of the credits will be based on income estimated from tax returns for prior years. If taxpayers' circumstances change to the extent that their advance payments exceed the premium assistance credits to which they are entitled, they may be required to repay some or all of the credits, subject to certain limits based on income.

Enacting the overpayments provision would eliminate existing limits on the amounts to be repaid by taxpayers whose advance payments exceed the premium assistance credits to which they are entitled. Taxpayers would therefore be liable for the full amount of overpayments. CBO and JCT expect that, under the provision, fewer people would apply for premium assistance credits and purchase insurance through exchanges than under current law. Some people would not apply for the credits because of concern that unforeseen changes in their income or family composition could result in a large repayment liability they would have difficulty meeting. Others would anticipate changes in income or family composition that would reduce the subsidy they would receive to purchase health insurance or could cause a larger increase in liability under the proposal.

Reduced enrollment in exchanges is expected to result in an increase in the number of people who obtain health insurance through an employer and an increase in the number of people without health insurance. Among individuals who continue to apply for and receive premium assistance credits, some would update their income information to reduce overpayments while others would end up repaying more as a result of the proposal. JCT estimates that the proposal would reduce net outlays for premium assistance credits and cost-sharing subsidies by nearly $32 billion over the 2013–2022 period and increase net revenues by about $12 billion over the same period. That effect on revenues includes reductions of less than $1 billion from payroll taxes for Social Security, which are off-budget.

Intergovernmental and private-sector impact: JCT has determined that the provision related to overpayments of health insurance subsidies contains no intergovernmental mandates and one private-sector mandate as defined in UMRA. That mandate would eliminate existing limits on the amounts taxpayers would be required to repay for advance premium assistance tax credits associated with health insurance exchanges, in the event of an overpayment. Based on information provided by JCT, the cost of the mandate would exceed the annual threshold established in UMRA for private-sector mandates ($146 million in 2012, adjusted annually for inflation) beginning in 2014.

Estimate prepared by: JCT and Sarah Anders.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

Macroeconomic impact analysis

In compliance with clause 3(h)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the budget reconciliation legislative recommendation amending the Internal Revenue Code of 1986: the effects of the legislative recommendation on economic activity are so small as to be incalculable within the context of a model of the aggregate economy.

OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

Committee oversight findings and recommendations

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of the budget reconciliation legislative recommendation that the Committee concluded that it is appropriate to transmit the legislative recommendation to the Committee on the Budget.

Statement of general performance goals and objectives

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the budget reconciliation legislative recommendation contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizing funding is required.

Constitutional authority statement

The Committee states that the Committee's action in transmitting this budget reconciliation legislative recommendation is derived from Article I of the United States Constitution, Section 8, Clause 1 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises . . . "), and from the 16th Amendment to the United States Constitution.

Information relating to unfunded mandates

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104–4).

The Committee has determined that the budget reconciliation legislative recommendation contains one private sector mandate: changes to the limitations on recapture of overpayments resulting from advance premium assistance tax credits for Federally-subsidized health insurance. The Committee has determined that the budget reconciliation legislative recommendation does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

Applicability of House Rule XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a

vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendation, and states that the provisions of the legislative recommendation do not involve any Federal income tax rate increases within the meaning of the rule.

Tax complexity analysis

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the budget reconciliation legislative recommendation contains no provisions that amend the Code and that have "widespread applicability" to individuals or small businesses, within the meaning of the rule.

Congressional earmarks, limited tax benefits, and limited tariff benefits

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendation, and states that the provisions of the legislative recommendation do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, 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):

SECTION 36B OF THE INTERNAL REVENUE CODE OF 1986

SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) * * *

* * * * * * *

(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

(1) * * *

[(2) EXCESS ADVANCE PAYMENTS.—

[(A) IN GENERAL.—If the]

(2) EXCESS ADVANCE PAYMENTS.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

[(B) LIMITATION ON INCREASE.—

[(i) IN GENERAL.—In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

[If the household income (expressed as a percent of poverty line) is:	The applicable dollar amount is:
Less than 200%	$600
At least 200% but less than 300%	$1,500
At least 300% but less than 400%	$2,500

[(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts in the table contained under clause (i) shall be increased by an amount equal to—

[(I) such dollar amount, multiplied by

[(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2013" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.]

* * * * * * *

DISSENTING VIEWS ON RECOMMENDATION TO CUT AFFORDABLE CARE ACT PREMIUM TAX CREDITS

These recommendations to the Budget Committee follow a disturbing but familiar pattern. Once again, the Majority has targeted seniors, children, people with disabilities, and middle-income families rather than ask the very wealthiest Americans to pay their fair share. We strongly oppose this unfair approach, these specific legislative proposals, and the complete lack of consultation, public discussion, or analysis of the consequences of these policies that preceded our Committee action. We support a fair and balanced approach to deficit reduction. The Majority's recommendation is neither fair nor balanced.

We oppose the provision that would amend the premium tax credits that are provided under the Affordable Care Act (ACA). This provision is designed to undercut the ACA's guarantee of quality, affordable health care for all.

The Affordable Care Act uses tax credits to make health coverage affordable to those with lower and middle incomes. While most uninsured individuals and families (or those at risk of becoming uninsured) have incomes at or below 200 percent of the poverty level—approximately $45,000 for a family of four in 2012—the premium tax credits are adjusted according to income and are fully phased-out at 400 percent of poverty. These tax credits are provided in advance to the insured's insurance company based on the individual or family's prior year income and then are reconciled with the individual or family's actual income for the year the health coverage is purchased.

Advance payment of the credits is critical to providing quality, affordable health care because individuals and families need real-time assistance in purchasing coverage. A credit that is reimbursed to the individual or family via their tax refund two or four or more months after the end of the year for which they were paying premiums is no assistance at all. Because people necessarily must use income information from prior tax years to qualify for advance payment of the tax credits, it is very possible that their actual incomes will be higher or lower for the year for which they are purchasing coverage.

Naturally, income from a previous year cannot reflect income fluctuations resulting from job loss or changes, raises or bonuses; likewise, it cannot anticipate or reflect changes in family size, including those due to death or divorce, which will affect the poverty level calculation and size of the credit. While the ACA requires some repayment in recognition of this income fluctuation, it also recognizes that full repayment may create an unacceptably large and unanticipated burden on families that are struggling to get back on their feet. Therefore, the ACA also limited the amounts individuals and families would need to pay back if income increases.

Already Congress has revised this provision several times. The first modification, enacted at the end of 2010 in the Medicare and Medicaid Extenders Act of 2010 (Public Law 111–309), contained a significant improvement in that it eliminated payment cliffs at 400 percent of poverty. The second modification, enacted early in 2011 in the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Public Law 112–9), eliminated this improvement. The Joint Committee on Taxation (JCT) estimated that 265,000 individuals would lose health coverage as a result.

Now, the majority seeks to eliminate the payment cap protection entirely.

We oppose this provision because it will lead to further coverage losses and unfairly penalize individuals and families for economic progress or personal tragedy. JCT estimates that 350,000 individuals would lose coverage as a result of this provision.

We also oppose this provision because it is a tax increase on lower-income and middle-class individuals and families. According to JCT, this provision raises revenues by $43.9 billion dollars. This is clearly a tax increase on the middle class. The language of the section of the Internal Revenue Code that this provision amends makes that abundantly clear: "If the advance payments to a taxpayer . . . exceed the credit allowed by this section . . ., the tax imposed by *this chapter* for the taxable year shall be increased by the amount of such excess." Section 36B(f)(2) of the Internal Revenue Code (emphasis added). The reference to "this chapter" is to the income tax that is contained in Subtitle A and Chapter 1 of the Internal Revenue Code.

A final reason for our opposition is because the ACA already contains a strong penalty in the case of fraud in the application for advance payment of the premium tax credits. Section 1411(h)(1)(B) of the ACA provides for a civil penalty of up to $250,000 in such cases. This budget reconciliation legislative proposal does not prevent fraud or abuse. It is not an effort to penalize only those who intentionally misrepresent their income and receive a credit under dubious circumstances. This proposal only serves to raise taxes on families in certain circumstances, including families where one spouse is able to finally find full-time employment in his or her field, after a substantial period of unemployment or under-employment—due perhaps to a prior layoff, finishing job training or education, or raising children or caring for a dependent relative. For this reason, this provision will impose a significant and unexpected tax burden on middle-class individuals and American families whose employment or family circumstances have changed unexpectedly, or because of events beyond their control, and are still struggling financially on account of these circumstances.

We are committed to bringing our budget into balance, but do not believe that children, senior citizens and the disabled should be targeted for massive cuts, as the wealthiest among us are asked to contribute nothing. We attempted to substitute these and other cuts with an equal amount of deficit reduction through the so-called "Buffett Rule," which would have affected only those with annual incomes of $1 million or more a year. Regrettably, the ma-

jority refused to allow a vote on this more equitable approach for reducing our deficit.

SANDER LEVIN.

SUBTITLE B—SOCIAL SECURITY NUMBER REQUIRED TO CLAIM THE REFUNDABLE PORTION OF THE CHILD TAX CREDIT

CONTENTS

	Page
Summary and Background	493
Explanation of Provision	494
Votes of the Committee	495
Budget Effects of the Provisions	496
Other Matters To Be Discussed Under The Rules of the House	499
Changes in Existing Law Made by the Legislative Recommendations, as Transmitted	501
Dissenting Views	503

SUMMARY AND BACKGROUND

PURPOSE AND SUMMARY

In partial fulfillment of the reconciliation instructions included in section 201(b)(6) of the Concurrent Resolution on the Budget for Fiscal Year 2013 (H. Con. Res. 112), the Committee on Ways and Means favorably transmitted the Budget Reconciliation Legislative Recommendations Relating to Social Security Number Requirements for the Refundable Portion of the Child Tax Credit without amendment (with a quorum being present). The Committee recommends that a Social Security Number (SSN) be required in order to claim the refundable portion of the child tax credit (sometimes referred to as the "additional child tax credit" or ACTC). Under current law, individuals must earn income in the United States in order to obtain the ACTC; however, the absence of an SSN requirement effectively permits individuals who are not authorized to work in the U.S.—and who, therefore, cannot legally earn the income that is necessary to qualify for the credit—to claim it. The Committee's recommendation ensures that only those with an SSN, and thus only those who are eligible to earn income in the United States, may obtain the ACTC.

BACKGROUND AND NEED FOR LEGISLATION

Given the Federal government's current fiscal situation, it is imperative that Congress scrutinize the Federal budget to identify potential improper payments resulting from waste, fraud, and abuse. Once identified, it is incumbent on Congress to amend statutes and address programs that fail to fully protect taxpayer dollars. According to a July 7, 2011 report by the Treasury Inspector General for Tax Administration (TIGTA), the number of filers without an SSN whose ACTC claims were processed in 2010 was 2.3 million, and those individuals claimed approximately $4.2 billion in benefits that year. TIGTA also found that filers without an SSN received 15 percent of all ACTC payments processed in 2010. In 1996, Con-

gress enacted legislation making those without SSNs ineligible to receive the earned income tax credit (EITC), a similar refundable tax credit. The proposal embodied in this recommendation—based on legislation (H.R. 1956) introduced by Rep. Sam Johnson (R-TX)—would bring the pertinent rules applicable to the ACTC in line with those of the EITC, reflecting ongoing bipartisan concerns about payments to individuals who are not authorized to work in the United States.

LEGISLATIVE HISTORY

Budget resolution

On March 29, 2012, the House of Representatives approved H. Con. Res. 112, the budget resolution for fiscal year 2013. Pursuant to section 201(b)(6) of H. Con. Res. 112, the Committee on Ways and Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of the Committee on Ways and Means sufficient to reduce the deficit by $1,200,000,000 for the period of fiscal years 2012 and 2013; by $23,000,000,000 for the period of fiscal years 2012 through 2017; and by $53,000,000,000 for the period of fiscal years 2012 through 2022.

Committee action

On April 18, 2012, in partial fulfillment of its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative recommendation, and ordered the recommendation relating to Social Security Number Requirements for the Refundable Portion of the Child Tax Credit favorably transmitted.

Committee hearings

On May 25, 2011, the Oversight Subcommittee held a hearing on improper payments in the administration of refundable tax credits, which explored the $106 billion in improper refundable tax credits paid out in recent years. This hearing featured testimony regarding improper ACTC payments, including on the increase of such improper payments, from $62 million in 2000 to $4.2 billion in 2010, to non-SSN holders.

EXPLANATION OF PROVISION

SOCIAL SECURITY NUMBER REQUIRED TO CLAIM THE REFUNDABLE PORTION OF THE CHILD TAX CREDIT

Present Law

An individual may claim a tax credit for each qualifying child under the age of 17. The maximum amount of the credit per child is $1,000 through 2012 and $500 thereafter. A child who is not a citizen, national, or resident of the United States cannot be a qualifying child.

For taxable years beginning in 2012, the child tax credit is allowable against both the regular tax and the alternative minimum tax. For taxable years beginning after 2012, the credit is allowable only to the extent the regular tax exceeds the tentative minimum tax.

To the extent that the child tax credit is not allowed to offset the taxpayer's tax liability, the taxpayer may be eligible for an additional credit which is refundable. For taxable years beginning in 2012, the additional credit is in an amount equal to the greater of (1) 15 percent of the taxpayer's earned income in excess of $3,000, or (2) in the case of a family with three or more children, the amount by which the taxpayer's social security taxes exceed the earned income credit. For taxable years beginning after 2012, the additional credit applies only in the case of a family with three or more children in the amount described in (2) above.

No credit is allowed to any taxpayer with respect to any qualifying child unless the taxpayer includes the name and the taxpayer identification number of the qualifying child on the tax return for the taxable year.

Any taxpayer required to file a Federal income tax return must furnish his or her own taxpayer identification number on the return. For individual filers, a taxpayer identification number may be either a SSN or an IRS individual taxpayer identification number (ITIN).

Reasons for change

Given that the refundable portion of the child tax credit requires earned income as a condition of eligibility, the Committee believes that additional steps should be taken to ensure that those who cannot legally earn income in the United States cannot collect the refundable portion of this credit. The Committee observes that, in 1996, Congress enacted legislation making those without SSNs ineligible to receive the EITC, a similar refundable tax credit. The Committee believes that in order to prevent abuse in the refundable portion of the child tax credit—such as that identified in the July 7, 2011 TIGTA report—that SSN requirement should be extended to the refundable portion of the child tax credit as well.

Explanation of provision

The legislative recommendation adds a requirement that the additional child tax credit is allowable only if the tax return includes the taxpayer's SSN (or in the case of a joint return, the SSN of either spouse).

The rule does not apply to the extent the taxpayer's tentative minimum tax exceeds his or her earned income credit for the taxable year. Thus, under the legislative recommendation, a taxpayer can offset income tax liability with an ACTC, despite not entering a SSN as the taxpayer's identification number on the tax return.

Effective date

The legislative recommendation is effective for taxable years beginning after the date of enactment.

VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of "Budget Reconciliation Legislative Recommendations

Relating to Social Security Number Requirements for Refundable Portion of the Child Tax Credit."

The budget reconciliation legislative recommendation was ordered favorably transmitted without amendment by a roll call vote of 22 yeas to 12 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Camp	X			Mr. Levin		X	
Mr. Herger	X			Mr. Rangel		X	
Mr. Johnson	X			Mr. Stark		X	
Mr. Brady	X			Mr. McDermott		X	
Mr. Ryan	X			Mr. Lewis		X	
Mr. Nunes	X			Mr. Neal		X	
Mr. Tiberi	X			Mr. Becerra		X	
Mr. Davis	X			Mr. Doggett		X	
Mr. Reichert	X			Mr. Thompson		X	
Mr. Boustany	X			Mr. Larson		X	
Mr. Roskam	X			Mr. Blumenauer		X	
Mr. Gerlach	X			Mr. Kind		X	
Mr. Price	X			Mr. Pascrell		X	
Mr. Buchanan	X			Ms. Berkley		X	
Mr. Smith	X			Mr. Crowley		X	
Mr. Schock	X						
Ms. Jenkins	X						
Mr. Paulsen	X						
Mr. Marchant	X						
Mr. Berg	X						
Ms. Black	X						
Mr. Reed	X						

BUDGET EFFECTS OF THE PROVISION

COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the "Budget Reconciliation Legislative Recommendations Relating to Social Security Number Requirements for Refundable Portion of the Child Tax Credit," as transmitted.

The budget reconciliation legislative recommendation, as transmitted, is estimated to have the following effect on budget receipts for fiscal years 2013–2022:

FISCAL YEARS

[Billions of Dollars]

Item	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013–17	2013–22
Social Security Number Required to Claim the Refundable Portion of the Child Tax Credit [1]	.....	1.0	1.0	0.9	0.9	0.8	0.8	0.8	0.8	0.7	3.7	7.6

Note: Details do not add to totals due to rounding.

[1] Estimate includes the following outlay effects:

2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013–17	2013–22
.....	−1.0	−1.0	−0.9	−0.9	−0.8	−0.8	−0.8	−0.8	−0.7	−3.7	−7.6

STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the budget reconciliation legislative recommendation involves no new or increased budget authority. The Committee states further that the budget reconciliation legislative recommendation involves no new or increased tax expenditures.

COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by the CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 24, 2012.

Hon. DAVE CAMP,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the committee's reconciliation recommendation related to a Social Security Number Required to Claim the Refundable Portion of the Child Tax Credit, as approved on April 18, 2012.

If you wish further details on this estimate, we will be pleased to provide them. The staff contact is Kalyani Parthasarathy, who can be reached at 6–2800.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

Social Security Number Required to Claim the Refundable Portion of the Child Tax Credit

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 that reconciliation process, the House Committee on Ways and Means has approved three separate provisions as reconciliation recommendations. The following analysis presents estimated budgetary effects for one of those three provisions.

The legislation would require taxpayers to provide their Social Security Number (SSN) in order to claim the refundable portion of the child tax credit. The staff of the Joint Committee on Taxation (JCT) estimates that the legislation would have no budgetary impact in 2012 or 2013, but would reduce outlays by $3.7 billion over the 2012–2017 period and by $7.6 billion over the 2012–2022 period. Because the legislation would have no budgetary impact in 2012 or 2013, those estimates would be the same for any enactment date this year.

Under current law, taxpayers who have either an individual taxpayer identification number or an SSN and include it on their in-

come tax return can claim a tax credit—$1,000 this year and $500 starting in 2013—for each of their qualifying children under the age of 17. If the credit exceeds the tax liability of the taxpayer, the excess may be refunded depending on the taxpayer's earnings, and the refunded portion is classified as an outlay in the federal budget. The legislation would allow only taxpayers who provide their SSN to claim the refundable portion of the credit, starting in 2013. JCT's estimate of the legislation's impact is shown in the following table.

	By Fiscal Year, in Billions of Dollars												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012–2017	2012–2022
CHANGES IN DIRECT SPENDING													
Estimated Budget Authority	0	0	−1.0	−1.0	−0.9	−0.9	−0.8	−0.8	−0.8	−0.8	−0.7	−3.7	−7.6
Estimated Outlays	0	0	−1.0	−1.0	−0.9	−0.9	−0.8	−0.8	−0.8	−0.8	−0.7	−3.7	−7.6

JCT has determined that the legislation contains no intergovernmental mandates and one private-sector mandate as defined in the Unfunded Mandates Reform Act (UMRA). Based on information provided by JCT, the cost of the private-sector mandate would exceed the annual threshold established in UMRA for private-sector mandates ($146 million in 2012, adjusted annually for inflation) beginning in 2014.

The CBO staff contact for this estimate is Kalyani Parthasarathy. This estimate was approved by Frank Sammartino, Assistant Director for Tax Analysis.

MACROECONOMIC IMPACT ANALYSIS

In compliance with clause 3(h)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the budget reconciliation legislative recommendation amending the Internal Revenue Code of 1986: the effects of the legislative recommendation on economic activity are so small as to be incalculable within the context of a model of the aggregate economy.

OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of the budget reconciliation legislative recommendation that the Committee concluded that it is appropriate to transmit the legislative recommendation to the Committee on the Budget.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the budget reconciliation legislative recommendation contains no measure that

authorizes funding, so no statement of general performance goals and objectives for which any measure authorizing funding is required.

CONSTITUTIONAL AUTHORITY STATEMENT

The Committee states that the Committee's action in transmitting this budget reconciliation legislative recommendation is derived from Article of the United States Constitution, Section 8, Clause 1 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises . . ."), and from the 16th Amendment to the United States Constitution.

INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104–4).

The Committee has determined that the budget reconciliation legislative recommendation contains one private sector mandate: requiring those who claim the refundable child tax credit to enter a Social Security Number on their tax return. The Committee has determined that the budget reconciliation legislative recommendation does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

APPLICABILITY OF HOUSE RULE XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendation, and states that the provisions of the legislative recommendation do not involve any Federal income tax rate increases within the meaning of the rule.

TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the budget reconciliation legislative recommendation contains no provisions that amend the Code and that have "widespread applicability" to individuals or small businesses, within the meaning of the rule.

CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the budget reconciliation legislative recommendation, and states that the provisions of the legislative recommendation do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

Subtitle A—Income Taxes

* * * * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * * * *

Subchapter A—Determination of Tax Liability

* * * * * * *

PART IV—CREDITS AGAINST TAX

* * * * * * *

Subpart A—Nonrefundable Personal Credits

* * * * * * *

SEC. 24. CHILD TAX CREDIT.

(a) * * *

* * * * * * *

(d) PORTION OF CREDIT REFUNDABLE.—

(1) * * *

* * * * * * *

(5) IDENTIFICATION REQUIREMENT WITH RESPECT TO TAXPAYER.—

(A) IN GENERAL.—Paragraph (1) shall not apply to any taxpayer for any taxable year unless the taxpayer includes the taxpayer's Social Security number on the return of tax for such taxable year.

(B) JOINT RETURNS.—In the case of a joint return, the requirement of subparagraph (A) shall be treated as met if

the Social Security number of either spouse is included on such return.

(C) LIMITATION.—Subparagraph (A) shall not apply to the extent the tentative minimum tax (as defined in section 55(b)(1)(A)) exceeds the credit allowed under section 32.

(e) IDENTIFICATION REQUIREMENT *WITH RESPECT TO QUALIFYING CHILDREN*.—No credit shall be allowed under this section to a taxpayer with respect to any qualifying child unless the taxpayer includes the name and taxpayer identification number of such qualifying child on the return of tax for the taxable year.

* * * * * * *

Subtitle F—Procedure and Administration

* * * * * * *

CHAPTER 63—ASSESSMENT

* * * * * * *

Subchapter B—Deficiency Procedures in the Case of Income, Estate, Gift, and Certain Excise Taxes

* * * * * * *

SEC. 6213. RESTRICTIONS APPLICABLE TO DEFICIENCIES; PETITION TO TAX COURT.

(a) * * *

* * * * * * *

(g) DEFINITIONS.—For purposes of this section—

(1) * * *

(2) MATHEMATICAL OR CLERICAL ERROR.—The term "mathematical or clerical error" means—

(A) * * *

* * * * * * *

[(I) an omission of a correct TIN required under section 24(e) (relating to child tax credit) to be included on a return,**]**

(I) an omission of a correct Social Security number required under section 24(d)(5) (relating to refundable portion of child tax credit), or a correct TIN under section 24(e) (relating to child tax credit), to be included on a return,

* * * * * * *

DISSENTING VIEWS ON RECOMMENDATION TO REDUCE THE AVAILABILITY OF THE REFUNDABLE CHILD TAX CREDIT

These recommendations to the Budget Committee follow a disturbing but familiar pattern. Once again, the Majority has targeted seniors, children, people with disabilities, and middle-income families rather than ask the very wealthiest Americans to pay their fair share. We strongly oppose this unfair approach, these specific legislative proposals, and the complete lack of consultation, public discussion, or analysis of the consequences of these policies that preceded our Committee action. We support a fair and balanced approach to deficit reduction. The Majority's recommendation is neither fair nor balanced.

In 2013 alone, this recommendation is estimated to affect one million families and more than three million children. We urge the Majority to slow down and proceed in a manner that ensures that no United States citizens would be harmed by this recommendation.

We have three primary concerns.

First, we are concerned that this recommendation would harm low-income families. In 2010, over 21 million families claimed the Additional Child Tax Credit. The average adjusted gross income of families claiming this credit was about $22,000, and the average amount claimed was $1,800. This recommendation would take an average of $1,800 from one million, very low-income families.

Second, we are concerned that this recommendation would harm children living in low-income families. More than one in five children—over 16 million children—in the United States live in families with income below the federal poverty level. From 2006 to 2010, the poverty rate increased for children from 17.4 percent (12.8 million children) to 22.0 percent (16.4 million children), respectively. Children of immigrants account for over one-quarter of all children in the United States living in low-income families. More than one in three Latino children lived in poverty in 2010. Unlike the Earned Income Tax Credit that is designed to promote work, the child tax credit is designed to fight child poverty and ensure the well-being of children. In 2009, the child tax credit kept nearly 1.3 million children out of poverty. This recommendation would reduce the effectiveness of the child tax credit as an anti-poverty measure for more than three million children.

Third, we are concerned that this recommendation would harm millions of children who are United States citizens. More specifically, it would harm millions of American children who are United States citizens living in immigrant families. In 2010, more than nine in ten children (92 percent) claimed under the child tax credits were United States citizens. In 2010, there were 4.5 million U.S.-born children (i.e., United States citizens) living in mixed-sta-

tus, immigrant families. Overall, an estimated 85 percent of families that would be affected by this recommendation are Hispanic.

We are committed to bringing our budget into balance, but do not believe that children, senior citizens and the disabled should be targeted for massive cuts, as the wealthiest among us are asked to contribute nothing. We attempted to substitute these and other cuts with an equal amount of deficit reduction through the so-called "Buffett Rule," which would have affected only those with annual incomes of $1 million or more a year. Regrettably, the majority refused to allow a vote on this more equitable approach for reducing our deficit.

SANDER LEVIN.

SUBTITLE C—HUMAN RESOURCES PROVISIONS

CONTENTS

	Page
Summary of the Major Policy Decisions in the Legislation	505
Report Language: Section-by-Section	513
Committee Oversight Findings	513
Constitutional Authority Statement	514
Committee Votes	514
Congressional Budget Office Estimate	515
Changes in Existing Law Made by the Budget Reconcilliation Legislative	517
Dissenting Views	539

SUMMARY OF THE MAJOR POLICY DECISIONS IN THE LEGISLATION

The predecessor to the current Social Services Block Grant (SSBG) began in 1956 as a way to match targeted State spending on specific services to help families leave welfare. Over the ensuing decades, SSBG evolved in both structure and purpose, and is now a 100 percent Federal funding stream used to support a wide range of services to individuals regardless of their income. The Committee, after conducting an oversight hearing on program duplication and reviewing related reports by the nonpartisan Government Accountability Office (GAO), has determined that the SSBG program has critical program flaws that argue for its elimination, which will both minimize program duplication and achieve significant savings for taxpayers. Accordingly, the Committee legislation eliminates the SSBG effective on October 1, 2012 (that is, for FY 2013 and beyond), saving just under $1.4 billion in FY 2013 and almost $17 billion over 10 years.

The Committee is not opposed to the specific services funded by the SSBG, nor does the Committee believe that individuals receiving these services are not in need of assistance. Indeed, as is described in greater detail below, an important argument for ending the SSBG is the fact that it duplicates so many other programs, which generally provide far greater support than SSBG currently offers for many of the same services, such as child care, child welfare and Meals on Wheels. Further, the Committee is concerned with the design of this program, which President Clinton's FY 1999 budget suggested lacks "statutory performance goals or measures of progress" in arguing for substantial reductions in funding for SSBG.[1]

In sum, the following key flaws in the SSBG program reflect how it clearly does not serve taxpayers well:

• *No focus:* SSBG spends $1.7 billion per year to support 29 different types of social services, including a catchall category called

[1] Budget of the United States Government. Fiscal Year 1999. Available online: *http://www.gpo.gov/fdsys/pkg/BUDGET-1999-BUD/pdf/BUDGET-1999-BUD.pdf*

"other." The program has no Federal eligibility requirements for persons receiving social services funded from the SSBG.

• *Duplicative:* Since the predecessor to the current SSBG was created in the 1950s, programs that today provide more than $446 billion per year in specific social services have been created. In nearly all cases, those other programs—including child care, Head Start, foster care, adoption assistance, SSI, and Medicaid—provide far more support than SSBG for various social services, but also require State financial participation and contain accountability measures to track results.

• *No State partnership:* Unlike other anti-poverty programs under the jurisdiction of the Committee on Ways and Means, SSBG does not require any State investment to match Federal dollars spent through the program. As a result, SSBG is structured more like a permanent State aid program than a focused anti-poverty program with shared Federal and State responsibilities.

• *No accountability:* SSBG includes no accountability for results. State reporting on recipients is limited to a simple count of the number of people receiving services funded with SSBG dollars, and there is no information collected on the demographics of recipients, their earnings, or their progress out of poverty and toward self-sufficiency.

History of the Social Services Block Grant

The SSBG began as many Federal programs do—as a relatively small program focused on helping a specific population achieve specific goals. But in ensuing years it devolved into a simple transfer from Federal taxpayers to States for a broad array of services with no accountability for real results.

Created in 1956, the precursor to the SSBG began as a 50/50 Federal/State match program designed to provide services to help families on welfare move off public assistance. When many States declined to participate, in 1962 the Federal match rate was increased to 75 percent, allowable spending was expanded to include child welfare, adult disability services, and elderly services, and eligibility was broadened to include potential welfare recipients.

In 1967, the program was again expanded to cover job training and child care services, and the Federal match rate was raised yet again to 85 percent. As a result, spending exploded from $282 million in FY 1967 to $1.7 billion in FY 1972, leading Congress to cap Federal spending at $2.5 billion per year. In 1974, program services were broadened yet again to include an even wider range of social services, and eligibility was expanded to include anyone below 85 percent of state median income (which is about $43,000 in current terms).

This prior funding stream officially became the SSBG in 1981, when annual funding was set at $2.4 billion and all State matching and eligibility requirements were eliminated. Since 1981, annual SSBG funding rose to $2.8 billion in 1991 through 1995 before falling in the late 1990s and finally settling at $1.7 billion since 2001.

Duplication between the SSBG and other Social Service Programs

On March 1, 2011, the Government Accountability Office (GAO) released its first annual report identifying duplicative and wasteful

government programs, agencies, and offices.[2] The report highlighted billions of dollars spent on redundant federal programs. In an April 5, 2011 hearing of the Ways and Means Subcommittee on Human Resources on the GAO report on program duplication, GAO provided testimony on fragmentation, overlap, and duplication among programs under the Subcommittee's jurisdiction, including SSBG.

Summarizing their work on human services programs, GAO reported that: "This array of programs plays a key role in supporting those in need, but our work has shown it to be too fragmented and overly complex—for clients to navigate, for program operators to administer efficiently, and for program managers and policymakers to assess program performance."[3]

States report spending SSBG funds on 29 different types of social services, including a catchall category called "other." A significant portion of this State-reported SSBG spending is for services funded under a variety of other Federal programs, including a number under the jurisdiction of the Committee, as described in detail below.

Child Care

The largest category of SSBG spending reported by States is day care for children. However, a 2000 GAO report cited the SSBG as one of 69 programs, administered by nine different Federal agencies, funding early education and care for children under five.[4] Total SSBG spending on child care in FY 2009 was $391 million (including $110 million spent from State's annual allotments for SSBG and $280 million in funds transferred to SSBG from the Temporary Assistance for Needy Families or TANF program). However, this SSBG spending on child care is less than four percent of all Federal funding for child care. Direct funding for the Child Care and Development Fund, the major Federal child care program, rose from $3.5 billion in 2000 to $5.1 billion in 2011. States spent another $5.4 billion from the TANF block grant on child care in FY 2010. An additional $2 billion in child care funding was awarded to States through the American Recovery and Reinvestment Act. The credit for child and dependent care, the exclusion of employer-provided child care, and the credit for employer-provided dependent care also help individuals offset the cost of paying for child care, and the Joint Committee on Taxation's Estimates of Federal Tax Expenditures for Fiscal Years 2011–2015, estimated that these provisions would result in $4.6 billion of forgone revenue for 2011.[5]

---

[2] U.S. Government Accountability Office. Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue. March 1, 2011. Available online: *http://www.gao.gov/products/GAO-11-318SP*

[3] U.S. Government Accountability Office. Human Services Programs: Opportunities to Reduce Inefficiencies. April 5, 2011. Available online: *http://www.gao.gov/assets/130/125910.pdf*

[4] U.S. Government Accountability Office. Early Education and Care: Overlap Indicates Need to Assess Crosscutting Programs. April, 2000. Available online: *http://www.gao.gov/new.items/he00078.pdf.*

[5] Joint Committee on Taxation. Estimates of Federal Tax Expenditures for Fiscal Years 2011–2015, JCS–1–12, page 46. Available online: *http://www.jct.gov/publications.html?func=startdown&id=4386,* page 42.

Child Welfare

Child welfare is a shared responsibility between the States and the Federal government. Federal foster care and adoption assistance programs match State spending on child welfare services. In contrast, spending on child welfare under the SSBG program includes no State matching requirement. Recent and ongoing trends in child welfare funding suggest that, even without SSBG funds, Federal support for various child welfare services and supports will only continue to grow in the years ahead.

Recent non-SSBG child welfare spending growth has been larger than all current SSBG spending on child welfare. Total SSBG spending in FY 2009 on all child welfare services (including foster care, adoption, and child protective services) totaled $714 million; meanwhile, other Federal spending on child welfare grew by $753 million in the past five years alone. States also spend a significant amount of money from TANF on child welfare. A report on child welfare spending in 2006 revealed that TANF funds spent on child welfare ($2.4 billion) comprised 19 percent of total Federal and State child welfare spending; it is likely that both that share as well as absolute TANF spending on child welfare have increased since that survey was completed.[6]

Major Federal child welfare programs are scheduled to continue to grow in the years ahead. Due to Federal changes enacted in 2008, States will receive Federal funding to support an increasing proportion of adoptions in future years. Overall Federal funding for supporting adoption is expected to rise by more than $1 billion in the next six years, dwarfing current SSBG spending on adoption, as well as all other child welfare activities. Also as a result of this additional federal investment, State spending on adoption is expected to decrease in the coming years, freeing State funds that can and should be reinvested into other child welfare services.

States are also beginning to receive new Federal entitlement funding to support children placed with relatives. As the Federal government begins paying for the cost of kinship care (i.e. when a child is placed with a relative or close family friend) CBO projects that Federal reimbursement for kinship care will rise from $53 million per year in FY 2012 to $568 million per year by 2018, constituting a significant new source of child welfare funding for States and families with child welfare needs.[7]

Disability Services

In FY 2009, States reported spending 11 percent of their SSBG funds on special services for the disabled. A GAO report published in 2005 identified almost 200 programs in 20 agencies that provided over $120 billion in federal funds to serve people with disabilities.[8] In addition to these programs, the GAO determined that

---

[6] Child Trends. Federal, State, and Local Spending to Address Child Abuse and Neglect in SFY 2006. December, 2008. Available online: *http://www.childtrends.org/Files/Child_Trends-2009_02_17_FR_CWFinancePaper.pdf.*

[7] Congressional Budget Office. Foster Care and Adoption Assistance—March 2012 Baseline. April 10, 2012. Available online: *http://www.cbo.gov/publication/43068.*

[8] Government Accountability Office. Federal Disability Assistance: Wide Array of Programs Needs to be Examined in Light of 21st Century Challenges. June 2, 2005. Available online: *http://gao.gov/products/GAO-05-626.*

Medicare and Medicaid spent $132 billion in 2002 on services for the disabled.

Meals on Wheels

Eighteen States reported spending a small portion of their SSBG funds on home-delivered meals. According to the nonpartisan Congressional Research Service, "home-delivered meals" constituted just one percent of SSBG expenditures in FY 2009.[9] Other current government programs provide far more support for meals on wheels than SSBG, showing how it is duplicative.

Primary funding for what is commonly referred to as "meals on wheels" is provided under the Elderly Nutrition Services program authorized under Title III of the Older Americans Act. This program, under the jurisdiction of the Committee on Education and the Workforce, provides grants to state agencies on aging to support congregate and home-delivered meals for people aged 60 and older. According to CRS, Title III of the Older Americans Act spent $217 million on meals on wheels services in 2011 (out of a total of $818 million the program spent on all nutrition assistance).[10] The share of Older Americans Act spending on meals on wheels has been rising in recent years. As a result, the program has grown by almost 47 percent from FY 1990 to FY 2009.

Significant funding for meals on wheels also comes from private sources. For example, the Meals on Wheels Association of America, "the oldest and largest organization in the United States representing those who offer meal services to people in need," reports that 92 percent of their funding comes from sources other than government grants.[11]

Adult Protective Services

States report that about eight percent of their SSBG spending is for Adult Protective Services. However, a separate Federal program was recently created for this specific purpose. Created as part of the Patient Protection and Affordable Care Act (P.L. 111–148), Subtitle B of Title XX of the Social Security Act titled "Elder Justice" established 1) an Elder Justice Coordinating Council; 2) an Advisory Board on Elder Abuse, Neglect, and Exploitation; 3) a new grant program for forensic centers to help organizations develop specialized expertise related to elder abuse, neglect, and exploitation; and 4) a number of new grant programs to promote elder justice. Together, the provisions in the Elder Justice subtitle are authorized at a level of $165 million per year.

In addition to the Elder Justice program, Medicaid funds are also used for this purpose. In a March 2011 report, GAO reported that based on their State survey States received at least $42 million in FY 2009 from Medicaid for Adult Protective Services programs.[12]

---

[9] Congressional Research Service. Social Services Block Grant: Background and Funding (Report 94–953). January 3, 2012.

[10] Congressional Research Service. Older Americans Act: Title III Nutrition Services Program (Report RS21202). June 17, 2011.

[11] Meals on Wheels Association of America. Where Your Dollars Go. Retrieved April 26, 2012. Available online: *http://www.mowaa.org/yourdollars.*

[12] U.S. Government Accountability Office. Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse. March, 2011. Available online: *http://www.gao.gov/new.items/d11208.pdf.*

Beyond Federal funding provided for this purpose, States are—and should be—a critical source of funding for Adult Protective Services as well. In the same March 2011 GAO report and survey, States reported that more than half of the budget for Adult Protective Services came from State and local revenues. In some States, the entire budget came from these sources.

Education and Training

States reported spending $22 million in SSBG funds on education and training services. A recent GAO report on education and training programs revealed that in FY2009 the federal government spent $18 billion through 47 different education and training programs across 9 federal agencies, not including SSBG; only one in 10 of these programs had been evaluated for effectiveness in the prior seven years.[13]

Other Funds Provided in the Recovery Act for Similar Purposes

Many other Federal programs exist that fund services covered by SSBG, such as child care, child welfare, education and training, housing services, and disability services as described above. In addition to such programs, the 2009 stimulus law (officially titled the "American Recovery and Reinvestment Act of 2009") provided significant shares of its $787 billion in total funding for many of the services the SSBG is designed to support, such as:

- $20.8 billion in additional nutrition assistance funding;
- $11.8 billion for special education and services for disabled children;
- $5.0 billion in additional funds for low-income families through TANF;
- $4.2 billion in additional funds for employment and training;
- $2.1 billion additional for Head Start;
- $2.0 billion in additional child care funding;
- $1.5 billion in additional funding for homeless prevention;
- $1.0 billion in additional funding for the Community Services Block Grant, which has almost identical purposes to SSBG;
- $1.0 billion in additional child welfare funding for foster care and adoption;
- $500 million for health professions training programs (a new program);
- $100 million for senior nutrition programs; and
- $50 million for new grants for nonprofit organizations to provide social services.

State Partnership Lacking in the SSBG

Although the SSBG program is referred to as a block grant, SSBG lacks many features commonly associated with block grants and related Federal funding streams. First, the program contains no match requirement. Other block grant programs, such as Temporary Assistance for Needy Families (TANF) and the Child Care

[13] Multiple Employment and Training Programs: Providing Information on Colocating Services and Consolidating Administrative Structures Could Promote Efficiencies. Available online: *http://www.gao.gov/products/GAO-11-92.*

and Development Fund (CCDF) require States to maintain a specified spending level in order to receive Federal funding. Although the SSBG originally began as a program requiring States to match Federal spending, the match was eliminated over 30 years ago and States are no longer required to invest State dollars to receive funding. Since the State match was eliminated, States have received over $70 billion in Federal SSBG without having to spend even a single dollar in State funds.

No Accountability

Unlike other block grants, the SSBG is not targeted to a specific population through Federal eligibility requirements. The program also lacks data on recipients or program services that would reveal the impact and effectiveness of the program. Due to the lack of eligibility requirements and metrics on program performance, the program does not include financial penalties for State failure to satisfy program purposes and thus States cannot be held accountable for achieving any specific outcomes such as reducing poverty, promoting work, or ending dependence on government benefits.

These ongoing flaws have resulted in the SSBG being repeatedly cited in both Democrat and Republican budgets as a program lacking accountability for results. For example, President Clinton's FY 1999 budget proposed substantial reductions in funding for the SSBG, stating that "the budget targets funding to programs that can better demonstrate positive performance. The Social Services Block Grant supports a broad range of social service programs, but without statutory performance goals or measures of progress." [14]

In proposing a reduction in funding for the SSBG in President Bush's FY 2007 budget, the Administration stated that "the SSBG program was rated Results Not Demonstrated in the PART process, was found to lack a national system of performance measures against which program performance can be measured and improvements sought, and critiqued for an absence of evaluations of sufficient scope of SSBG-funded activities and programs. The program's flexibility and lack of State reporting requirements pose a challenge in developing measures." [15] In later proposing the elimination of funding for the program, the Bush Administration stated, "The program's minimal requirements maximize State flexibility but, at the same time, do not ensure that funded activities are effective. This is because SSBG is a funding stream rather than a program with measurable performance objectives." [16]

Conclusion

The SSBG began as a focused program created to match State spending on helping welfare recipients reduce their dependence on government benefits. Over ensuing decades, the program evolved to cover more services, at greater Federal cost, for more beneficiaries, and with less accountability and fewer measurable results. Since

---

[14] Budget of the United States Government. Fiscal Year 1999. Available online: *http://www.gpo.gov/fdsys/pkg/BUDGET-1999-BUD/pdf/BUDGET-1999-BUD.pdf.*

[15] U.S. Department of Health and Human Services. FY 2007 ACF Congressional Justification: Social Services Block Grant. Available online: *http://www.acf.hhs.gov/programs/olab/budget/2007/cj2007/sec3h_ssbg_/_2007cj.pdf.*

[16] House Document 110–123. A Request for Budget Amendment for Fiscal Year 2009. Available online: *http://www.gpo.gov/fdsys/pkg/CDOC-110hdoc123/pdf/CDOC-110hdoc123.pdf.*

its creation, dozens of other programs have been created to fund similar services, most of which contain focused objectives, include better oversight, and can point to tangible results.

Congress has generally agreed to share the cost of social services with States. For those services not funded by the Federal government, States support services with their own State funds, local funds, or even private dollars. The role of the Federal government has never been to pay for the full cost of all types of programs and services that States provide to assist families in need, nor should it be. Ending the duplicative and unaccountable SSBG program means that States will have to make choices in prioritizing assistance and services. However, to support them and individuals in need, States will continue to receive significant and rising funding from the Federal government for a range of other social service programs, most of which requires some State contribution—unlike the SSBG. The Committee believes this will provide for a stronger partnership between the Federal government and States and in the long run better social services for those in need.

The decision to end funding for this program is based on the Committee's view of the Federal government's proper role in helping States administer social services, as well as on serious flaws in the design of the SSBG program. The Committee does not believe continued funding for the SSBG represents a wise and effective use of taxpayer dollars, especially as the Congress continues to provide hundreds of billions of dollars each year to States for a range of social services in programs that are more focused and more accountable than the SSBG.

Such spending on means-tested benefits has grown rapidly in recent years—by more than 50 percent from FY 2007 through FY 2011. This range of means-tested programs provide for a broad array of programs and services to low-income families, and these programs often serve the same individuals who receive services through the SSBG.

TABLE 1. GROWTH IN MEANS-TESTED SPENDING [17]

	Federal Spending (in billions)	State Spending (in billions)	Total Spending (in billions)
FY 2007	$468.7	$189.2	$657.9
FY 2008	522.3	191.6	714.1
FY 2009	612.7	167.2	779.9
FY 2010	695.3	192.7	888.0
FY 2011	717.1	210.1	927.2

In this time of staggering deficits, the Federal government cannot afford to award money to States with no focus, no accountability, and no proven results. President Obama said as much in his FY 2013 budget document, stating "for far too long, many Government programs have been allowed to continue or to grow even when their objectives are no longer clear and they lack rigorous assessment of whether the programs are achieving the desired goals. The result has been the profusion of programs that are duplicative,

[17] Robert Rector, Testimony before the Committee on the Budget, U.S. House of Representatives. April 17, 2012. Available online: *http://budget.house.gov/UploadedFiles/rectortestimony04172012.pdf*

ineffective, or outdated—at a significant cost to taxpayers."[18] When a program is known to fund the same services that are provided in literally dozens of other Federal programs, as well as having been repeatedly cited as ineffective, the Committee believes it is our responsibility to say it should end.

REPORT LANGUAGE: SECTION-BY-SECTION

Section 1. Repeal of the program of block grants to states for social services

Subsection (a) of this section repeals sections 2001 through 2007 of Title XX of the Social Security Act, which now provides authorization for the Social Services Block Grant (SSBG).

Subsection (b) of this section makes various conforming amendments to the Social Security Act and other laws to remove references to the SSBG given its repeal.

Subsection (c) of this section specifies the effective date of the repeal of the SSBG, which is October 1, 2012.

COMMITTEE OVERSIGHT FINDINGS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee concluded that it was appropriate and timely to repeal the Social Services Block Grant program as specified in the bill, as transmitted.

In reviewing the effectiveness of social services under the jurisdiction of the Committee on Ways and Means, in April 2011 the Subcommittee on Human Resources heard testimony from GAO on fragmentation, overlap, and duplication in SSBG and other programs. While GAO reiterated the importance of Federal support for social services, they noted that "at the same time, the federal government is facing a structural imbalance in its budget, causing policymakers to carefully consider the effectiveness and efficiency of all federal programs. In particular, concerns have been raised about the multiplicity of programs that may show signs of fragmentation, overlap, and duplication that could introduce inefficiencies and increase costs."

The decision to repeal this program was reached as the result of this hearing on duplication in social services programs, a review of the structure and purpose of the program, a study of other programs providing similar services to low-income families and others in need, an analysis of prior budget submissions from both Democratic and Republican administrations, and a review of accountability and performance measures for the program.

CONSTITUTIONAL AUTHORITY STATEMENT

Congress has the power to enact this legislation pursuant to the following:

---

[18] Fiscal Year 2013 Budget of the U.S. Government: Cutting Waste, Reducing the Deficit, and Asking all to Pay their Fare Share. Available online: *http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/cutting.pdf*

Article I, Section 8, Clause 1 of the United States Constitution, to "provide for the common Defence and general Welfare of the United States."

VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the committee print.

The committee print was ordered favorably transmitted by a roll call vote of 22 yeas to 14 nays (with a quorum being present).

The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Camp		X		Mr. Levin	X		
Mr. Herger		X		Mr. Rangel			
Mr. Johnson		X		Mr. Stark	X		
Mr. Brady		X		Mr. McDermott	X		
Mr. Ryan		X		Mr. Lewis	X		
Mr. Nunes		X		Mr. Neal	X		
Mr. Tiberi		X		Mr. Becerra	X		
Mr. Davis		X		Mr. Doggett	X		
Mr. Reichert		X		Mr. Thompson	X		
Mr. Boustany		X		Mr. Larson	X		
Mr. Roskam		X		Mr. Blumenauer	X		
Mr. Gerlach		X		Mr. Kind	X		
Mr. Price		X		Mr. Pascrell	X		
Mr. Buchanan		X		Ms. Berkley	X		
Mr. Smith		X		Mr. Crowley	X		
Mr. Schock		X					
Ms. Jenkins		X					
Mr. Paulsen		X					
Mr. Marchant		X					
Mr. Berg		X					
Ms. Black		X					
Mr. Reed		X					

PERFORMANCE GOALS

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee establishes the following performance related goals and objectives for this legislation: To end funding for the Social Services Block Grant, beginning October 1, 2012.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 23, 2012.

Hon. DAVE CAMP,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the Repeal of the Program of Block Grants to States for Social Services.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Jonathan Morancy.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

Repeal of the Program of Block Grants to States for Social Services

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 that reconciliation process, the House Committee on Ways and Means has approved three separate provisions as reconciliation recommendations. The following analysis presents estimated budgetary effects for one of those three provisions.

This legislation would repeal sections 2001 through 2007 of the Social Security Act, relating to the Social Services Block Grant (SSBG) program, starting in fiscal year 2013. SSBG, which is administered by the Department of Health and Human Services, supports a variety of programs, including child welfare services, day care for both children and adults, home-delivered meals, disabilities services, and transportation.

SSBG has a permanent authorization of $1.7 billion per year. Spending for this program is classified as direct spending; the program's funding, however, is provided in annual appropriation acts.

As shown in the following table, enacting a repeal of the SSBG programs would reduce direct spending by nearly $1.4 billion in 2013 and by about $16.7 billion over the 2012–2022 period, relative to CBO's current baseline projections.

	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													
Repeal Block Grants for Social Services:													
Budget Authority	0	−1,700	−1,700	−1,700	−1,700	−1,700	−1,700	−1,700	−1,700	−1,700	−1,700	−8,500	−17,000
Estimated Outlays	0	−1,360	−1,666	−1,802	−1,717	−1,700	−1,700	−1,700	−1,700	−1,700	−1,700	−8,245	−16,745

For this estimate, CBO assumes that the legislation will be enacted by October 1, 2012. Because the SSBG repeal would take effect in fiscal year 2013 under the legislation proposed by the Committee on Ways and Means, the estimate of budgetary savings would be unchanged for enactment any time prior to October 1 (the beginning of that fiscal year). In other words, there would be no effect on spending in fiscal year 2012 even if the legislation is enacted sometime during the remainder of this fiscal year.

The legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

The CBO staff contact for this estimate is Jonathan Morancy. The estimate was approved by Peter H. Fontaine, Assistant Director for Budget Analysis.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

* * * * * * *

PART A—BLOCK GRANTS TO STATES FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

* * * * * * *

SEC. 404. USE OF GRANTS.

(a) * * *

* * * * * * *

(d) AUTHORITY TO USE PORTION OF GRANT FOR OTHER PURPOSES.—

(1) IN GENERAL.—Subject to paragraph (2), a State may use not more than 30 percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out a State program pursuant to [any or all of the following provisions of law:

[(A) Subtitle A of title XX of this Act.

[(B) The] *the* Child Care and Development Block Grant Act of 1990.

[(2) LIMITATION ON AMOUNT TRANSFERABLE TO SUBTITLE 1 OF TITLE XX PROGRAMS.—

[(A) IN GENERAL.—A State may use not more than the applicable percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out State programs pursuant to subtitle 1 of title XX.

[(B) APPLICABLE PERCENT.—For purposes of subparagraph (A), the applicable percent is 4.25 percent in the case of fiscal year 2001 and each succeeding fiscal year.]

[(3)] *(2)* APPLICABLE [RULES.—

[(A) IN GENERAL.—Except as provided in subparagraph (B) of this paragraph, any amount paid] *RULES.—Any amount paid* to a State under this part that is used to carry out a State program pursuant to [a provision of law specified in paragraph (1)] *the Child Care and Development Block Grant Act of 1990* shall not be subject to the requirements of this part, but shall be subject to the requirements that apply to Federal funds provided directly under the provision of law to carry out the program, and the expenditure of any amount so used shall not be considered to be an expenditure under this part.

[(B) EXCEPTION RELATING TO SUBTITLE 1 OF TITLE XX PROGRAMS.—All amounts paid to a State under this part that are used to carry out State programs pursuant to subtitle 1 of title XX shall be used only for programs and services to children or their families whose income is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.]

* * * * * * *

PART B—CHILD AND FAMILY SERVICES

Subpart 1—Stephanie Tubbs Jones Child Welfare Services Program

* * * * * * *

STATE PLANS FOR CHILD WELFARE SERVICES

SEC. 422. (a) * * *

(b) Each plan for child welfare services under this subpart shall—

(1) provide that (A) the individual or agency that [administers or supervises] *administered or supervised* the administration of the State's services program under [subtitle 1 of title XX] *subtitle A of title XX (as in effect before the repeal of such subtitle)* will administer or supervise the administration of the plan (except as otherwise provided in section 103(d) of the Adoption Assistance and Child Welfare Act of 1980), and (B) to the extent that child welfare services are furnished by the staff of the State agency or local agency administering the plan, a single organizational unit in such State or local agency, as the case may be, will be responsible for furnishing such child welfare services;

(2) provide for coordination between the services provided for children under the plan and the services and assistance provided [under subtitle 1 of title XX,] under the State program

funded under part A, under the State plan approved under subpart 2 of this part, under the State plan approved under the State plan approved under part E, and under other State programs having a relationship to the program under this subpart, with a view to provision of welfare and related services which will best promote the welfare of such children and their families;

* * * * * * *

PART E—FEDERAL PAYMENTS FOR FOSTER CARE AND ADOPTION ASSISTANCE

* * * * * * *

STATE PLAN FOR FOSTER CARE AND ADOPTION ASSISTANCE

SEC. 471. (a) In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which—

(1) * * *

* * * * * * *

(4) provides that the State shall assure that the programs at the local level assisted under this part will be coordinated with the programs at the State or local level assisted under parts A and B of this title**[**, under subtitle 1 of title XX of this Act,**]** and under any other appropriate provision of Federal law;

* * * * * * *

(8) subject to subsection (c), provides safeguards which restrict the use of or disclosure of information concerning individuals assisted under the State plan to purposes directly connected with (A) the administration of the plan of the State approved under this part, the plan or program of the State under part A, B, or D of this title (including activities under part F) or under title I, V, X, XIV, XVI (as in effect in Puerto Rico, Guam, and the Virgin Islands), **[**XIX, or XX**]** *or XIX*, or the supplemental security income program established by title XVI, (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connection with the administration of any such plan or program, (C) the administration of any other Federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need, (D) any audit or similar activity conducted in connection with the administration of any such plan or program by any governmental agency which is authorized by law to conduct such audit or activity, and (E) reporting and providing information pursuant to paragraph (9) to appropriate authorities with respect to known or suspected child abuse or neglect; and the safeguards so provided shall prohibit disclosure, to any committee or legislative body (other than an agency referred to in clause (D) with respect to an activity referred to in such clause), of any information which identifies by name or address any such applicant or recipient; except that nothing contained herein shall preclude a State from providing standards which restrict disclosures to purposes more limited than

those specified herein, or which, in the case of adoptions, prevent disclosure entirely;

* * * * * * *

FOSTER CARE MAINTENANCE PAYMENTS PROGRAM

SEC. 472. (a) * * *

* * * * * * *

(h)(1) For purposes of title XIX, any child with respect to whom foster care maintenance payments are made under this section is deemed to be a dependent child as defined in section 406 (as in effect as of July 16, 1996) and deemed to be a recipient of aid to families with dependent children under part A of this title (as so in effect). **[**For purposes of subtitle 1 of title XX, any child with respect to whom foster care maintenance payments are made under this section is deemed to be a minor child in a needy family under a State program funded under part A of this title and is deemed to be a recipient of assistance under such part.**]**

* * * * * * *

ADOPTION AND GUARDIANSHIP ASSISTANCE PROGRAM

SEC. 473. (a) * * *

(b)(1) For purposes of title XIX, any child who is described in paragraph **[**(3)**]** *(2)* is deemed to be a dependent child as defined in section 406 (as in effect as of July 16, 1996) and deemed to be a recipient of aid to families with dependent children under part A of this title (as so in effect) in the State where such child resides.

[(2) For purposes of subtitle 1 of title XX, any child who is described in paragraph (3) is deemed to be a minor child in a needy family under a State program funded under part A of this title and deemed to be a recipient of assistance under such part.**]**

[(3)**]** *(2)* A child described in this paragraph is any child—

(A) * * *

* * * * * * *

[(4)**]** *(3)* For purposes of **[**paragraphs (1) and (2)**]** *paragraph (1)*, a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to the child's minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are being made under section 472.

* * * * * * *

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

* * * * * * *

USE OF ALLOTMENT FUNDS

SEC. 504. (a) * * *

(b) Amounts described in subsection (a) may not be used for—

(1) * * *

* * * * * * *

(6) payment for any item or service (other than an emergency item or service) furnished—

(A) by an individual or entity during the period when such individual or entity is excluded under this title or title XVIII, [XIX, or XX] *or XIX* pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this title or title XVIII, [XIX, or XX] *or XIX* pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

* * * * * * *

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

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 1101. (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, XIX, and XXI includes the Virgin Islands and Guam. Such term when used in titles III, IX, and XII also includes the Virgin Islands. Such term when used in title V and in part B of this title also includes American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands. Such term when used in titles XIX and XXI also includes the Northern Mariana Islands and American Samoa. In the case of Puerto Rico, the Virgin Islands, and Guam, titles I, X, and XIV, and title XVI (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term "State" when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam. [Such term when used in title XX also includes the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.] Such term when used in title IV also includes American Samoa.

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) * * *

* * * * * * *

(h) DEFINITION OF STATE HEALTH CARE PROGRAM.—For purposes of this section and sections 1128A and 1128B, the term "State health care program" means—

(1) * * *

(2) any program receiving funds under title V or from an allotment to a State under such title, *or*

[(3) any program receiving funds under subtitle 1 of title XX or from an allotment to a State under such subtitle, or]

[(4)] *(3)* a State child health plan approved under title XXI.

* * * * * * *

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) * * *

* * * * * * *

(i) For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designated to administer the State's program under title V [or subtitle 1 of title XX] of this Act.

* * * * * * *

PERIOD WITHIN WHICH CERTAIN CLAIMS MUST BE FILED

SEC. 1132. (a) Notwithstanding any other provision of this Act (but subject to subsection (b)), any claim by a State for payment with respect to an expenditure made during any calendar quarter by the State—

(1) in carrying out a State plan approved under title I, IV, X, XIV, XVI, [XIX, or XX] *or XIX* of this Act, or

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) * * *

* * * * * * *

(e)(1) * * *

* * * * * * *

(13) EXPRESS LANE OPTION.—

(A) * * *

* * * * * * *

(F) EXPRESS LANE AGENCY.—

(i) * * *

* * * * * * *

(iii) [EXCLUSIONS] *EXCLUSION*.—Such term does not include [an agency that determines eligibility for a program established under the Social Services Block Grant established under title XX or] a private, for-profit organization.

* * * * * * *

TITLE XX—[BLOCK GRANTS TO STATES FOR SOCIAL SERVICES] *HEALTH PROFESSIONS DEMONSTRATIONS AND ENVIRONMENTAL HEALTH CONDITION DETECTION*

* * * * * * *

Subtitle A—[Block Grants to States for Social Services] *Health Professions Demonstrations and Environmental Health Condition Detection*

[PURPOSES OF TITLE; AUTHORIZATION OF APPROPRIATIONS

[SEC. 2001. For the purposes of consolidating Federal assistance to States for social services into a single grant, increasing State flexibility in using social service grants, and encouraging each State, as far as practicable under the conditions in that State, to furnish services directed at the goals of—

[(1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

[(2) achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

[(3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families;

[(4) preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and

[(5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions, there are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of this title.

[PAYMENTS TO STATES

[SEC. 2002. (a)(1) Each State shall be entitled to payment under this title for each fiscal year in an amount equal to its allotment for such fiscal year, to be used by such State for services directed at the goals set forth in section 2001, subject to the requirements of this title.

[(2) For purposes of paragraph (1)—

[(A) services which are directed at the goals set forth in section 2001 include, but are not limited to, child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, family planning services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and alcoholics and drug addicts; and

[(B) expenditures for such services may include expenditures for—

[(i) administration (including planning and evaluation);

[(ii) personnel training and retraining directly related to the provision of those services (including both short-and long-term training at educational institutions through grants to such institutions or by direct financial assistance to students enrolled in such institutions); and

[(iii) conferences or workshops, and training or retraining through grants to nonprofit organizations within the meaning of section 501(c)(3) of the Internal Revenue Code of 1954 or to individuals with social services expertise, or through financial assistance to individuals participating in such conferences, workshops, and training or retraining (and this clause shall apply with respect to all persons involved in the delivery of such services).

[(b) The Secretary shall make payments in accordance with section 6503 of title 31, United States Code, to each State from its allotment for use under this title.

[(c) Payments to a State from its allotment for any fiscal year must be expended by the State in such fiscal year or in the succeeding fiscal year.

[(d) A State may transfer up to 10 percent of its allotment under section 2003 for any fiscal year for its use for that year under other provisions of Federal law providing block grants for support of health services, health promotion and disease prevention activities, or low-income home energy assistance (or any combination of those activities). Amounts allotted to a State under any provisions of Federal law referred to in the preceding sentence and transferred by a State for use in carrying out the purposes of this title shall be treated as if they were paid to the State under this title but shall not affect the computation of the State's allotment under this title. The State shall inform the Secretary of any such transfer of funds.

[(e) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, or administering programs funded under this title.

[(f) A State may use funds provided under this title to provide vouchers, for services directed at the goals set forth in section 2001, to families, including—

[(1) families who have become ineligible for assistance under a State program funded under part A of title IV by reason of a durational limit on the provision of such assistance; and

[(2) families denied cash assistance under the State program funded under part A of title IV for a child who is born to a member of the family who is—

[(A) a recipient of assistance under the program; or

[(B) a person who received such assistance at any time during the 10-month period ending with the birth of the child.

[ALLOTMENTS

[SEC. 2003. (a) The allotment for any fiscal year to each of the jurisdictions of Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands shall be an amount which bears the same ratio to the amount specified in subsection (c) as the amount which was specified for allocation to the particular jurisdiction involved for the fiscal year 1981 under section 2002(a)(2)(C) of this Act (as in effect prior to the enactment of this section) bore to $2,900,000,000. The allotment for fiscal year 1989 and each succeeding fiscal year to American Samoa shall be an amount which bears the same ratio to the amount allotted to the Northern Mariana Islands for that fiscal year as the population of American Samoa bears to the population of the Northern Mariana Islands determined on the basis of the most recent data available at the time such allotment is determined.

[(b) The allotment for any fiscal year for each State other than the jurisdictions of Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands shall be an amount which bears the same ratio to—

[(1) the amount specified in subsection (c), reduced by

[(2) the total amount allotted to those jurisdictions for that fiscal year under subsection (a), as the population of that State bears to the population of all the States (other than Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands) as determined by the Secretary (on the basis of the most recent data available from the Department of Commerce) and promulgated prior to the first day of the third month of the preceding fiscal year.

[(c) The amount specified for purposes of subsections (a) and (b) shall be—

[(1) $2,400,000,000 for the fiscal year 1982;

[(2) $2,450,000,000 for the fiscal year 1983;

[(3) $2,700,000,000 for the fiscal years 1984, 1985, 1986, 1987, and 1989;

[(4) $2,750,000,000 for the fiscal year 1988;

[(5) $2,800,000,000 for each of the fiscal years 1990 through 1995;

[(6) $2,381,000,000 for the fiscal year 1996;

[(7) $2,380,000,000 for the fiscal year 1997;

[(8) $2,299,000,000 for the fiscal year 1998;

[(9) $2,380,000,000 for the fiscal year 1999;

[(10) $2,380,000,000 for the fiscal year 2000; and

[(11) $1,700,000,000 for the fiscal year 2001 and each fiscal year thereafter.

[STATE ADMINISTRATION

[SEC. 2004. Prior to expenditure by a State of payments made to it under section 2002 for any fiscal year, the State shall report on the intended use of the payments the State is to receive under this title, including information on the types of activities to be supported and the categories or characteristics of individuals to be served. The report shall be transmitted to the Secretary and made public within the State in such manner as to facilitate comment by

any person (including any Federal or other public agency) during development of the report and after its completion. The report shall be revised throughout the year as may be necessary to reflect substantial changes in the activities assisted under this title, and any revision shall be subject to the requirements of the previous sentence.

[LIMITATIONS ON USE OF GRANTS

[SEC. 2005. (a) Except as provided in subsection (b), grants made under this title may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this title—

[(1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

[(2) for the provision of cash payments for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

[(3) for payment of the wages of any individual as a social service (other than payment of the wages of welfare recipients employed in the provision of child day care services);

[(4) for the provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug dependent individual) unless it is an integral but subordinate part of a social service for which grants may be used under this title;

[(5) for social services (except services to an alcoholic or drug dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution;

[(6) for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income;

[(7) for any child day care services unless such services meet applicable standards of State and local law;

[(8) for the provision of cash payments as a service (except as otherwise provided in this section);

[(9) for payment for any item or service (other than an emergency item or service) furnished—

[(A) by an individual or entity during the period when such individual or entity is excluded under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

[(B) at the medical direction or on the prescription of a physician during the period when the physician is excluded under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period

after reasonable notice has been furnished to the person); or

[(10) in a manner inconsistent with the Assisted Suicide Funding Restortation Act of 1997.

[(b) The Secretary may waive the limitation contained in subsection (a)(1) and (4) upon the State's request for such a waiver if he finds that the request describes extraordinary circumstances to justify the waiver and that permitting the waiver will contribute to the State's ability to carry out the purposes of this title.

[REPORTS AND AUDITS

[SEC. 2006. (a) Each State shall prepare reports on its activities carried out with funds made available (or transferred for use) under this title. Reports shall be prepared annually, covering the most recently completed fiscal year, and shall be in such form and contain such information (including but not limited to the information specified in subsection (c)) as the State finds necessary to provide an accurate description of such activities, to secure a complete record of the purposes for which funds were spent, and to determine the extent to which funds were spent in a manner consistent with the reports required by section 2004. The State shall make copies of the reports required by this section available for public inspection within the State and shall transmit a copy to the Secretary. Copies shall also be provided, upon request, to any interested public agency, and each such agency may provide its views on these reports to the Congress.

[(b) Each State shall, not less often than every two years, audit its expenditures from amounts received (or transferred for use) under this title. Such State audits shall be conducted by an entity independent of any agency administering activities funded under this title, in accordance with generally accepted auditing principles. Within 30 days following the completion of each audit, the State shall submit a copy of that audit to the legislature of the State and to the Secretary. Each State shall repay to the United States amounts ultimately found not to have been expended in accordance with this title, or the Secretary may offset such amounts against any other amount to which the State is or may become entitled under this title.

[(c) Each report prepared and transmitted by a State under subsection (a) shall set forth (with respect to the fiscal year covered by the report)—

[(1) the number of individuals who received services paid for in whole or in part with funds made available under this title, showing separately the number of children and the number of adults who received such services, and broken down in each case to reflect the types of services and circumstances involved;

[(2) the amount spent in providing each such type of service, showing separately for each type of service the amount spent per child recipient and the amount spent per adult recipient;

[(3) the criteria applied in determining eligibility for services (such as income eligibility guidelines, sliding fee scales, the effect of public assistance benefits, and any requirements for enrollment in school or training programs); and

[(4) the methods by which services were provided, showing separately the services provided by public agencies and those provided by private agencies, and broken down in each case to reflect the types of services and circumstances involved. The Secretary shall establish uniform definitions of services for use by the States in preparing the information required by this subsection, and make such other provision as may be necessary or appropriate to assure that compliance with the requirements of this subsection will not be unduly burdensome on the States.

[(d) For other provisions requiring States to account for Federal grants, see section 6503 of title 31, United States Code.

[SEC. 2007. ADDITIONAL GRANTS.

[(a) ENTITLEMENT.—

[(1) IN GENERAL.—In addition to any payment under section 2002, each State shall be entitled to—

[(A) 2 grants under this section for each qualified empowerment zone in the State; and

[(B) 1 grant under this section for each qualified enterprise community in the State.

[(2) AMOUNT OF GRANTS.—

[(A) EMPOWERMENT GRANTS.—The amount of each grant to a State under this section for a qualified empowerment zone shall be—

[(i) if the zone is designated in an urban area, $50,000,000, multiplied by that proportion of the population of the zone that resides in the State; or

[(ii) if the zone is designated in a rural area, $20,000,000, multiplied by each proportion.

[(B) ENTERPRISE GRANTS.—The amount of the grant to a State under this section for a qualified enterprise community shall be 1/95 of $280,000,000, multiplied by that proportion of the population of the community that resides in the State.

[(C) POPULATION DETERMINATIONS.—The Secretary shall make population determinations for purposes of this paragraph based on the most recent decennial census data available.

[(3) TIMING OF GRANTS.—

[(A) QUALIFIED EMPOWERMENT ZONES.—With respect to each qualified empowerment zone, the Secretary shall make—

[(i) 1 grant under this section to each State in which the zone lies, on the date of the designation of the zone under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986; and

[(ii) 1 grant under this section to each such State, on the 1st day of the 1st fiscal year that begins after the date of the designation.

[(B) QUALIFIED ENTERPRISE COMMUNITIES.—With respect to each qualified enterprise community, the Secretary shall make 1 grant under this section to each State in which the community lies, on the date of the designation of the com-

munity under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986.

[(4) FUNDING.—$1,000,000,000 shall be made available to the Secretary for grants under this section.

[(b) PROGRAM OPTIONS.—NOTWITHSTANDING SECTION 2005(A):

[(1) In order to prevent and remedy the neglect and abuse of children, a State may use amounts paid under this section to make grants to, or enter into contracts with, entities to provide residential or nonresidential drug and alcohol prevention and treatment programs that offer comprehensive services for pregnant women and mothers, and their children.

[(2) In order to prevent to assist disadvantaged adults and youths in achieving and maintaining self-sufficiency, a State may use amounts paid under this section to make grants to, or enter into contracts with—

[(A) organizations operated for profit or not for profit, for the purpose of training and employing disadvantaged adults and youths in construction, rehabilitation, or improvement of affordable housing, public infrastructure, and community facilities; and

[(B) nonprofit organizations and community or junior colleges, for the purpose of enabling such entities to provide short-term training courses in entrepreneurism and self-employment, and other training that will promote individual self-sufficiency and the interests of the community.

[(3) A State may use amounts paid under this section to make grants to, or enter into contracts with, nonprofit community-based organizations to enable such organizations to provide activities designed to promote and protect the interests of children and families, outside of school hours, including keeping schools open during evenings and weekends for mentoring and study.

[(4) In order to assist disadvantaged adults and youths in achieving and maintain economic self-support, a State may use amounts paid under this section to—

[(A) fund services designed to promote community and economic development in qualified empowerment zones and qualified enterprise communities, such as skills training, job counseling, transportation services, housing counseling, financial management, and business counseling;

[(B) assist in emergency and transitional shelter for disadvantaged families and individuals; or

[(C) support programs that promote home ownership, education, or other routes to economic independence for low-income families and individuals.

[(c) USE OF GRANTS.—

[(1) IN GENERAL.—Subject to subsection (d) of this section, each State that receives a grant under this section with respect to an area shall use the grant—

[(A) for services directed only at the goals set forth in paragraphs (1), (2), and (3) of section 2001;

[(B) in accordance with the strategic plan for the area; and

[(C) for activities that benefit residents of the area for which the grant is made.

[(2) TECHNICAL ASSISTANCE.—A State may use a portion of any grant made under this section in the manner described in section 2002(e).

[(d) REMITTANCE OF CERTAIN AMOUNTS.—

[(1) PORTION OF GRANT UPON TERMINATION OF DESIGNATION.—Each State to which an amount is paid under this subsection during a fiscal year with respect to an area the designation of which under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986 ends before the end of the fiscal year shall remit to the Secretary an amount equal to the total of the amounts so paid with respect to the area, multiplied by that proportion of the fiscal year remaining after the designation ends.

[(2) AMOUNTS PAID TO THE STATES AND NOT OBLIGATED WITHIN 2 YEARS.—Each State shall remit to the Secretary any amount paid to the State under this section that is not obligated by the end of the 2-year period that begins with the date of the payment.

[(e) REALLOCATION OF REMAINING FUNDS.—

[(1) REMITTED AMOUNTS.—The amount specified in section 2003(c) for any fiscal year is hereby increased by the total of the amounts remitted during the fiscal year pursuant to subsection (d) of this section.

[(2) AMOUNTS NOT PAID TO THE STATES.—The amount specified in section 2003(c) for fiscal year 1998 is hereby increased by the amount made available for grants under this section that has not been paid to any State by the end of fiscal year 1997.

[(f) DEFINITIONS.—As used in this section:

[(1) QUALIFIED EMPOWERMENT ZONE.—The term "qualified empowerment zone" means, with respect to a State, an area—

[(A) which has been designated (other than by the Secretary of the Interior) as an empowerment zone under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986;

[(B) with respect to which the designation is in effect;

[(C) the strategic plan for which is a qualified plan; and

[(D) part or all of which is in the State.

[(2) QUALIFIED ENTERPRISE COMMUNITY.—The term "qualified enterprise community" means, with respect to a State, an area—

[(A) which has been designated (other than by the Secretary of the Interior) as an enterprise community under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986;

[(B) with respect to which the designation is in effect;

[(C) the strategic plan for which is a qualified plan; and

[(D) part or all of which is in the State.

[(3) STRATEGIC PLAN.—The term "strategic plan" means, with respect to an area, the plan contained in the application for designation of the area under part I of subchapter U of chapter 1 of the Internal Revenue Code of 1986.

[(4) QUALIFIED PLAN.—The term "qualified plan" means, with respect to an area, a plan that—

[(A) includes a detailed description of the activities proposed for the area that are to be funded with amounts provided under this section;

[(B) contains a commitment that the amounts provided under this section to any State for the area will not be used to supplant Federal or non-Federal funds for services and activities which promote the purposes of this section;

[(C) was developed in cooperation with the local government or governments with jurisdiction over the area; and

[(D) to the extent that any State will not use the amounts provided under this section for the area in the manner described in subsection (b), explains the reasons why not.

[(5) RURAL AREA.—The term "rural area" has the meaning given such term in section 1393(a)(2) of the Internal Revenue Code of 1986.

[(6) URBAN AREA.—The term "urban area" has the meaning given such term in section 1393(a)(3) of the Internal Revenue Code of 1986.]

* * * * * * *

SECTION 16 OF THE FOOD AND NUTRITION ACT OF 2008

ADMINISTRATIVE COST-SHARING AND QUALITY CONTROL

SEC. 16. (a) * * *

* * * * * * *

(k) REDUCTIONS IN PAYMENTS FOR ADMINISTRATIVE COSTS.—

(1) * * *

* * * * * * *

(5) ALLOCATION OF ADMINISTRATIVE COSTS.—

(A) * * *

(B) FUNDS AND EXPENDITURES.—Subparagraph (A) applies to—

(i) funds made available to carry out part A of title IV[, or title XX,] of the Social Security Act (42 U.S.C. 601 et seq., 1397 et seq.);

* * * * * * *

SECTION 402 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996

SEC. 402. LIMITED ELIGIBILITY OF QUALIFIED ALIENS FOR CERTAIN FEDERAL PROGRAMS.

(a) * * *

(b) LIMITED ELIGIBILITY FOR DESIGNATED FEDERAL PROGRAMS.—

(1) * * *

* * * * * * *

(3) DESIGNATED FEDERAL PROGRAM DEFINED.—For purposes of this title, the term "designated Federal program" means any of the following:

(A) * * *

[(B) SOCIAL SERVICES BLOCK GRANT.—The program of block grants to States for social services under title XX of the Social Security Act.]

[(C)] *(B)* MEDICAID.—A State plan approved under title XIX of the Social Security Act, other than medical assistance described in section 401(b)(1)(A).

* * * * * * *

SECTION 245A OF THE IMMIGRATION REFORM AND CONTROL ACT OF 1986

ADJUSTMENT OF STATUS OF CERTAIN ENTRANTS BEFORE JANUARY 1, 1982, TO THAT OF PERSON ADMITTED FOR LAWFUL RESIDENCE

SEC. 245A. (a) * * *

* * * * * * *

(h) TEMPORARY DISQUALIFICATION OF NEWLY LEGALIZED ALIENS FROM RECEIVING CERTAIN PUBLIC WELFARE ASSISTANCE.—

(1) * * *

* * * * * * *

(4) TREATMENT OF CERTAIN PROGRAMS.—Assistance furnished under any of the following provisions of law shall not be construed to be financial assistance described in paragraph (1)(A)(i):

(A) * * *

* * * * * * *

(I) Titles V[, XVI, and XX] *and XVI*, and parts B, D, and E of title IV, of the Social Security Act (and titles I, X, XIV, and XVI of such Act as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972).

SECTION 17 OF THE RICHARD B. RUSSELL NATIONAL SCHOOL LUNCH ACT

SEC. 17. CHILD AND ADULT CARE FOOD PROGRAM.

(a) PROGRAM PURPOSE, GRANT AUTHORITY AND INSTITUTION ELIGIBILITY.—

(1) * * *

(2) DEFINITION OF INSTITUTION.—In this section, the term "institution" means—

(A) * * *

(B) any other private organization providing nonresidential child care or day care outside school hours for school children, if[—

[(i)] at least 25 percent of the children served by the organization meet the income eligibility criteria es-

tablished under section 9(b) for free or reduced price meals; [or]

[(ii) the organization receives compensation from amounts granted to the States under title XX of the Social Security Act (42 U.S.C. 1397 et seq.) (but only if the organization receives compensation under that title for at least 25 percent of its enrolled children or 25 percent of its licensed capacity, whichever is less);]

* * * * * * *

(D) any other private organization acting as a sponsoring organization for, and that is part of the same legal entity as, one or more organizations that are—

(i) * * *

(ii) proprietary title XIX [or title XX] centers (as defined in subsection (o)(2));

* * * * * * *

(o)(1) * * *

(2) For purposes of this subsection—

(A) * * *

(B) the term "proprietary title XIX [or title XX] center" means any private, for-profit center providing adult day care services for which it receives compensation from amounts granted to the States under title XIX [or XX] of the Social Security Act and which title XIX [or title XX] beneficiaries were not less than 25 percent of enrolled eligible participants in a calendar month preceding initial application or annual reapplication for program participation.

* * * * * * *

SECTION 201 OF THE INDIAN CHILD WELFARE ACT OF 1978

SEC. 201. (a) * * *

(b) Funds appropriated for use by the Secretary in accordance with this section may be utilized as non-Federal matching share in connection with funds provided under [titles IV–B and XX] *part B of title IV* of the Social Security Act or under any other Federal financial assistance programs which contribute to the purpose for which such funds are authorized to be appropriated for use under this Act. The provision or possibility of assistance under this Act shall not be a basis for the denial or reduction of any assistance otherwise authorized under [titles IV–B and XX] *part B of title IV* of the Social Security Act or any other federally assisted program. For purposes of qualifying for assistance under a federally assisted program, licensing or approval of foster or adoptive homes or institutions by an Indian tribe shall be deemed equivalent to licensing or approval by a State.

* * * * * * *

SECTION 3803 OF TITLE 31, UNITED STATES CODE

§ 3803. Hearing and determinations

(a) * * *

* * * * * * *

(c)(1) * * *

(2)(A) * * *

* * * * * * *

(C) For purposes of this subsection, the term "benefits" means—

(i) * * *

* * * * * * *

[(vi) benefits under title XX of the Social Security Act;**]**

[(vii)**]** *(vi)* benefits under the supplemental nutrition assistance program (as defined in section 3(l) of the Food and Nutrition Act of 2008);

[(viii)**]** *(vii)* benefits under chapters 11, 13, 15, 17, and 21 of title 38;

[(ix)**]** *(viii)* benefits under the Black Lung Benefits Act;

[(x)**]** *(ix)* benefits under the special supplemental nutrition program for women, infants, and children established under section 17 of the Child Nutrition Act of 1966;

[(xi)**]** *(x)* benefits under section 336 of the Older Americans Act;

[(xii)**]** *(xi)* any annuity or other benefit under the Railroad Retirement Act of 1974;

[(xiii)**]** *(xii)* benefits under the Richard B. Russell National School Lunch Act;

[(xiv)**]** *(xiii)* benefits under any housing assistance program for lower income families or elderly or handicapped persons which is administered by the Secretary of Housing and Urban Development or the Secretary of Agriculture;

[(xv)**]** *(xiv)* benefits under the Low-Income Home Energy Assistance Act of 1981; and

[(xvi)**]** *(xv)* benefits under part A of the Energy Conservation in Existing Buildings Act of 1976,

which are intended for the personal use of the individual who receives the benefits or for a member of the individual's family.

* * * * * * *

SECTION 14502 OF TITLE 40, UNITED STATES CODE

§ 14502. Demonstration health projects

(a) * * *

* * * * * * *

(d) OPERATION GRANTS.—

(1) * * *

* * * * * * *

(3) SOURCES OF ASSISTANCE.—The federal contribution may be provided entirely from amounts appropriated to carry out this section or in combination with amounts provided under

other federal grant programs for the operation of health related facilities and the provision of health and child development services, including parts A and B of title IV [and title XX] of the Social Security Act (42 U.S.C. 601 et seq., 620 et seq.[, 1397 et seq.]).

* * * * * * *

SECTION 2006 OF THE PUBLIC HEALTH SERVICE ACT

REQUIREMENTS FOR APPLICATIONS

SEC. 2006. (a) An application for a grant for a demonstration project for services under this title shall be in such form and contain such information as the Secretary may require, and shall include—

(1) * * *

* * * * * * *

(15) assurances that the applicant has or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing services to persons entitled to services under parts B and E of title IV [and title XX] of the Social Security Act;

* * * * * * *

OLDER AMERICANS ACT OF 1965

* * * * * * *

TITLE II—ADMINISTRATION ON AGING

* * * * * * *

FEDERAL AGENCY CONSULTATION

SEC. 203. (a) * * *

(b) For the purposes of subsection (a), programs related to the objectives of this Act shall include—

(1) * * *

* * * * * * *

(3) titles XVI, XVIII, [XIX, and XX] *and XIX* of the Social Security Act,

* * * * * * *

SURPLUS PROPERTY ELIGIBILITY

SEC. 213. Any State or local government agency, and any nonprofit organization or institution, which receives funds appropriated for programs for older individuals under this Act, under title IV [or title XX] of the Social Security Act, or under titles VIII and X of the Economic Opportunity Act of 1964 and the Community Services Block Grant Act, shall be deemed eligible to receive for such programs, property which is declared surplus to the needs

of the Federal Government in accordance with laws applicable to surplus property.

* * * * * * *

TITLE III—GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING

PART A—GENERAL PROVISIONS

* * * * * * *

AREA PLANS

SEC. 306. (a) * * *

* * * * * * *

(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and [titles XIX and XX] *title XIX* of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and [titles XIX and XX] *title XIX* of the Social Security Act.

* * * * * * *

SECTION 2605 OF THE LOW-INCOME HOME ENERGY ASSISTANCE ACT OF 1981

APPLICATIONS AND REQUIREMENTS

SEC. 2605. (a) * * *

(b) As part of the annual application required by subsection (a), the chief executive officer of each State shall certify that the State agrees to—

(1) * * *

* * * * * * *

(4) coordinate its activities under this title with similar and related programs administered by the Federal Government and such State, particularly low-income energy-related programs under subtitle B of title VI (relating to community services block grant program), under the supplemental security income program, under part A of title IV of the Social Security Act, [under title XX of the Social Security Act,] under the low-income weatherization assistance program under title IV of the Energy Conservation and Production Act, or under any other provision of law which carries out programs which were admin-

istered under the Economic Opportunity Act of 1964 before the date of the enactment of this Act;

* * * * * * *

(j) In verifying income eligibility for purposes of subsection (b)(2)(B), the State may apply procedures and policies consistent with procedures and policies used by the State agency administering programs under part A of title IV of the Social Security Act, [under title XX of the Social Security Act,] under subtitle B of title VI of this Act (relating to community services block grant program), under any other provision of law which carries out programs which were administered under the Economic Opportunity Act of 1964 before the date of the enactment of this Act, or under other income assistance or service programs (as determined by the State).

* * * * * * *

SECTION 602 OF THE CHILD DEVELOPMENT ASSOCIATE SCHOLARSHIP ASSISTANCE ACT OF 1985

[SEC. 602. GRANTS AUTHORIZED.

[The Secretary is authorized to make a grant for any fiscal year to any State receiving a grant under title XX of the Social Security Act for such fiscal year to enable such State to award scholarships to eligible individuals within the State who are candidates for the Child Development Associate credential.]

* * * * * * *

SECTION 3 OF THE ASSISTED SUICIDE FUNDING RESTRICTION ACT OF 1997

SEC. 3. RESTRICTION ON USE OF FEDERAL FUNDS UNDER HEALTH CARE PROGRAMS.

(a) * * *

* * * * * * *

(d) LIST OF PROGRAMS TO WHICH RESTRICTIONS APPLY.—

(1) FEDERAL HEALTH CARE FUNDING PROGRAMS.—Subsection (a) applies to funds appropriated under or to carry out the following:

(A) * * *

* * * * * * *

[(C) TITLE XX SOCIAL SERVICES BLOCK GRANT.—Title XX of the Social Security Act.]

[(D)] *(C)* MATERNAL AND CHILD HEALTH BLOCK GRANT PROGRAM.—Title V of the Social Security Act.

[(E)] *(D)* PUBLIC HEALTH SERVICE ACT.—The Public Health Service Act.

[(F)] *(E)* INDIAN HEALTH CARE IMPROVEMENT ACT.—The Indian Health Care Improvement Act.

[(G)] *(F)* FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—Chapter 89 of title 5, United States Code.

[(H)] *(G)* MILITARY HEALTH CARE SYSTEM (INCLUDING TRICARE AND CHAMPUS PROGRAMS).—Chapter 55 of title 10, United States Code.

[(I)] *(H)* VETERANS MEDICAL CARE.—Chapter 17 of title 38, United States Code.

[(J)] *(I)* HEALTH SERVICES FOR PEACE CORPS VOLUNTEERS.—Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

[(K)] *(J)* MEDICAL SERVICES FOR FEDERAL PRISONERS.—Section 4005(a) of title 18, United States Code.

* * * * * * *

DISSENTING VIEWS ON RECOMMENDATION TO ELIMINATE THE SOCIAL SERVICES BLOCK GRANT

These recommendations to the Budget Committee follow a disturbing but familiar pattern. Once again, the Majority has targeted seniors, children, people with disabilities, and middle-income families rather than ask the very wealthiest Americans to pay their fair share. We strongly oppose this unfair approach, these specific legislative proposals, and the complete lack of consultation, public discussion, or analysis of the consequences of these policies that preceded our Committee action. We support a fair and balanced approach to deficit reduction. The Majority's recommendation is neither fair nor balanced.

We strongly oppose eliminating the Social Services Block Grant, which helps fund protective services for abused children, home-based services for the disabled and elderly, and a variety of other services for vulnerable populations.

The Social Services Block Grant (SSBG) was signed into law by President Reagan in 1981 to provide States and local communities with a flexible funding source to meet challenging social service needs. Annual funding for the SSBG has declined in nominal terms from $2.8 billion in 1995 to $1.7 billion today, so this program already has been significantly reduced in scope and cost.

Without a single hearing, or even the introduction of a bill, the majority has moved to repeal the SSBG forever—a step that would have drastic consequences for millions of at-risk Americans. Services for up to 1.7 million older Americans, including home care and home delivered meals; services for up to 1 million disabled individuals, including respite care and transportation; and child care and child protective services for several million children would be severely jeopardized if the SSBG was eliminated.

In opposing the repeal of this program, the National Conference of State Legislatures notes that *"State legislators would not necessarily be able to backfill programs funded by the SSBG due to four years of back to back reductions in their own state budgets."* Only by raising taxes or cutting other important programs would States be able to maintain even some of the vital services provided by the SSBG.

Even as the majority's Budget Resolution proposes to cut and replace Medicaid and the Supplemental Nutrition Assistance Program (SNAP) with block grants to supposedly make the programs more flexible, the majority has suggested they are seeking to eliminate the Social Services Block Grant in part because it is too flexible. This is especially disappointing given the past bipartisan support for the SSBG in this Committee. For example, between 2000 and 2003, Chairman Camp signed four separate letters urging an *increase* in SSBG funding, making the point that *"SSBG has been a key source of flexible funding for critical social services."*

We are committed to bringing our budget into balance, but do not believe that children, senior citizens and the disabled should be targeted for massive cuts, as the wealthiest among us are asked to contribute nothing. We attempted to substitute these and other cuts with an equal amount of deficit reduction through the so-called "Buffett Rule," which would have affected only those with annual incomes of $1 million or more a year. Regrettably, the majority refused to allow a vote on this more equitable approach for reducing our deficit.

SANDER LEVIN.

The Committee on the Budget Report Requirements of the House

VOTES OF THE COMMITTEE

Clause 3(b) of House Rule XIII requires each committee report to accompany any bill or resolution of a public character to include the total number of votes cast for and against each roll call vote, on a motion to report and any amendments offered to the measure or matter, together with the names of those voting for and against.

Listed below are the actions taken in the Committee on the Budget of the House of Representatives on the Sequester Replacement Act of 2012.

On May 7, 2012, the committee met in open session, a quorum being present.

Chairman Ryan asked unanimous consent to be authorized, consistent with clause 4 of House Rule XVI, to declare a recess at any time during the committee meeting.

There was no objection to the unanimous consent request.

Chairman Ryan asked unanimous consent to dispense with the first reading of the bill and the bill be considered as read and open to amendment at any point.

There was no objection to the unanimous consent request.

The committee adopted and ordered reported the Sequester Replacement Reconciliation Act of 2012.

Mr. Garrett made a motion that the committee report the bill with a favorable recommendation and that the bill do pass.

The motion was agreed to by a roll call vote of 21 ayes and 9 noes.

ROLLCALL VOTE NO. 1

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
RYAN (WI) (Chairman)	X			VAN HOLLEN (MD) (Ranking)		X	
GARRETT (NJ)	X			SCHWARTZ (PA)		X	
SIMPSON (ID)	X			KAPTUR (OH)			
CAMPBELL (CA)	X			DOGGETT (TX)			
CALVERT (CA)	X			BLUMENAUER (OR)			
AKIN (MO)				McCOLLUM (MN)		X	
COLE (OK)	X			YARMUTH (KY)		X	
PRICE (GA)	X			PASCRELL (NJ)			

ROLLCALL VOTE NO. 1—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
McCLINTOCK (CA)	X			HONDA (CA)			
CHAFFETZ (UT)	X			RYAN (OH)			
STUTZMAN (IN)	X			WASSERMAN SCHULTZ (FL)		X	
LANKFORD (OK)	X			MOORE (WI)			
BLACK (TN)	X			CASTOR (FL)		X	
RIBBLE (WI)	X			SHULER (NC)		X	
FLORES (TX)	X			BASS (CA)		X	
MULVANEY (SC)	X			BONAMICI (OR)		X	
HUELSKAMP (KS)	X						
YOUNG (IN)	X						
AMASH (MI)	X						
ROKITA (IN)	X						
GUINTA (NH)	X						
WOODALL (GA)	X						

Mr. Garrett made a motion that, pursuant to clause 1 of rule XXII, the Chairman be authorized to offer such motions as may be necessary in the House to go to conference with the Senate, and staff be authorized to make any necessary technical and conforming changes to the bill.

The motion was agreed to without objection.

MOTIONS ON THE RULE FOR CONSIDERATION OF THE SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012

A Motion Offered by Ms. Castor

1. Representative Castor moved that the Committee on the Budget direct its chairman to request on behalf of the committee, that the rule for consideration of the Sequester Replacement Reconciliation Act of 2012 make in order an amendment that would strike the repeal of the Maintenance of Effort requirements and the Children's Health Insurance Program bonus payments and replace the section with a revenue increase from domestic oil companies through the elimination of certain deductions.

The motion was not agreed to by a roll call vote of 12 ayes and 21 noes.

ROLLCALL VOTE NO. 2

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
RYAN (WI) (Chairman)		X		VAN HOLLEN (MD) (Ranking)	X		
GARRETT (NJ)		X		SCHWARTZ (PA)	X		

ROLLCALL VOTE NO. 2—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
SIMPSON (ID)		X		KAPTUR (OH)	X		
CAMPBELL (CA)		X		DOGGETT (TX)	X		
CALVERT (CA)		X		BLUMENAUER (OR)			
AKIN (MO)				McCOLLUM (MN)	X		
COLE (OK)		X		YARMUTH (KY)	X		
PRICE (GA)		X		PASCRELL (NJ)			
McCLINTOCK (CA)		X		HONDA (CA)			
CHAFFETZ (UT)		X		RYAN (OH)	X		
STUTZMAN (IN)		X		WASSERMAN SCHULTZ (FL)	X		
LANKFORD (OK)		X		MOORE (WI)			
BLACK (TN)		X		CASTOR (FL)	X		
RIBBLE (WI)		X		SHULER (NC)	X		
FLORES (TX)		X		BASS (CA)	X		
MULVANEY (SC)		X		BONAMICI (OR)	X		
HUELSKAMP (KS)		X					
YOUNG (IN)		X					
AMASH (MI)		X					
ROKITA (IN)		X					
GUINTA (NH)		X					
WOODALL (GA)		X					

A Motion Offered by Ms. Schwartz and Ms. Wasserman Schultz

2. Representatives Schwartz and Wasserman Schultz moved that the Committee on the Budget direct its chairman to request on behalf of the committee, that the rule for consideration of the Sequester Replacement Reconciliation Act of 2012 make in order an amendment that strikes the repeal of the Prevention and Public Health Fund under the Affordable Care Act and replace the section with a revenue increase from U.S. businesses with international operations.

The motion was not agreed to by a roll call vote of 12 ayes and 21 noes.

ROLLCALL VOTE NO. 3

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
RYAN (WI) (Chairman)		X		VAN HOLLEN (MD) (Ranking)	X		

ROLLCALL VOTE NO. 3—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
GARRETT (NJ)		X		SCHWARTZ (PA)	X		
SIMPSON (ID)		X		KAPTUR (OH)	X		
CAMPBELL (CA)		X		DOGGETT (TX)	X		
CALVERT (CA)		X		BLUMENAUER (OR)			
AKIN (MO)		X		McCOLLUM (MN)	X		
COLE (OK)		X		YARMUTH (KY)	X		
PRICE (GA)				PASCRELL (NJ)			
McCLINTOCK (CA)		X		HONDA (CA)			
CHAFFETZ (UT)		X		RYAN (OH)	X		
STUTZMAN (IN)		X		WASSERMAN SCHULTZ (FL)	X		
LANKFORD (OK)		X		MOORE (WI)			
BLACK (TN)		X		CASTOR (FL)	X		
RIBBLE (WI)		X		SHULER (NC)	X		
FLORES (TX)		X		BASS (CA)	X		
MULVANEY (SC)		X		BONAMICI (OR)	X		
HUELSKAMP (KS)		X					
YOUNG (IN)		X					
AMASH (MI)		X					
ROKITA (IN)		X					
GUINTA (NH)		X					
WOODALL (GA)		X					

A Motion Offered by Mr. Doggett and Ms. Bonamici

3. Representatives Doggett and Bonamici moved that the Committee on the Budget direct its chairman to request on behalf of the committee, that the rule for consideration of the Sequester Replacement Reconciliation Act of 2012 make in order an amendment that strikes the repeal of the Social Services Block Grant and replaces it with a revenue increase from the largest five oil companies.

The motion was not agreed to by a roll call vote of 13 ayes and 21 noes.

ROLLCALL VOTE NO. 4

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
RYAN (WI) (Chairman)		X		VAN HOLLEN (MD) (Ranking)	X		

ROLLCALL VOTE NO. 4—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
GARRETT (NJ)		X		SCHWARTZ (PA)	X		
SIMPSON (ID)		X		KAPTUR (OH)	X		
CAMPBELL (CA)		X		DOGGETT (TX)	X		
CALVERT (CA)		X		BLUMENAUER (OR)	X		
AKIN (MO)				McCOLLUM (MN)	X		
COLE (OK)		X		YARMUTH (KY)	X		
PRICE (GA)		X		PASCRELL (NJ)			
McCLINTOCK (CA)		X		HONDA (CA)			
CHAFFETZ (UT)		X		RYAN (OH)	X		
STUTZMAN (IN)		X		WASSERMAN SCHULTZ (FL)	X		
LANKFORD (OK)		X		MOORE (WI)			
BLACK (TN)		X		CASTOR (FL)	X		
RIBBLE (WI)		X		SHULER (NC)	X		
FLORES (TX)		X		BASS (CA)	X		
MULVANEY (SC)		X		BONAMICI (OR)	X		
HUELSKAMP (KS)		X					
YOUNG (IN)		X					
AMASH (MI)		X					
ROKITA (IN)		X					
GUINTA (NH)		X					
WOODALL (GA)		X					

A Motion Offered by Mr. Blumenauer and Mr. Yarmuth

4. Representatives Blumenauer and Yarmuth moved that the Committee on the Budget direct its chairman to request on behalf of the committee, that the rule for consideration of the Sequester Replacement Reconciliation Act of 2012 make in order an amendment that strikes the reductions in Supplemental Nutrition Assistance Program and replaces it with reduced agriculture subsidies.

The motion was not agreed to by a roll call vote of 13 ayes and 19 noes.

ROLLCALL VOTE NO. 5

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
RYAN (WI) (Chairman)		X		VAN HOLLEN (MD) (Ranking)	X		
GARRETT (NJ)		X		SCHWARTZ (PA)	X		

ROLLCALL VOTE NO. 5—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
SIMPSON (ID)		X		KAPTUR (OH)	X		
CAMPBELL (CA)		X		DOGGETT (TX)	X		
CALVERT (CA)		X		BLUMENAUER (OR)	X		
AKIN (MO)		X		McCOLLUM (MN)	X		
COLE (OK)		X		YARMUTH (KY)	X		
PRICE (GA)		X		PASCRELL (NJ)			
McCLINTOCK (CA)		X		HONDA (CA)			
CHAFFETZ (UT)				RYAN (OH)	X		
STUTZMAN (IN)		X		WASSERMAN SCHULTZ (FL)	X		
LANKFORD (OK)				MOORE (WI)			
BLACK (TN)		X		CASTOR (FL)	X		
RIBBLE (WI)				SHULER (NC)	X		
FLORES (TX)		X		BASS (CA)	X		
MULVANEY (SC)		X		BONAMICI (OR)	X		
HUELSKAMP (KS)		X					
YOUNG (IN)		X					
AMASH (MI)		X					
ROKITA (IN)		X					
GUINTA (NH)		X					
WOODALL (GA)		X					

At the end of the vote on the fourth motion, Mr. Akin made a unanimous consent request that the record reflect that he had been unavoidably detained due to medical reasons, and had he been present he would have voted favorably to report the Sequester Reconciliation Replacement Act and would have voted against the first motion offered by Ms. Castor.

STATEMENT ON COMMITTEE OVERSIGHT FINDINGS

Clause 3(c)(1) of rule XIII of the Rules of the House of Representatives requires the report of a committee on a measure that has been approved by the committee to contain oversight findings and recommendations required pursuant to clause (2)(b)(1) of rule X. These oversight findings and a description of hearings held by the Committee on the Budget may be found in the introduction to this report.

PERFORMANCE GOALS AND OBJECTIVES

With respect to the requirement of clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the performance goals and objectives of this legislation are to reform government, make it more efficient, and to reduce spending.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 7 of rule XII of the Rules of the House of Representatives, the committee finds the constitutional authority for this legislation in Article I, section 9, clause 7.

ADVISORY COMMITTEE STATEMENT

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

APPLICABILITY TO THE 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 (Public Law 104-1).

FEDERAL MANDATES STATEMENT

The committee adopted the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act (Public Law 104-4).

ADVISORY ON EARMARKS

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, this measure does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(e), 9(f), or 9(g) of rule XXI.

CHANGES IN EXISTING LAW MADE BY THE BILL AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the provisions of the bill, as reported, 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). These changes may be found in the individual titles of this report.

COMMITTEE COST ESTIMATE

For purposes of clause 3(c)(2) and (3) of rule XIII of the Rules of the House of Representatives and section 308(a)(1) of the Congressional Budget Act of 1974 (relating to estimates of new budget authority, new spending authority, new credit authority, or increased or decreased revenues or tax expenditures), the committee report incorporates the cost estimate prepared by the Director of the Congressional Budget Office pursuant to sections 402 and 423 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

CONGRESSIONAL BUDGET OFFICE,
U.S. CONGRESS,
Washington, DC, May 8, 2012.

Hon. PAUL RYAN, *Chairman,*
Committee on the Budget, U.S. House of Representatives, Washington, DC 20515.

DEAR MR. CHAIRMAN: The Congressional Budget Office (CBO) has reviewed the Sequester Replacement Reconciliation Act, as ordered reported by the House Committee on the Budget on May 7, 2012. The two enclosed tables present estimates of the legislation's effects on direct spending and revenues under two alternative enactment date assumptions. Table 1 provides estimates assuming enactment around October 1, 2012, while Table 2 provides estimates assuming enactment by July 1, 2012, as you directed in your letter to CBO dated April 2, 2012.

Assuming enactment around October 1, 2012, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that the reconciliation act would reduce deficits by $15.3 billion over the 2012-2013 period, by $136.9 billion over the 2012-2017 period, and by $328.0 billion over the 2012-2022 period.

Under assumed enactment by July 1, 2012, CBO and JCT estimate that the legislation would reduce deficits by $19.7 billion over the 2012-2013 period, by $142.0 billion over the 2012-2017 period, and by $333.0 billion over the 2012-2022 period.

The tables present changes in estimated direct spending and revenues, by title. The legislation's six titles reflect reconciliation recommendations approved by the House Committees on Agriculture, Energy and Commerce, Financial Services, Judiciary, Oversight and Government Reform, and Ways and Means. CBO previously transmitted cost estimates during the week of April 23-27 for the recommendations approved by those committees, all of which received reconciliation instructions under H. Con. Res. 112, the budget resolution for fiscal year 2013, as passed by the House of Representatives on March 29, 2012. The estimates for individual committee recommendations are posted under "cost estimates" on CBO's Web site (www.cbo.gov).

The composite bill approved by the Committee on the Budget does not make any changes to the recommendations approved by the six committees. The estimates presented in Tables 1 and 2, however, account for the overlap and interactions between some of those committee proposals. Specifically, there are overlapping provisions in the recommendations contained in title II (Energy and Commerce) and title IV (Judiciary) that would impose limits on medical malpractice litigation in state and federal courts. Further, there are interactions between the health care provisions included in title II and title VI (Ways and Means).

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

ENCLOSURE.

cc: Hon. CHRIS VAN HOLLEN, *Ranking Member.*

TABLE 1.—ESTIMATE OF THE EFFECTS ON DIRECT SPENDING AND REVENUES FOR THE SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON THE BUDGET ON MAY 7, 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—Agriculture:													
Estimated Budget Authority	0	−5,638	−3,347	−3,104	−3,127	−3,091	−3,061	−3,063	−3,075	−3,093	−3,096	−18,307	−33,694
Estimated Outlays	0	−5,633	−3,342	−3,104	−3,127	−3,091	−3,061	−3,063	−3,075	−3,093	−3,096	−18,297	−33,684
Title II—Energy and Commerce:													
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
Title III—Financial Services:[a]													
Estimated Budget Authority	0	−3,283	−4,586	−4,907	−4,122	−3,680	−3,845	−3,864	−4,068	−4,254	−4,443	−20,578	−41,052
Estimated Outlays	0	−3,207	−4,579	−4,905	−4,120	−3,678	−3,842	−3,861	−4,065	−4,251	−4,440	−20,489	−40,948
Title IV—Judiciary:													
Estimated Budget Authority	0	−100	−650	−2,250	−3,850	−4,850	−5,200	−5,500	−5,900	−6,300	−6,700	−11,700	−41,300
Estimated Outlays	0	−100	−650	−2,250	−3,850	−4,850	−5,200	−5,500	−5,900	−6,300	−6,700	−11,700	−41,300
Title V—Oversight and Government Reform:[b]													
Estimated Budget Authority	0	157	283	400	499	581	559	539	515	494	469	1,919	4,493
Estimated Outlays	0	157	283	400	499	581	559	539	515	494	469	1,919	4,493
Title VI—Ways and Means:													
Estimated Budget Authority	0	−1,700	−3,561	−4,548	−5,635	−6,164	−6,512	−6,739	−6,904	−7,253	−7,483	−21,609	−56,501
Estimated Outlays	0	−1,360	−3,527	−4,650	−5,652	−6,164	−6,512	−6,739	−6,904	−7,253	−7,483	−21,354	−56,246
Interactions:[c]													
Estimated Budget Authority	0	100	785	2,462	4,041	4,910	5,210	5,511	5,911	6,312	6,713	12,298	41,955
Estimated Outlays	0	100	785	2,462	4,041	4,910	5,210	5,511	5,911	6,312	6,713	12,298	41,955
Total changes in direct spending:													
Estimated Budget Authority	0	−24,554	−17,546	−20,407	−24,795	−23,344	−23,129	−24,017	−24,351	−25,565	−31,410	−110,646	−239,119
Estimated Outlays	0	−12,913	−17,550	−24,267	−25,180	−22,872	−22,966	−23,854	−24,118	−25,512	−31,077	−102,782	−230,310
CHANGES IN REVENUES ASSUMING ENACTMENT AROUND OCTOBER 1, 2012[d]													
Title II—Energy and Commerce	0	−10	−190	−960	650	1,210	1,340	1,570	1,640	1,720	1,820	700	8,790
Title III—Financial Services	0	−67	−248	−474	−715	−976	−1,207	−1,428	−1,644	−1,845	−1,981	−2,480	−10,585
Title IV—Judiciary	0	8	83	324	578	882	985	1,026	1,082	1,145	1,210	1,875	7,323
Title V—Oversight and Government Reform	0	2,426	4,505	6,625	8,633	10,514	10,671	10,849	11,009	11,212	11,350	32,704	87,794
Title VI—Ways and Means	0	0	238	700	1,116	1,422	1,542	1,664	1,718	1,748	1,864	3,476	12,013
Interactions[c]	0	−8	−119	−412	−664	−928	−990	−1,030	−1,086	−1,149	−1,215	−2,131	−7,601
Total changes in revenues	0	2,349	4,269	5,803	9,598	12,124	12,341	12,651	12,719	12,830	13,048	34,144	97,734

TABLE 1.—ESTIMATE OF THE EFFECTS ON DIRECT SPENDING AND REVENUES FOR THE SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON THE BUDGET ON MAY 7, 2012, ASSUMING ENACTMENT AROUND OCTOBER 1, 2012—Continued

[By fiscal year, in millions of dollars]

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012–2017	2012–2022
INCREASE OR DECREASE (−) IN THE DEFICIT ASSUMING ENACTMENT AROUND OCTOBER 1, 2012													
Net effect on deficits	0	−15,262	−21,819	−30,071	−34,778	−34,996	−35,308	−36,505	−36,837	−38,342	−44,126	−136,926	−328,044
On-Budget	0	−15,106	−21,737	−30,228	−34,426	−34,269	−34,493	−35,655	−36,005	−37,516	−43,309	−135,766	−322,743
Off-Budget e	0	−157	−82	157	−351	−727	−816	−850	−832	−826	−817	−1,161	−5,302
Memorandum:													
Reduction in Offsetting Receipts Resulting from Lower Employer Contributions[b]	0	1,887	3,633	5,439	7,191	8,882	9,149	9,446	9,722	10,026	10,265	27,032	75,641
Increased net income to the National Flood Insurance Program[f]	0	0	−60	−150	−265	−405	−580	−775	−830	−890	−945	−880	−4,900

Sources: CBO and the staff of the Joint Committee on Taxation

Note: Components may not sum to totals because of rounding

a. In addition, CBO estimates that implementing title III (Financial Services) would cost $766 million over the 2012-2017 period, assuming appropriation of the necessary amounts. That estimate includes funding for the Bureau of Consumer Financial Protection, the Financial Stability Oversight Council, and for mapping and mitigation efforts under the National Flood Insurance Program

b. Employer contributions are intragovernmental transactions that do not affect the deficit; positive numbers indicate a decrease in such intragovernmental receipts. The receipts shown in the memorandum result from federal employer contributions financed by future appropriations; such receipts are not considered to be an offset to direct spending because they are contingent on future appropriations

c. There are interactions between the medical malpractice provisions in Titles II and IV and additional interactions between the health provisions in Titles II and VI

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

e. Title V includes off-budget direct spending; Titles II, IV, and VI include both on- and off-budget revenues

f. The proposed language would raise premiums for certain subsidized flood insurance policies, increasing net income to the National Flood Insurance Program by $4.9 billion. However, because many policies would continue to be subsidized and the program would continue to face significant interest costs for borrowing over the past decade, CBO expects that additional receipts collected under this legislation would be spent to cover future program shortfalls, resulting in no net effect on the budget over the 2012-2022 period

TABLE 2.—ESTIMATE OF THE EFFECTS ON DIRECT SPENDING AND REVENUES FOR THE SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON THE BUDGET ON MAY 7, 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—Agriculture:													
Estimated Budget Authority	−720	−7,064	−3,347	−3,104	−3,127	−3,091	−3,061	−3,063	−3,075	−3,093	−3,096	−20,453	−35,840
Estimated Outlays	−720	−7,059	−3,342	−3,104	−3,127	−3,091	−3,061	−3,063	−3,075	−3,093	−3,096	−20,443	−35,830
Title II—Energy and Commerce:													
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
Title III—Financial Services:[a]													
Estimated Budget Authority	−585	−3,994	−4,381	−4,826	−4,108	−3,765	−3,857	−3,869	−4,073	−4,258	−4,444	−21,659	−42,160
Estimated Outlays	−585	−3,918	−4,374	−4,824	−4,106	−3,763	−3,854	−3,866	−4,070	−4,255	−4,441	−21,570	−42,056
Title IV—Judiciary:													
Estimated Budget Authority	0	−100	−650	−2,250	−3,850	−4,850	−5,200	−5,500	−5,900	−6,300	−6,700	−11,700	−41,300
Estimated Outlays	0	−100	−650	−2,250	−3,850	−4,850	−5,200	−5,500	−5,900	−6,300	−6,700	−11,700	−41,300
Title V—Oversight and Government Reform:[b]													
Estimated Budget Authority	0	157	283	400	499	581	559	539	515	494	469	1,919	4,493
Estimated Outlays	0	157	283	400	499	581	559	539	515	494	469	1,919	4,493
Title VI—Ways and Means:													
Estimated Budget Authority	0	−1,700	−3,561	−4,548	−5,635	−6,164	−6,512	−6,739	−6,904	−7,253	−7,483	−21,609	−56,501
Estimated Outlays	0	−1,360	−3,527	−4,650	−5,652	−6,164	−6,512	−6,739	−6,904	−7,253	−7,483	−21,354	−56,246
Interactions:[c]													
Estimated Budget Authority	0	100	785	2,462	4,041	4,910	5,210	5,511	5,911	6,312	6,713	12,298	41,955
Estimated Outlays	0	100	785	2,462	4,041	4,910	5,210	5,511	5,911	6,312	6,713	12,298	41,955
Total changes in direct spending:													
Estimated Budget Authority	−13,745	−16,371	−17,341	−20,326	−24,781	−23,429	−23,141	−24,022	−24,356	−25,569	−31,411	−115,993	−244,493
Estimated Outlays	−1,715	−15,650	−17,985	−24,486	−25,266	−23,017	−22,978	−23,859	−24,123	−25,516	−31,078	−108,119	−235,674
CHANGES IN REVENUES ASSUMING ENACTMENT BY JULY 1, 2012[d]													
Title II—Energy and Commerce	0	−10	−190	−960	650	1,210	1,340	1,570	1,640	1,720	1,820	700	8,790
Title III—Financial Services	−15	−102	−298	−524	−760	−1,011	−1,247	−1,463	−1,674	−1,860	−1,996	−2,710	−10,950
Title IV—Judiciary	0	8	83	324	578	882	985	1,026	1,082	1,145	1,210	1,875	7,323
Title V—Oversight and Government Reform	0	2,426	4,505	6,625	8,633	10,514	10,671	10,849	11,009	11,212	11,350	32,704	87,794
Title VI—Ways and Means	0	0	238	700	1,116	1,422	1,542	1,664	1,718	1,748	1,864	3,476	12,013

TABLE 2.—ESTIMATE OF THE EFFECTS ON DIRECT SPENDING AND REVENUES FOR THE SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON THE BUDGET ON MAY 7, 2012, ASSUMING ENACTMENT BY JULY 1, 2012, AS DIRECTED BY THE CHAIRMAN OF THE HOUSE COMMITTEE ON THE BUDGET—Continued

[By fiscal year, in millions of dollars]

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2012–2017	2012–2022
Interactions[c]	0	−8	−119	−412	−664	−928	−990	−1,030	−1,086	−1,149	−1,215	−2,131	−7,601
Total changes in revenues	−15	2,314	4,219	5,753	9,553	12,089	12,301	12,616	12,689	12,815	13,033	33,914	97,369
INCREASE OR DECREASE (−) IN THE DEFICIT ASSUMING ENACTMENT BY JULY 1, 2012													
Net effect on deficits	−1,700	−17,964	−22,204	−30,240	−34,819	−35,106	−35,280	−36,475	−36,812	−38,331	−44,112	−142,033	−333,043
On-Budget	−1,700	−17,808	−22,122	−30,397	−34,467	−34,379	−34,465	−35,625	−35,980	−37,505	−43,295	−140,873	−327,742
Off-Budget[e]	0	−157	−82	157	−351	−727	−816	−850	−832	−826	−817	−1,161	−5,302
Memorandum:													
Reduction in Offsetting Receipts Resulting from Lower Employer Contributions[b]	0	1,887	3,633	5,439	7,191	8,882	9,149	9,446	9,722	10,026	10,265	27,032	75,641
Increased net income to the National Flood Insurance Program[f]	0	0	−60	−150	−265	−405	−580	−775	−830	−890	−945	−880	−4,900

Sources: CBO and the staff of the Joint Committee on Taxation

Note: Components may not sum to totals because of rounding

a. In addition, CBO estimates that implementing title III (Financial Services) would cost $766 million over the 2012-2017 period, assuming appropriation of the necessary amounts. That estimate includes funding for the Bureau of Consumer Financial Protection, the Financial Stability Oversight Council, and for mapping and mitigation efforts under the National Flood Insurance Program. Employer contributions are intragovernmental transactions that do not affect the deficit; positive numbers indicate a decrease in such intragovernmental receipts. The receipts shown in the memorandum result from federal employer contributions financed by future appropriations; such receipts are not considered to be an offset to direct spending because they are contingent on future appropriations

c. There are interactions between the medical malpractice provisions in Titles II and IV and additional interactions between the health provisions in Titles II and VI

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

e. Title V includes off-budget direct spending; Titles II, IV, and VI include both on- and off-budget revenues

f. The proposed language would raise premiums for certain subsidized flood insurance policies, increasing net income to the National Flood Insurance Program by $4.9 billion. However, because many policies would continue to be subsidized and the program would continue to face significant interest costs for borrowing over the past decade, CBO expects that additional receipts collected under this legislation would be spent to cover future program shortfalls, resulting in no net effect on the budget over the 2012-2022 period

Appendix

The "Revenue" chapter of the Committee Report on the Concurrent Resolution on the Budget for Fiscal Year 2013 (H. Con. Res. 112 of the 112th Congress) did not reflect the full intent of the resolution as reported by the House Budget Committee. The following text represents the full and accurate "Revenue" chapter as the Committee intended it to appear.

REVENUE

Led by House Ways and Means Committee Chairman Dave Camp of Michigan, this budget advances a framework that calls for an American tax system that is simple, efficient and fair to promote innovation and sustained job creation in the private sector.

The House Ways and Means Committee held more than a dozen hearings devoted to tax reform last year. Last October, Chairman Camp formally released an international tax reform discussion draft, with proposals designed to boost competitiveness and job creation in the United States. This budget reflects the progress that has been made over the past year by the House Ways and Means Committee, and calls for continued leadership to advance tax reform in the year ahead.

This budget starts with the proposition that first, Congress must do no harm. It assumes that Congress will not allow massive, across-the-board tax increases to hit the economy in 2013. This budget then attacks complexity, unfairness, and inefficiency in the tax code with a set of fundamental reforms designed to lower tax rates, broaden the tax base, and reform the U.S. international tax rules, while getting rid of distortions, loopholes and preferences that divert economic resources from their most efficient uses.

Following the unveiling of a principled approach to tax reform in last year's budget resolution, an overwhelming consensus has emerged that the country is in dire need of reform that lowers rates, broadens the tax base, and addresses global competitiveness. After three years, the administration also has begun to recognize the need for tax reform. The outline for corporate tax reform released by the administration in February, however, falls woefully short: the rates are too high; the tax base is too narrow (and used as a tool to provide political favors); and the international reforms are anti-competitive.

By contrast, the principles of reform outlined in this budget ensure a simpler, fairer tax code not just for large corporations but for small businesses and American families as well. Unlike the administration's plan, it improves the competitiveness of American workers and businesses in the global economy. America's trading partners have already reformed their tax systems to provide their

companies with a competitive advantage. Competing in a 21st century global economy requires that America do the same.

Simplifying the Tax Code and Promoting Job Creation and Economic Growth

Major proposals in this area are:

- Reject the President's call to raise taxes.
- Consolidate the current six individual income tax brackets into just two brackets of 10 and 25 percent.
- Reduce the corporate rate to 25 percent.
- Repeal the Alternative Minimum Tax.
- Broaden the tax base to maintain revenue at the appropriate level designated by this budget resolution for the next 10 years, and at a share of the economy consistent with historical norms of 18 to 19 percent in the following decades. These are levels compatible with growth, and—if the spending restraints in this budget are enacted—sufficient to fund government operations over time.
- Shift from a "worldwide" system of taxation to a "territorial" tax system that puts American companies and their workers on a level playing field with foreign competitors and ends the "lock-out effect" that discourages companies from bringing back foreign earnings to invest in the United States.

In 1981, President Ronald Reagan inherited a stagnant economy and a tax code that featured 16 brackets, with a top rate of 70 percent. When he left office in 1989, the tax code had been simplified down to just three brackets, with a top rate of 28 percent. Reagan's tax reforms proved to be a cornerstone of the unprecedented economic boom that occurred in the decade during his presidency and continued in the decade that followed.

Over time, additional brackets, credits, carve-outs and lobbyist loopholes have undone the simpler and fairer tax code ushered in by the 1986 tax reform. In the last 10 years alone, there have been nearly 4,500 changes made to the tax code. The current version for individuals has six brackets, with a top rate of 35 percent (which is set to climb to over 40 percent after the end of 2012, when hidden rates are considered). Individuals react negatively toward the tax code partly because it is complex and attempts to steer them toward certain activities and away from others. In addition, there are always a few "surprises" that end up raising their tax bills. One such surprise—the Alternative Minimum Tax (AMT)—was initially designed to hit only the very highest-income taxpayers but now ensnares a growing number of middle-class households because of a flawed design.

This budget affirmatively rejects President Obama's efforts to raise tax rates on small businesses and investors and to add new loopholes to the tax code for favored interests. Economic theory and analysis show that increasing marginal tax rates—tax increases that reduce incentives to work, save and invest that next dollar of income—reduces economic output. By contrast, reductions in marginal tax rates increase output, mainly by letting people keep more of each dollar they earn and thereby strengthening incentives to work, produce, and invest in the future. The House plan both realizes the job-promoting benefits of lower rates and ensures these reductions are revenue neutral through base broadening.

Unlike President Obama's proposal, the House plan would not penalize the nearly three quarters of America's small businesses that file taxes as individuals by imposing higher individual rates that make it harder for these vital enterprises to compete. As President Obama repeatedly says, small businesses have been responsible for two-thirds of the jobs created in the United States over the past 15 years, yet he often neglects to point out that roughly 50 percent of small-business profits are taxed at the top two individual tax rates. Raising these rates means increasing taxes on the most successful job creators.

Raising taxes on capital is another idea that purports to affect the wealthy but actually hurts all participants in the economy. Mainstream economics, not to mention common sense, teaches that raising taxes on any activity generally results in less of it. Economics and common sense also teach that the size of a nation's capital stock—the pool of saved money available for investment and job creation—has an effect on employment, productivity, and wages. Tax reform should promote savings and investment because more savings and more investment mean a larger stock of capital available for job creation. That means more jobs, more productivity, and higher wages for all American workers.

The negative effects of high tax rates on work, savings and investment are compounded when a large mix of exemptions, deductions and credits are added to the system. These tax preferences are similar to government spending—instead of markets directing economic resources to their most efficient uses, the government directs resources to politically favored uses, creating a drag on economic growth and job creation.

In the worst cases, these tax subsidies literally take the form of spending through the tax code, because they take taxes paid by hardworking Americans and issue government checks to individuals and corporations who do not owe any taxes at all. In fact, President Obama's corporate tax "reform" framework would expand this practice by transferring taxes paid by middle-income Americans to the pockets of politically favored industries.

Eliminating large tax subsidies would not be for the purpose of increasing total tax revenues. Instead, when offset by lower rates, it would have a doubly positive impact on the economy—it would stop diverting economic resources to less productive uses, while making possible the lower tax rates that provide greater incentives for economic growth.

There is an emerging bipartisan consensus for tax reform that lowers tax rates, broadens the tax base, and promotes growth and job creation. President Reagan's tax reforms inaugurated an era of great prosperity. It is time to build upon his leadership and advance a fundamental reform of the broken tax code as a critical step in rebuilding the foundations for economic growth: spending restraint, reasonable and predictable regulations, sound money, and a simple tax code with low rates.

Economists have shown that lowering overall rates and broadening the tax base will promote economic growth and support job creation by the private sector. There are many good ideas on that front—growth-oriented tax plans that could strengthen the economy and support the Nation's funding priorities. Congressman

Woodall, for instance, has submitted a fundamental tax reform plan for consideration by the Ways and Means Committee that would eliminate taxes on wages, corporations, self-employment, capital gains, and gift and death taxes in favor of a personal consumption tax that would provide the economic certainty that American businesses, entrepreneurs, and taxpayers desire. Congress should consider this and the full myriad of pro-growth plans as it moves toward tax reform.

Views of Committee Members

Clause 2(l) of rule XI requires each committee to provide two days to Members of the committee to file Minority, additional, supplemental, or dissenting views and to include such views in the report on legislation considered by the committee.

The following views were submitted:

MINORITY VIEWS

REPUBLICANS REJECT A BALANCED APPROACH TO DEFICIT REDUCTION

Democrats and Republicans agree on the importance of reducing the deficit, but we disagree on how to do it. Democrats remain focused on creating more jobs now to support the fragile economy while pursuing a plan to reduce the deficit in a balanced way. That's why this spring, House Democrats offered a budget that preserves the Medicare guarantee, helps create more jobs now, makes us stronger through investments that build long-term growth, abides by the tight spending caps established last summer—which save nearly $1 trillion over ten years—and reduces the deficit through shared responsibility. In contrast, the House-passed Republican budget resolution for fiscal year 2013 reflects the Majority's unbalanced approach to deficit reduction: it provides costly additional tax breaks for millionaires while finding savings by ending the Medicare guarantee for seniors, slashing investments that strengthen our economy, and shredding the social safety net. Because Republicans reject a balanced approach and refuse to ask millionaires to contribute one cent to deficit reduction, their budget hits everyone and everything else.

House Republicans are attempting to use the fast-track procedures provided under budget reconciliation to hasten consideration of some of their budget resolution's harmful priorities. Their resolution directed six committees to make recommendations for legislative changes that reduce the deficit by $261.5 billion over the 2012–2022 period. The results are shown in the table below.

[Cuts in billions of dollars]

Committee	Budget Resolution Target			Reconciliation Measure [2]		
	2012–2013	2012–2017	2012–2022	2012–2013	2012–2017	2012–2022
Agriculture [1]	7.710	19.700	33.200	7.779	20.443	35.830
Energy & Commerce	3.750	28.430	96.760	3.870	47.970	115.480
Financial Services [1 3]	3.490	16.700	29.800	4.386	19.740	36.006
Judiciary	0.100	11.200	39.700	0.108	13.575	48.623
Oversight & Government Reform	2.200	30.100	78.900	2.269	30.785	83.301
Ways & Means	1.200	23.000	53.000	1.360	24.830	68.258
Gross Reconciliation Savings	18.450	129.130	331.360	19.764	156.470	382.577
Remove overlap	−0.100	−12.800	−69.900	−0.108	−14.429	−49.556
Net Total Reconciliation Savings	18.350	116.330	261.460	19.664	142.913	337.943

[1] The rule ''deeming'' the House-passed budget resolution as the concurrent budget resolution shifted $490 million from Agriculture to Financial Services. The 2012–2013 Agriculture target was originally $8.2 billion, while the Financial Services target was $3.0 billion. The 2012–2017 and 2012–2022 amounts, as well as the totals, were not changed.

[2] Assuming July 1 enactment, as reported by the Budget Committee on May 7, 2012.

[3] The Financial Services score includes $4.9 billion from floor insurance savings, per scoring direction from the Budget Committee.

In addition, the Sequester Replacement Act of 2012, which the Budget Committee marked up on May 7, formalizes the plan laid out in the Republican budget resolution. The bill eliminates most

of the roughly $100 billion across-the-board sequester of spending—50 percent from defense and 50 percent from non-defense programs—scheduled for 2013. The bill leaves in place only the non-defense sequester of mandatory programs, which will affect programs such as Medicare. In place of the rest of the 2013 sequester, the bill uses both the multi-year savings from the permanent mandatory spending cuts included in the reconciliation package, and the savings from lowering the discretionary spending cap for fiscal year 2013 by $19 billion below the level set in the bipartisan Budget Control Act of 2011 (BCA).

Sequestration is a meat-ax approach to deficit reduction that does not make sense for our country. It was included in the BCA as a last resort intended to pressure Congress to develop a bipartisan alternative to achieve long-term deficit reduction. But because House Republicans continue to resist the balanced approach to deficit reduction that has been recommended by every bipartisan group that has looked at the budget challenge, on January 2, 2013, this "Sword of Damocles" will go into effect. The sequestration would impose indiscriminate cuts of almost $1 trillion over the next ten years—50 percent from defense and 50 percent from non-defense programs.

Unfortunately, instead of looking for a balanced solution, the Republican reconciliation package targets programs that help the less powerful while protecting the tax breaks of powerful special interests. In fact, the reconciliation package makes deep cuts to food and nutrition programs for low-income families and Medicaid—both programs that would have been entirely exempt from any sequestration cuts.

This unbalanced approach to deficit reduction—focused only on cutting investments rather than also closing tax loopholes—is the wrong choice for America.

DEMOCRATS OFFERED BETTER, BALANCED DEFICIT REDUCTION PLANS

The deep spending cuts coming through the Republican reconciliation instructions and the sequestration of spending scheduled under the BCA are neither the right nor only ways to reduce the deficit. In fact, Democrats have proposed to achieve *greater* deficit reduction from targeted, balanced policy choices, rather than the slash-and-burn approach taken by an across-the-board sequester or the deep cuts made in the Republican reconciliation proposal. The President provided Congress with specific policies to reduce the deficit last fall and in his 2013 budget. This spring, the House Democratic budget would have replaced meat-ax spending cuts under sequestration with a combination of mandatory spending cuts and revenues from eliminating tax loopholes and asking millionaires to return to the same top tax rate they paid during the Clinton Administration, a time of strong economic growth and fiscal responsibility.

Finally, in the Budget Committee mark-up this week, Democrats offered amendments to replace the Republican plans for deficit reduction in 2013 and beyond with a balanced approach that includes both spending cuts and revenues. Democrats offered an amendment that would have replaced both the reconciliation cuts and the entire multi-year sequester with at least $1.2 trillion of deficit reduc-

tion through a balanced approach. The deficit reduction would come through legislation that increases revenues without increasing the tax burden on middle-income Americans, that decreases spending while maintaining the Medicare guarantee and protecting Social Security and the social safety net for vulnerable Americans, and that promotes economic growth and jobs. In addition, Democrats offered a targeted amendment to replace the remaining 2013 sequester of Medicare with greater deficit reduction from ending a tax break for the "Big 5" oil and gas companies. Republicans defeated both of these amendments on party-line votes.

PART I OF MARK-UP: SEQUESTER REPLACEMENT RECONCILIATION ACT OF 2012

The Republican reconciliation package includes many cuts to vital services that will affect Americans in many harmful ways. Budget Committee Democrats offered motions to achieve similar savings by cutting tax breaks and subsidies to special interests.

• **Rejecting the elimination of the Social Services Block Grant while ending taxpayer subsidies to "Big Oil."** The Social Services Block Grant gives states and localities the flexibility to target funding for essential services. Overall, it helps 23 million children, seniors, and disabled Americans become self-sufficient and economically independent. It provides states with flexible funds that support a range of services, such as providing Meals on Wheels, preventing child abuse and neglect for at-risk children, and helping low-income parents return to work by providing child care and related assistance. During the Budget Committee reconciliation mark-up this week, Democrats offered a motion to preserve the Social Services Block Grant and to replace cuts with even greater savings from repealing tax breaks for the "Big 5" oil companies. This motion was defeated on a party-line vote.

• **Protecting food and nutrition support for struggling children and families while cutting taxpayer direct payments to agricultural Interests.** The Republican proposal cuts the Supplemental Nutrition Assistance Program (SNAP), which helps struggling households purchase adequate food and nutrition. The legislation reduces assistance to every single household receiving SNAP benefits almost immediately and cuts 1.8 million people off of food assistance entirely. In addition, nearly 300,000 children will lose free school meals, on top of losing the benefits that provide food at home. During the Budget Committee reconciliation mark-up this week, Democrats offered a motion to preserve the food and nutrition assistance, and instead reduce the deficit through reform of agricultural commodity payments and risk management programs. This motion was defeated on a party-line vote.

• **Protecting health care coverage for at least 300,000 low-income children and lowering the deficit by eliminating certain tax subsidies for Big Oil.** The Republican proposal allows states to cut their support for Medicaid and the Children's Health Insurance Program (CHIP) by covering fewer people, and repeals bonuses to states for enrolling additional low-income children in the program. The first provision will result in a sharp increase in the number of uninsured Americans—100,000 children and adults in 2013 and at least 300,000 children in 2015, according to CBO.

The second provision eliminates incentives for states to increase their enrollment of children, also likely increasing the number of uninsured children. Further, the legislation eliminates funding for state insurance exchanges that will take effect in 2014 to help uninsured people find affordable coverage. States will either have to raise their own funds for these exchanges or rely on the federal government to run their exchange. During the Budget Committee reconciliation mark-up this week, Democrats offered a motion to preserve the Medicaid and CHIP payments, and to replace the proposed deficit reduction with savings from ending a wasteful tax break that encourages the "Big 5" oil and gas companies to produce oil in foreign countries rather than here at home. This motion was defeated on a party-line vote.

• **Protecting the health of women and children through the Prevention and Public Health Fund while closing tax loopholes that reward corporations that ship American jobs overseas.** The Republican proposal repeals the Prevention and Public Health Fund. The ACA appropriated funding to support such programs as cancer screenings, immunizations, research on prevention, and education and outreach. The goal of the fund is to provide an expanded and sustained investment in these programs to improve overall health and help restrain the rate of growth in private- and public-sector health care costs. Some of the funding to be cut is allocated for women's health, including breast cancer and cervical cancer screening. During the Budget Committee mark-up, Democrats offered a motion to reject the Republican recommendation, and instead close loopholes in the U.S. international corporate tax system that encourage companies to ship jobs overseas. This motion was defeated on a party-line vote.

ANALYSIS OF REPUBLICAN COMMITTEE PROPOSALS INCLUDED IN RECONCILIATION

AGRICULTURE COMMITTEE RECONCILIATION RECOMMENDATIONS

The Agriculture Committee recommended reconciliation legislation cutting *$36 billion* from SNAP (formerly known as Food Stamps). The Committee chose to target all its cuts to food and nutrition assistance to low-income Americans, largely families with children, the disabled, and elderly, rather than look for savings from any other programs supporting the agriculture sector. All together, the recommendations make changes to the SNAP program that will reduce benefits to all 47 million people currently receiving SNAP and entirely eliminate benefits to almost 2 million people. The Republican plan makes the following cuts:

• **Almost immediately sunsets the Recovery Act SNAP enhancement.** The enhancement is currently due to end on October 31, 2013. This enhancement has been shortened twice already, most recently to provide an offset for the Child Nutrition Reauthorization Act in 2010. This saves *$6.0 billion* under the directed scoring ordered by the Committee (see below for more details), and *$4.4 billion* without it.

• **Makes it more difficult to apply for and receive SNAP benefits.** The bill limits categorical eligibility—a process that allows households who qualify for certain programs to automatically

be eligible for SNAP—to those receiving cash assistance from Temporary Assistance for Needy Families, Supplemental Security Income, or a state general assistance program. This change not only stops households from receiving SNAP benefits, it removes nearly 300,000 children from the child nutrition program. The bill also eliminates the state option to apply a Standard Utility Allowance in determining SNAP benefits for anyone receiving LIHEAP benefits. Together these provisions reduce SNAP by *$25 billion* while taking an additional *$0.5 billion* from child nutrition.

• **Eliminates federal match for SNAP's employment and training program.** Republicans say that this is one of many job training programs funded by the federal government and is duplicative. However, many job programs are oversubscribed and this one is geared to a very vulnerable population. Total savings over the 11 years are *$3.1 billion*.

• **Ends the state bonus program.** The program provides additional funds to states that meet certain administrative targets. Elimination saves *$0.5 billion.*

• **Removes automatic indexing from SNAP's nutrition education and obesity prevention program.** Over time, this change gradually reduces the program's purchasing power. This saves *$0.5 billion* over 11 years.

ENERGY AND COMMERCE COMMITTEE RECONCILIATION RECOMMENDATIONS

The Energy and Commerce Committee reported reconciliation legislation that cuts $115 billion from health expenditures. All of the cuts come from repeal of certain provisions of the Affordable Care Act (ACA), cuts to Medicaid, and medical malpractice reform, over which it shares jurisdiction with the Judiciary Committee.

Title I—Repeals and defunds parts of the ACA

The recommendation impedes implementation of the ACA that is already benefitting millions of Americans. Overall, the changes cut *$26.3 billion* over the next decade.

• **Repeals the Prevention and Public Health Fund.** Repealing this fund and rescinding unobligated funding reduces spending on prevention and public health by *$11.9 billion.* The ACA appropriated a total of $5 billion for 2010 through 2014 and $2 billion for each subsequent year to support such programs as cancer screenings, immunizations, research on prevention, and education and outreach. The goal of the fund is to provide an expanded and sustained investment in these programs to improve overall health and help restrain the rate of growth in private- and public-sector health care costs. Some of the funding to be cut is allocated for women's health, including breast cancer and cervical cancer screening. The Middle Class Tax Relief and Job Creation Act of 2012 (the first payroll tax cut extension bill) already reduced funding for this fund by $5.0 billion.

• **Repeals funding for state health insurance exchanges.** The proposal strikes the mandatory funding for state exchanges and rescinds unobligated funds, cutting *$13.5 billion.* Starting in 2014, these exchanges will allow individuals and small businesses to compare health plans, determine if they are eligible for tax cred-

its for private insurance or health programs like the CHIP, and enroll in a health plan that meets their needs. As a result of this proposal, states will either have to raise their own funds to pay for setting up an exchange or rely on the federal government to run their exchange.

• **Defunds the Consumer Operated and Oriented Plan (CO-OP) program.** The proposal reduces spending by *$0.9 billion* by rescinding all unobligated funds for the CO-OP program, which provides subsidized loans to qualified non-profit health insurance plans.

Title II—Cuts Medicaid and CHIP

The recommendation cuts Medicaid spending and reduces the deficit by *$22.7 billion* over the next decade, harming hundreds of thousands of low-income Americans, including at least 300,000 children.

• **Repeals states' Medicaid and CHIP Maintenance of Effort (MOE) requirements.** The ACA requires states to maintain their current Medicaid eligibility standards until 2014 (and CHIP eligibility standards until 2019), when nationwide Medicaid eligibility standards take effect and state-based health insurance exchanges will begin operating. Repealing the MOE provision would increase the number of Americans who are uninsured, as states scale back eligibility for low-income children, parents, seniors, and people with serious disabilities. CBO estimates that the provision will increase the number of uninsured children and adults by 100,000 in 2013 and increase the number of uninsured children by at least 300,000 in 2015. Repealing the MOE reduces the deficit by *$0.6 billion*.

• **Repeals CHIP performance bonus payments for states that provide more low-income children with health care coverage.** The bonus payments, currently slated to end in 2013, help states with the additional coverage-related costs in Medicaid as well as CHIP; the more children a state enrolls above the target, the larger the federal bonus payment. Eliminating the bonuses reduces spending by *$0.4 billion*.

• **Rebases the Disproportionate Share Hospital (DSH) allotment for uncompensated care** to maintain the 2021 level of reductions for an additional year, which reduces spending by *$4.2 billion*. Current law includes annual aggregate DSH allotment reductions for 2014 through 2021, to reflect the expected reduction in uncompensated care that will result from the ACA.

• **Repeals increased federal Medicaid funding cap and match for territories.** The proposal replaces the ACA's increased Medicaid federal match and cap for the territories with the levels in place prior to the ACA, reducing spending by *$6.3 billio*n, or 64 percent.

• **Reduces the state provider tax threshold to 5.5 percent,** down from the current threshold of no higher than 6.0 percent of the net patient service revenues. States can use these revenues from health care provider taxes to help finance the state share of Medicaid expenditures. This proposal reduces spending by *$11.3 billion*.

Title III—Medical Malpractice

Jurisdiction over medical malpractice is shared by the Energy and Commerce and the Judiciary Committees. The medical malpractice proposal approved by Energy and Commerce differs in a few respects from the version approved by Judiciary. The Energy and Commerce version generates *$66.5 billion* in on-budget savings over ten years ($56 billion in reduced spending and $10.5 billion in increased revenues). The Judiciary version saves about $18 billion less. The Energy and Commerce version saves more because it includes a provision to allow evidence of income from collateral sources (such as life insurance payouts and health insurance) at trial. Like the Judiciary bill, it caps non-economic damages at $250,000, imposes a strict statute of limitations on filing lawsuits, places restrictions on punitive damages, replaces joint-and-several liability with a "fair-share" rule, provides a safe harbor from punitive damages for products that meet FDA applicable safety requirements, limits contingency fee payments, and applies the legislation's provisions beyond medical malpractice to "any health care liability claim." Both the Judiciary and Energy and Commerce bills override applicable state laws in all 50 states.

WAYS AND MEANS COMMITTEE RECONCILIATION RECOMMENDATIONS

The Ways and Means Committee recommended reconciliation changes that save $68 billion. Instead of cutting tax loopholes that encourage the outsourcing of jobs overseas, eliminating egregious tax breaks, or eliminating additional tax breaks for millionaires, the Committee chose instead to raise taxes on families with children, eliminate valuable social services that help to support child protection services and home-based services, including Meals on Wheels, and make it harder to purchase health insurance for those returning to work. Ways and means Democrats attempted to offer the Buffett Rule as a substitute for the cuts, but were ruled out of order. The Republican proposal makes the following changes:

• **Eliminates the Social Services Block Grant**, which gives states and localities the flexibility to target funding for essential services. Overall, the Block Grant helps 23 million children, seniors, and disabled Americans become self-sufficient and economically independent through services funded in whole, or in part, by the program. It provides home-based services, such as Meals on Wheels, for 1.7 million seniors. It helps prevent child abuse and neglect, providing child protective services for 1.8 million at-risk children. It supports low-income parents returning to work by providing child care and related assistance for 4.4 million children. It also provides services for nearly 1 million disabled individuals, including respite care and transportation. Ending the program saves *$16.7 billion*.

• **Attacks the ACA so another 350,000 Americans go without health care coverage.** Under the ACA, Americans whose incomes are low but who are ineligible for Medicaid and do not have employer-sponsored coverage can receive a subsidy to help them afford private coverage. For them to receive real-time assistance, the tax credit is paid in advance (and directly to the insurer) based on prior-year income. However, if their incomes increase later in the

year, they are responsible for repaying some or all of this subsidy through a process called "true up." The ACA sensibly limits true-up payments to encourage participation and avoid penalizing individuals and families whose circumstances change mid-year. Congress already raised the true-up limit twice. The Republican proposal requires these families to repay everything even if they got the subsidy they were eligible for at the time, saving *$43.9 billion.* The Joint Committee on Taxation estimates that, as a result, 350,000 people will forgo purchasing health insurance—mostly healthier people who are willing to take the risk. That will leave these families at risk and drive up premiums for the remaining less-healthy people purchasing health coverage through insurance exchanges.

• **Denies refundable child tax credit to taxpayers filing with Individual Taxpayer Identification Numbers (ITINs).** This provision requires a taxpayer to include his or her Social Security number on tax returns to claim the refundable child tax credit, saving $7.6 billion. This measure ends refundable child tax credits for more than 3 million children in 2013 alone in families with an average income of about $20,000.

FINANCIAL SERVICES COMMITTEE RECONCILIATION RECOMMENDATIONS

The Financial Services Committee recommended cuts that save $31.1 billion, assuming a July 1 enactment date, as the Republicans requested (in its score, CBO noted that the proposal would also increase the net income to the National Flood Insurance Program by $4.9 billion). The reconciliation instruction called for a total of $29.8 billion in net savings. Each of the five components to the Committee's proposal is controversial or raises scoring issues.

• **'Repeals regulators' authority to shut down a failing large financial firm when that failure would threaten the financial stability of the U.S.** This proposal relies on a budget gimmick to generate savings. The Dodd-Frank legislation designed this authority to pay for itself over time, with any initial up-front costs being recouped by selling assets and imposing an assessment, after the resolution, on financial institutions with more than $50 billion in assets. Thus, some of the offsetting recoveries are estimated to come outside the scoring window. Repealing the authority entirely eliminates the appearance of costs in the ten-year window, and therefore shows savings of *$22.6 billion.* But repealing the authority will prevent regulators from managing the orderly wind down of a failing firm—that inability could result in the disorderly collapse of large financial institutions—making future bailouts more likely and making it more likely that taxpayers will again be stuck with the bill.

• **Eliminates the Home Affordable Modification Program (HAMP).** Dismantling HAMP eliminates virtually the only federal assistance that helps homeowners who are struggling with foreclosure and need loan modifications. Its elimination saves $2.8 billion.

• **Jeopardizes consumers' rights and protections by eliminating direct spending for the new Consumer Financial Pro-**

tection Bureau (CFPB) and making it subject to appropriations, thereby further violating the discretionary spending caps in the BCA. This latest attack on the CFPB will likely lessen consumer protection while adding to the pressure of keeping to a low discretionary spending cap. The proposal scores *$5.4 billion* in savings from eliminating direct spending for the CFPB, and makes the CFPB the only banking regulator to be subject to appropriations. If the Budget Committee Chairman exercises his authority to modify the discretionary caps to reflect the shift of the CFPB spending from the mandatory to the discretionary category, then there are no savings. If he does not adjust the discretionary cap, then he is effectively further lowering the discretionary cap by requiring more items to be funded under the same limit. Republicans may use that argument to further their efforts to slash spending for the CFPB.

• **Elimination of the Office of Financial Research.** This office supports the Financial Stability Oversight Council by collecting information on financial markets and conducting research on financial stability issues. It is authorized to collect fees from financial institutions with more than $50 billion in assets to offset its expenses. Eliminating the office saves slightly over *$250 million.* Because the office's fees also support the activities of the Financial Stability Oversight Council, new appropriations of about $10 million per year will be necessary to fund those activities, putting more pressure on the discretionary spending cap.

• **Reforms the flood insurance program.** The estimate of *$4.9 billion* in savings relies on the provision in the budget resolution directing CBO to treat the change in the program's net income as if it were deposited in the General Fund. The provisions are the same as those in H.R. 1309, which passed the House in July 2011.

JUDICIARY COMMITTEE RECONCILIATION RECOMMENDATIONS

The Judiciary Committee recommended medical malpractice legislation that is substantively identical to the medical malpractice provisions in H.R. 5 that the House passed in March. CBO scores this legislation as saving a net total of *$48.6 billion*, for total deficit reduction that exceeds the Committee's instruction to find $39.7 billion in savings. The legislation caps noneconomic damages at $250,000 and makes it more difficult to recover punitive damages, replaces joint and several liability for losses with a "fair share" rule, imposes a strict statute of limitations for filing lawsuits, provides a safe harbor from punitive damages for products that meet FDA applicable safety requirements, and puts limits on contingency fee payments. The provisions of the bill apply to not only medical malpractice, but also to any "health care liability claims"—providing new protections for insurance companies, drug and device manufacturers, and nursing homes. Like the Energy and Commerce proposal on medical malpractice, the Judiciary legislation also overrides applicable state laws in all 50 states.

OVERSIGHT AND GOVERNMENT REFORM COMMITTEE RECONCILIATION RECOMMENDATIONS

The Committee on Oversight and Government Reform passed on a party-line vote reconciliation recommendations that generate *$83 billion* by requiring all federal employees, including postal workers,

to pay more for their retirement benefits. Consequently, each federal employee will, in effect, have their pay cut an average of more than $30,000 over the next ten years. These new cuts to federal employee pay come on top of $60 billion in cuts resulting from the two-year pay freeze and $15 billion in cuts resulting from increasing retirement contributions on new federal employees enacted in H.R. 3630, the Middle Class Tax Relief Act of 2012. Under the bill, most existing employees under the Civil Service Retirement System (CSRS) and the Federal Employee Retirement System (FERS) will face a 5 percentage point increase in their retirement contributions, which will be phased in over five years. The increase for new FERS employees is smaller—2.7 percentage points—because their contributions were already increased by 2.3 percentage points as part of the Middle Class Tax Relief Act of 2012, which will go into full effect starting 2013. (The table below shows all changes in employee contributions.)

Beneficiary	Contribution rate		
	Current (%)	Proposed increase (%)	Proposed final (%)
Existing:			
Federal Employees (CSRS)	7	5	12
Federal LEO Employees (CSRS)	7.5	5	12.5
Members of Congress (CSRS)	8	8.5	16.5
Congressional Staff (CSRS)	7.5	7.5	15
Federal Employees (FERS)	0.8	5	5.8
Federal LEO Employees (FERS)	1.3	5	6.3
Members of Congress (FERS)	1.3	8.5	9.8
Congressional Staff (FERS)	1.3	7.5	8.8
Newly Hired:			
Federal Employees (FERS+)	3.1	2.7	5.8
Federal LEO Employees (FERS+)	3.6	2.7	6.3
Newly Elected Members (FERS+)	3.1	2.7	5.8
Congressional Staff (FERS+)	3.1	2.7	5.8

The proposal requires larger contributions from the paychecks of current legislative employees than from other federal employees. Current Members of Congress will have to pay an additional 8.5 percent of their salaries for their retirement benefit and current Congressional staff will have to pay an additional 7.5 percent, increases that are also phased in over five years. After full phase-in of the increases, most FERS employees will pay 5.8 percent (6.3 percent if a law enforcement employee) of their salaries toward their retirement benefit, up from 0.8 percent (1.3 percent if law enforcement) they pay this year. Current Members of Congress will pay 9.8 percent and congressional staff will pay 8.8 percent, up from 1.3 percent.

The bill also eliminates the FERS annuity supplement for new employees, except those subject to mandatory retirement, starting in 2013. However, any significant savings resulting from this provision will not be realized until beyond the 10-year budget window.

PART II OF MARK-UP: SEQUESTER REPLACEMENT ACT OF 2012

In the second part of the reconciliation mark-up, the Budget Committee marked up H.R. 4966, Chairman Ryan's Sequester Replacement Act of 2012. When that legislation is combined with the

reconciliation cuts considered during the first part of the mark-up, it fulfills the Majority's plan to repeal and replace the sequester scheduled for 2013 under the BCA, as envisioned by the Republican budget resolution. The Majority's complete reconciliation package makes no changes to the BCA that affect the discretionary requirements for 2014 and beyond. As a result, the sequester of funding for both defense and non-defense remains in place for those years.

Instead of the BCA's roughly $100 billion across-the-board sequester of spending for 2013—50 percent from defense and 50 percent from non-defense programs—H.R. 4966 cancels the entire defense sequester and the sequester of non-defense discretionary spending under existing law. However, certain non-defense mandatory programs—including Medicare—will still be subject to sequester for 2013. In addition, it establishes a temporary discretionary cap of $1.047 trillion for 2013—the level set by the BCA—without any firewall between defense and non-defense spending. Effective in January 2013, the bill reduces that cap by $19 billion, limiting regular discretionary spending to $1.028 trillion. Any discretionary spending above that level would trigger a sequester.

REPUBLICAN APPROACH TO REPLACING THE SEQUESTER IS UNFAIR AND UNBALANCED

The Majority's legislation is another example of their refusal to take a fair and balanced approach to reducing the deficit. Every bipartisan commission has recommended and the majority of Americans agree that we should take a balanced, bipartisan approach to reducing the deficit that both increases revenue and decreases spending. However, 98 percent of the Majority's Representatives have signed a pledge that they will not reduce the deficit by a single penny by cutting tax breaks for the wealthy.

Instead, the Republican budget resolution and this reconciliation mark-up took a lopsided approach to replacing the sequester and reducing the deficit that shreds the social safety net for vulnerable Americans, and that fails to protect Medicare from sequester for even one year. Rather than asking big corporations and wealthy special interests to give up tax breaks they do not need, the Majority passed a plan that asks hundreds of thousands of low-income children, women, seniors, and other Americans to give up vital assistance that helps them make it from day to day.

Two particularly egregious examples of their misguided choices are basic nutrition assistance and health care coverage. Although the Deficit Control Act of 1985 protects nutrition assistance and health care coverage for lower-income children and their families from sequester, the Republican reconciliation package that replaces the sequester for just one year specifically cuts funding for this important safety net assistance. Furthermore, the Majority made these harmful choices while protecting subsidies for agricultural businesses, big oil companies, and tax breaks for the wealthiest Americans. The Republican approach is not the fair and balanced approach to deficit reduction that most Americans want.

DEMOCRATIC AMENDMENTS WOULD HAVE MADE THE RIGHT CHOICES FOR AMERICAN FAMILIES AND REPLACED THE SEQUESTER FOR ALL 10 YEARS

During the Budget Committee's mark-up of H.R. 4966, Democrats offered two amendments to change the Majority's legislation so that it makes the right choices for American families by taking a fair and balanced approach to reducing the deficit. Democrats offered an amendment that would have replaced the sequester for the entire 10-year period called for under the BCA—not just one year, as the Republican plan does. The amendment would have replaced the sequester with balanced legislation that (1) cuts spending while maintaining the Medicare guarantee and protecting Social Security and a strong social safety net; (2) increases revenues without increasing the tax burden on middle-income Americans; and (3) grows jobs and the economy by, among other things, making strategic investments in education, science, research, and critical infrastructure necessary to compete in the global economy. This amendment was defeated on a party-line vote.

Democrats also offered an amendment to exempt Medicare from the 2013 sequester. This amendment would have prevented across-the-board payment cuts to doctors, hospitals, nursing homes, home health aides, and others that provide critical care to Medicare beneficiaries. The Democratic amendment would have paid for protecting Medicare from sequester by eliminating a wasteful tax break for big oil and gas companies. This amendment was defeated on a party-line vote.

DEMOCRATIC MOTIONS AND AMENDMENTS OFFERED IN BUDGET COMMITTEE MARK-UP

- **Motion #1: Protecting Health Care Coverage for At Least 300,000 Low-Income Children and Lowering the Deficit by Eliminating Certain Tax Subsidies for Big Oil**

A motion by Rep. Castor that the Committee on the Budget direct its Chairman to request on behalf of the Committee that the rule for consideration of the Sequester Replacement Reconciliation Act of 2012 make in order an amendment that would strike from Title II of the bill section 213, which repeals the maintenance of effort requirements for children in the Children's Health Insurance Program (CHIP) and children and adults in Medicaid; and section 215, which repeals CHIP performance bonus payments; and replaces them with a provision that increases revenue by eliminating a wasteful tax break that encourages big oil companies to produce oil in foreign countries rather than here at home.

- **Motion #2: Protecting the Health of Women and Children While Closing Tax Loopholes That Reward Corporations That Ship American Jobs Overseas**

A motion by Rep. Schwartz and Rep. Wasserman Schultz that the Committee on the Budget direct its Chairman to request on behalf of the Committee that the rule for consideration of the Sequester Replacement Reconciliation Act of 2012 make in order an amendment that would strike from Title II of the bill section 202, which repeals the Prevention and Public Health Fund under the

Affordable Care Act, and replace that section with changes in law to reduce the deficit by closing loopholes in the U.S. international corporate tax system that encourage companies to ship jobs overseas.

• **Motion #3: Rejecting the Elimination of the Social Services Block Grant While Ending Taxpayer Subsidies to Big Oil**

A motion by Rep. Doggett and Rep. Bonamici that the Committee on the Budget direct its Chairman to request on behalf of the Committee that the rule for consideration of the Sequester Replacement Reconciliation Act of 2012 make in order an amendment that strikes Subtitle C of Title VI—the elimination of the Social Services Block Grant—of the bill, and replaces that section with changes in law that reduce the deficit by repealing the tax subsidies for the "Big 5" major integrated oil companies.

Motion #4: Protect Food and Nutrition Support for Struggling Children and Families While Cutting Taxpayer Direct Payments to Agricultural Interests

A motion by Rep. Blumenauer and Rep. Yarmuth that the Committee on the Budget direct its Chairman to request on behalf of the Committee that the rule for consideration of the Sequester Replacement Reconciliation Act of 2012 make in order an amendment that (1) would strike Title 1, which reduces spending in the Supplemental Nutrition Assistance Program, and (2) replaces it with changes in law to reduce the deficit by reforming agricultural commodity and crop insurance programs.

Amendment #1: Taking a Fair and Balanced Approach To Reducing the Deficit and Replacing the Sequester

An amendment by Rep. Van HoIlen that replaces the sequester for the entire 10-year period called for under the Budget Control Act with balanced, bipartisan legislation that:

- increases revenues without increasing the tax burden on middle-income Americans,
- decreases spending while maintaining the Medicare guarantee and protecting Social Security and the social safety net for vulnerable Americans, and
- promotes economic growth and jobs.

Amendment #2: Prevent Cuts to Medicare

An amendment by Rep. McCollum and Rep. Tim Ryan (OH) that exempts Medicare from the 2013 sequester, preventing across-the-board payment cuts to doctors, hospitals, nursing homes, home health aides, and others that provide critical care to Medicare beneficiaries. The amendment pays for protecting Medicare from sequester by eliminating wasteful tax breaks for big oil and gas companies.

CHRIS VAN HOLLEN.
TIM RYAN.
MIKE HONDA.
DEBBIE WASSERMAN SCHULTZ.
KAREN BASS.
BILL PASCRELL, Jr.
MARCY KAPTUR.
LLOYD DOGGETT.
ALLYSON SCHWARTZ.
EARL BLUMENAUER.
BETTY MCCOLLUM.
KATHY CASTOR.
SUZANNE BONAMICI.
GWEN MOORE.
JOHN YARMUTH.
HEATH SHULER.

H. R. 5652

To provide for reconciliation pursuant to section 201 of the concurrent resolution on the budget for fiscal year 2013.

IN THE HOUSE OF REPRESENTATIVES

MAY 9, 2012

Mr. RYAN of Wisconsin from the Committee on the Budget, reported the following bill; which was committed to the Committee of the Whole House on the State of the Union and ordered to be printed

A BILL To provide for reconciliation pursuant to section 201 of the concurrent resolution on the budget for fiscal year 2013.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Sequester Replacement Reconciliation Act of 2012".

SEC. 2. TABLE OF CONTENTS.

The table of contents is as follows:

Sec. 1. Short title.
Sec. 2. Table of contents.

TITLE I—AGRICULTURE

Sec. 101. Short title.
Sec. 102. ARRA sunset at June 30, 2012.
Sec. 103. Categorical eligibility limited to cash assistance.
Sec. 104. Standard utility allowances based on the receipt of energy assistance payments.
Sec. 105. Employment and training; workfare.
Sec. 106. End State bonus program for the supplemental nutrition assistance program.
Sec. 107. Funding of employment and training programs.
Sec. 108. Turn off indexing for nutrition education and obesity prevention.
Sec. 109. Extension of Authorization of Food and Nutrition Act of 2008.
Sec. 110. Effective dates and application of amendments.

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.
Sec. 202. Repealing Prevention and Public Health Fund.
Sec. 203. Rescinding unobligated balances for CO-OP program.

Subtitle B—Medicaid

Sec. 211. Revision of provider tax indirect guarantee threshold.
Sec. 212. Rebasing of State DSH allotments for fiscal year 2022.

Sec. 213. Repeal of Medicaid and CHIP maintenance of effort requirements under PPACA.
Sec. 214. Medicaid payments to territories.
Sec. 215. Repealing bonus payments for enrollment under Medicaid and CHIP.

Subtitle C—Liability Reform

Sec. 221. Findings and purpose.
Sec. 222. Encouraging speedy resolution of claims.
Sec. 223. Compensating patient injury.
Sec. 224. Maximizing patient recovery.
Sec. 225. Additional HEALTH benefits.
Sec. 226. Punitive damages.
Sec. 227. Authorization of payment of future damages to claimants in HEALTH care lawsuits.
Sec. 228. Definitions.
Sec. 229. Effect on other laws.
Sec. 230. State flexibility and protection of States' rights.
Sec. 231. Applicability; effective date.

TITLE III—FINANCIAL SERVICES

Sec. 301. Table of contents.

Subtitle A—Orderly Liquidation Fund

Sec. 311. Repeal of liquidation authority.

Subtitle B—Home Affordable Modification Program

Sec. 321. Short title.
Sec. 322. Congressional findings.
Sec. 323. Termination of authority.
Sec. 324. Sense of Congress.

Subtitle C—Bureau of Consumer Financial Protection

Sec. 331. Bringing the Bureau of Consumer Financial Protection into the regular appropriations process.

Subtitle D—Flood Insurance Reform

Sec. 341. Short title.
Sec. 342. Extensions.
Sec. 343. Mandatory purchase.
Sec. 344. Reforms of coverage terms.
Sec. 345. Reforms of premium rates.
Sec. 346. Technical Mapping Advisory Council.
Sec. 347. FEMA incorporation of new mapping protocols.
Sec. 348. Treatment of levees.
Sec. 349. Privatization initiatives.
Sec. 350. FEMA annual report on insurance program.
Sec. 351. Mitigation assistance.
Sec. 352. Notification to homeowners regarding mandatory purchase requirement applicability and rate phase-ins.
Sec. 353. Notification to members of congress of flood map revisions and updates.
Sec. 354. Notification and appeal of map changes; notification to communities of establishment of flood elevations.
Sec. 355. Notification to tenants of availability of contents insurance.
Sec. 356. Notification to policy holders regarding direct management of policy by FEMA.
Sec. 357. Notice of availability of flood insurance and escrow in RESPA good faith estimate.
Sec. 358. Reimbursement for costs incurred by homeowners and communities obtaining letters of map amendment or revision.
Sec. 359. Enhanced communication with certain communities during map updating process.
Sec. 360. Notification to residents newly included in flood hazard areas.
Sec. 361. Treatment of swimming pool enclosures outside of hurricane season.
Sec. 362. Information regarding multiple perils claims.
Sec. 363. FEMA authority to reject transfer of policies.
Sec. 364. Appeals.

Sec. 365. Reserve fund.
Sec. 366. CDBG eligibility for flood insurance outreach activities and community building code administration grants.
Sec. 367. Technical corrections.
Sec. 368. Requiring competition for national flood insurance program policies.
Sec. 369. Studies of voluntary community-based flood insurance options.
Sec. 370. Report on inclusion of building codes in floodplain management criteria.
Sec. 371. Study on graduated risk.
Sec. 372. Report on flood-in-progress determination.
Sec. 373. Study on repaying flood insurance debt.
Sec. 374. No cause of action.
Sec. 375. Authority for the corps of engineers to provide specialized or technical services.

Subtitle E—Repeal of the Office of Financial Research

Sec. 381. Repeal of the Office of Financial Research.

TITLE IV—COMMITTEE ON THE JUDICIARY

Sec. 401. Short title.
Sec. 402. Encouraging speedy resolution of claims.
Sec. 403. Compensating patient injury.
Sec. 404. Maximizing patient recovery.
Sec. 405. Punitive damages.
Sec. 406. Authorization of payment of future damages to claimants in health care lawsuits.
Sec. 407. Definitions.
Sec. 408. Effect on other laws.
Sec. 409. State flexibility and protection of States' rights.
Sec. 410. Applicability; effective date.

TITLE V—COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

Sec. 501. Retirement contributions.
Sec. 502. Annuity supplement.
Sec. 503. Contributions to Thrift Savings Fund of payments for accrued or accumulated leave.

TITLE VI—COMMITTEE ON WAYS AND MEANS

Subtitle A—Recapture of Overpayments Resulting From Certain Federally-subsidized Health Insurance

Sec. 601. Recapture of overpayments resulting from certain federally-subsidized health insurance.

Subtitle B—Social Security Number Required to Claim the Refundable Portion of the Child Tax Credit

Sec. 611. Social security number required to claim the refundable portion of the child tax credit.

Subtitle C—Human Resources Provisions

Sec. 621. Repeal of the program of block grants to States for social services.

TITLE I—AGRICULTURE

SEC. 101. SHORT TITLE.

This title may be cited as the "Agricultural Reconciliation Act of 2012".

SEC. 102. ARRA SUNSET AT JUNE 30, 2012.

Section 101(a)(2) of division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat. 120) is amended by striking "October 31, 2013" and inserting "June 30, 2012".

SEC. 103. CATEGORICAL ELIGIBILITY LIMITED TO CASH ASSISTANCE.

Section 5 of the Food and Nutrition Act of 2008 (7 U.S.C. 2014) is amended—

(1) in the 2d sentence of subsection (a) by striking "households in which each member receives benefits" and inserting "households in which each member receives cash assistance", and

(2) in subsection (j) by striking "or who receives benefits under a State program" and inserting "or who receives cash assistance under a State program".

SEC. 104. STANDARD UTILITY ALLOWANCES BASED ON THE RECEIPT OF ENERGY ASSISTANCE PAYMENTS.

(a) STANDARD UTILITY ALLOWANCE.—Section 5 of the Food and Nutrition Act of 2008 (7 U.S.C. 2014) is amended—

(1) in subsection (e)(6)(C) by striking clause (iv), and

(2) in subsection (k) by striking paragraph (4) and inserting the following:

"(4) THIRD PARTY ENERGY ASSISTANCE PAYMENTS.—For purposes of subsection (d)(1), a payment made under a State law (other than a law referred to in paragraph (2)(G)) to provide energy assistance to a household shall be considered money payable directly to the household.".

(b) CONFORMING AMENDMENTS.—Section 2605(f)(2) of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8624(f)(2)) is amended—

(1) by striking "and for purposes of determining any excess shelter expense deduction under section 5(e) of the Food and Nutrition Act of 2008 (7 U.S.C. 2014(e))", and

(2) in subparagraph (A) by inserting before the semicolon the following: ", except that such payments or allowances shall not be deemed to be expended for purposes of determining any excess shelter expense deduction under section 5(e)(6) of the Food and Nutrition Act of 2008 (7 U.S.C. 2014(e)(6))".

SEC. 105. EMPLOYMENT AND TRAINING; WORKFARE.

(a) ADMINISTRATIVE COST-SHARING FOR EMPLOYMENT AND TRAINING PROGRAMS.—

(1) IN GENERAL.—Section 16 of the Food and Nutrition Act of 2008 (7 U.S.C. 2025) is amended—

(A) in subsection (a) by inserting "(other than a program carried out under section 6(d)(4) or section 20)" after "supplemental nutrition assistance program" the 1st place it appears, and

(B) in subsection (h)—

(i) by striking paragraphs (2) and (3), and

(ii) by redesignating paragraphs (4) and (5) as paragraphs (2) and (3), respectively.

(2) CONFORMING AMENDMENTS.—

(A) Section 17(b)(1)(B)(iv)(III)(hh) of the Food and Nutrition Act of 2008 (7 U.S.C. 2026(b)(1)(B)(iv)(III)(hh)) is amended by striking "(g), (h)(2), or (h)(3)" and inserting "or (g)".

(B) Section 22(d)(1)(B)(ii) of the Food and Nutrition Act of 2008 (7 U.S.C. 2031(d)(1)(B)(ii)) is amended is

amended by striking ", (g), (h)(2), and (h)(3)" and inserting "and (g)".

(b) ADMINISTRATIVE COST-SHARING AND REIMBURSEMENTS FOR WORKFARE.—Section 20 of the Food and Nutrition Act of 2008 (7 U.S.C. 2029) is amended by striking subsection (g).

SEC. 106. END STATE BONUS PROGRAM FOR THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.

Section 16 of the Food and Nutrition Act of 2008 (7 U.S.C. 2025) is amended by striking subsection (d).

SEC. 107. FUNDING OF EMPLOYMENT AND TRAINING PROGRAMS.

For purposes of fiscal year 2013, the reference to $90,000,000 in section 16(h)(1)(A) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(h)(1)(A)) shall be deemed to be a reference to $79,000,000.

SEC. 108. TURN OFF INDEXING FOR NUTRITION EDUCATION AND OBESITY PREVENTION.

Section 28(d) of the Food and Nutrition Act of 2008 (7 U.S.C. 2037(d)) is amended by striking "years—" and all that follows through the period at the end, and inserting "years, $375,000,000.".

SEC. 109. EXTENSION OF AUTHORIZATION OF FOOD AND NUTRITION ACT OF 2008.

Section 18(a)(1) of the Food and Nutrition Act of 2008 (7 U.S.C. 2027(a)(1)) is amended by striking "2012" and inserting "2013".

SEC. 110. EFFECTIVE DATES AND APPLICATION OF AMENDMENTS.

(a) GENERAL EFFECTIVE DATE.—Except as provided in subsection (b), this title and the amendments made by this title shall take effect on October 1, 2012, and shall apply only with respect to certification periods that begin on or after such date.

(b) SPECIAL EFFECTIVE DATE.—Section 107 and the amendments made by sections 102, 103, 104, and 109 shall take effect on the date of the enactment of this Act and shall apply only with respect to certification periods that begin on or after such date.

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 activi-

ties 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 applicable 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 maintaining 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 noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term "contingent fee" includes all compensation to any person or persons which is payable

only if a recovery is effected on behalf of one or more claimants.

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

(7) HEALTH CARE 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)), respectively, 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.

TITLE III—FINANCIAL SERVICES

SEC. 301. TABLE OF CONTENTS.

The table of contents for this title is as follows:

TITLE III—FINANCIAL SERVICES

Sec. 301. Table of contents.

Subtitle A—Orderly Liquidation Fund

Sec. 311. Repeal of liquidation authority.

Subtitle B—Home Affordable Modification Program

Sec. 321. Short title.
Sec. 322. Congressional findings.
Sec. 323. Termination of authority.
Sec. 324. Sense of Congress.

Subtitle C—Bureau of Consumer Financial Protection

Sec. 331. Bringing the Bureau of Consumer Financial Protection into the regular appropriations process.

Subtitle D—Flood Insurance Reform

Sec. 341. Short title.
Sec. 342. Extensions.
Sec. 343. Mandatory purchase.
Sec. 344. Reforms of coverage terms.
Sec. 345. Reforms of premium rates.
Sec. 346. Technical Mapping Advisory Council.
Sec. 347. FEMA incorporation of new mapping protocols.
Sec. 348. Treatment of levees.
Sec. 349. Privatization initiatives.
Sec. 350. FEMA annual report on insurance program.
Sec. 351. Mitigation assistance.
Sec. 352. Notification to homeowners regarding mandatory purchase requirement applicability and rate phase-ins.
Sec. 353. Notification to members of congress of flood map revisions and updates.
Sec. 354. Notification and appeal of map changes; notification to communities of establishment of flood elevations.
Sec. 355. Notification to tenants of availability of contents insurance.
Sec. 356. Notification to policy holders regarding direct management of policy by FEMA.
Sec. 357. Notice of availability of flood insurance and escrow in RESPA good faith estimate.
Sec. 358. Reimbursement for costs incurred by homeowners and communities obtaining letters of map amendment or revision.
Sec. 359. Enhanced communication with certain communities during map updating process.
Sec. 360. Notification to residents newly included in flood hazard areas.
Sec. 361. Treatment of swimming pool enclosures outside of hurricane season.
Sec. 362. Information regarding multiple perils claims.
Sec. 363. FEMA authority to reject transfer of policies.
Sec. 364. Appeals.
Sec. 365. Reserve fund.

Sec. 366. CDBG eligibility for flood insurance outreach activities and community building code administration grants.
Sec. 367. Technical corrections.
Sec. 368. Requiring competition for national flood insurance program policies.
Sec. 369. Studies of voluntary community-based flood insurance options.
Sec. 370. Report on inclusion of building codes in floodplain management criteria.
Sec. 371. Study on graduated risk.
Sec. 372. Report on flood-in-progress determination.
Sec. 373. Study on repaying flood insurance debt.
Sec. 374. No cause of action.
Sec. 375. Authority for the corps of engineers to provide specialized or technical services.

Subtitle E—Repeal of the Office of Financial Research

Sec. 381. Repeal of the Office of Financial Research.

Subtitle A—Orderly Liquidation Fund

SEC. 311. REPEAL OF LIQUIDATION AUTHORITY.

(a) IN GENERAL.—Title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act is hereby repealed and any Federal law amended by such title shall, on and after the date of enactment of this Act, be effective as if title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act had not been enacted.

(b) CONFORMING AMENDMENTS.—

(1) DODD-FRANK WALL STREET REFORM AND CONSUMER PROTECTION ACT.—The Dodd-Frank Wall Street Reform and Consumer Protection Act is amended—

(A) in the table of contents for such Act, by striking all items relating to title II;

(B) in section 165(d)(6), by striking ", a receiver appointed under title II,";

(C) in section 716(g), by striking "or a covered financial company under title II";

(D) in section 1105(e)(5), by striking "amount of any securities issued under that chapter 31 for such purpose shall be treated in the same manner as securities issued under section 208(n)(5)(E)" and inserting "issuances of such securities under that chapter 31 for such purpose shall by treated as public debt transactions of the United States, and the proceeds from the sale of any obligations acquired by the Secretary under this paragraph shall be deposited into the Treasury of the United States as miscellaneous receipts"; and

(E) in section 1106(c)(2), by amending subparagraph (A) to read as follows:

"(A) require the company to file a petition for bankruptcy under section 301 of title 11, United States Code; or".

(2) FEDERAL DEPOSIT INSURANCE ACT.—Section 10(b)(3) of the Federal Deposit Insurance Act (12 U.S.C. 1820(b)(3)) is amended by striking ", or of such nonbank financial company supervised by the Board of Governors or bank holding company described in section 165(a) of the Financial Stability Act of 2010, for the purpose of implementing its authority to provide

for orderly liquidation of any such company under title II of that Act".

(3) FEDERAL RESERVE ACT.—Section 13(3) of the Federal Reserve Act is amended—

(A) in subparagraph (B)—

(i) in clause (ii), by striking ", resolution under title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, or" and inserting "or is subject to resolution under"; and

(ii) in clause (iii), by striking ", resolution under title II of the Dodd-Frank Wall Street Reform and Consumer Protection Act, or" and inserting "or resolution under"; and

(B) by striking subparagraph (E).

Subtitle B—Home Affordable Modification Program

SEC. 321. SHORT TITLE.

This subtitle may be cited as the "HAMP Termination Act of 2012".

SEC. 322. CONGRESSIONAL FINDINGS.

The Congress finds the following:

(1) According to the Department of the Treasury—

(A) the Home Affordable Modification Program (HAMP) is designed to "help as many as 3 to 4 million financially struggling homeowners avoid foreclosure by modifying loans to a level that is affordable for borrowers now and sustainable over the long term"; and

(B) as of February 2012, only 782,609 active permanent mortgage modifications were made under HAMP.

(2) Many homeowners whose HAMP modifications were canceled suffered because they made futile payments and some of those homeowners were even forced into foreclosure.

(3) The Special Inspector General for TARP reported that HAMP "benefits only a small portion of distressed homeowners, offers others little more than false hope, and in certain cases causes more harm than good".

(4) Approximately $30 billion was obligated by the Department of the Treasury to HAMP, however, approximately only $2.54 billion has been disbursed.

(5) Terminating HAMP would save American taxpayers approximately $2.84 billion, according to the Congressional Budget Office.

SEC. 323. TERMINATION OF AUTHORITY.

Section 120 of the Emergency Economic Stabilization Act of 2008 (12 U.S.C. 5230) is amended by adding at the end the following new subsection:

"(c) TERMINATION OF AUTHORITY TO PROVIDE NEW ASSISTANCE UNDER THE HOME AFFORDABLE MODIFICATION PROGRAM.—

"(1) IN GENERAL.—Except as provided under paragraph (2), after the date of the enactment of this subsection the Secretary

may not provide any assistance under the Home Affordable Modification Program under the Making Home Affordable initiative of the Secretary, authorized under this Act, on behalf of any homeowner.

"(2) PROTECTION OF EXISTING OBLIGATIONS ON BEHALF OF HOMEOWNERS ALREADY EXTENDED AN OFFER TO PARTICIPATE IN THE PROGRAM.—Paragraph (1) shall not apply with respect to assistance provided on behalf of a homeowner who, before the date of the enactment of this subsection, was extended an offer to participate in the Home Affordable Modification Program on a trial or permanent basis.

"(3) DEFICIT REDUCTION.—

"(A) USE OF UNOBLIGATED FUNDS.—Notwithstanding any other provision of this title, the amounts described in subparagraph (B) shall not be available after the date of the enactment of this subsection for obligation or expenditure under the Home Affordable Modification Program of the Secretary, but should be covered into the General Fund of the Treasury and should be used only for reducing the budget deficit of the Federal Government.

"(B) IDENTIFICATION OF UNOBLIGATED FUNDS.—The amounts described in this subparagraph are any amounts made available under title I of the Emergency Economic Stabilization Act of 2008 that—

"(i) have been allocated for use, but not yet obligated as of the date of the enactment of this subsection, under the Home Affordable Modification Program of the Secretary; and

"(ii) are not necessary for providing assistance under such Program on behalf of homeowners who, pursuant to paragraph (2), may be provided assistance after the date of the enactment of this subsection.

"(4) STUDY OF USE OF PROGRAM BY MEMBERS OF THE ARMED FORCES, VETERANS, AND GOLD STAR RECIPIENTS.—

"(A) STUDY.—The Secretary shall conduct a study to determine the extent of usage of the Home Affordable Modification Program by, and the impact of such Program on, covered homeowners.

"(B) REPORT.—Not later than the expiration of the 90-day period beginning on the date of the enactment of this subsection, the Secretary shall submit to the Congress a report setting forth the results of the study under subparagraph (A) and identifying best practices, derived from studying the Home Affordable Modification Program, that could be applied to existing mortgage assistance programs available to covered homeowners.

"(C) COVERED HOMEOWNER.—For purposes of this subsection, the term 'covered homeowner' means a homeowner who is—

"(i) a member of the Armed Forces of the United States on active duty or the spouse or parent of such a member;

"(ii) a veteran, as such term is defined in section 101 of title 38, United States Code; or

"(iii) eligible to receive a Gold Star lapel pin under section 1126 of title 10, United States Code, as a widow, parent, or next of kin of a member of the Armed Forces person who died in a manner described in subsection (a) of such section.

"(5) PUBLICATION OF MEMBER AVAILABILITY FOR ASSISTANCE.—Not later than 5 days after the date of the enactment of this subsection, the Secretary of the Treasury shall publish to its Website on the World Wide Web in a prominent location, large point font, and boldface type the following statement: 'The Home Affordable Modification Program (HAMP) has been terminated. If you are having trouble paying your mortgage and need help contacting your lender or servicer for purposes of negotiating or acquiring a loan modification, please contact your Member of Congress to assist you in contacting your lender or servicer for the purpose of negotiating or acquiring a loan modification.'.

"(6) NOTIFICATION TO HAMP APPLICANTS REQUIRED.—Not later than 30 days after the date of the enactment of this subsection, the Secretary of the Treasury shall inform each individual who applied for the Home Affordable Modification Program and will not be considered for a modification under such Program due to termination of such Program under this subsection—

"(A) that such Program has been terminated;

"(B) that loan modifications under such Program are no longer available;

"(C) of the name and contact information of such individual's Member of Congress; and

"(D) that the individual should contact his or her Member of Congress to assist the individual in contacting the individual's lender or servicer for the purpose of negotiating or acquiring a loan modification.".

SEC. 324. SENSE OF CONGRESS.

The Congress encourages banks to work with homeowners to provide loan modifications to those that are eligible. The Congress also encourages banks to work and assist homeowners and prospective homeowners with foreclosure prevention programs and information on loan modifications.

Subtitle C—Bureau of Consumer Financial Protection

SEC. 331. BRINGING THE BUREAU OF CONSUMER FINANCIAL PROTECTION INTO THE REGULAR APPROPRIATIONS PROCESS.

Section 1017 of the Consumer Financial Protection Act of 2010 is amended—

(1) in subsection (a)—

(A) by amending the heading of such subsection to read as follows: "BUDGET, FINANCIAL MANAGEMENT, AND AUDIT.—";

(B) by striking paragraphs (1), (2), and (3);

(C) by redesignating paragraphs (4) and (5) as paragraphs (1) and (2), respectively; and

(D) by striking subparagraphs (E) and (F) of paragraph (1), as so redesignated;

(2) by striking subsections (b), (c), and (d);

(3) by redesignating subsection (e) as subsection (b); and

(4) in subsection (b), as so redesignated—

(A) by striking paragraphs (1), (2), and (3) and inserting the following:

"(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $200,000,000 to carry out this title for each of fiscal years 2012 and 2013."; and

(B) by redesignating paragraph (4) as paragraph (2).

Subtitle D—Flood Insurance Reform

SEC. 341. SHORT TITLE.

This subtitle may be cited as the "Flood Insurance Reform Act of 2012".

SEC. 342. EXTENSIONS.

(a) EXTENSION OF PROGRAM.—Section 1319 of the National Flood Insurance Act of 1968 (42 U.S.C. 4026) is amended by striking "the earlier of the date of the enactment into law of an Act that specifically amends the date specified in this section or May 31, 2012" and inserting "September 30, 2016".

(b) EXTENSION OF FINANCING.—Section 1309(a) of such Act (42 U.S.C. 4016(a)) is amended by striking "the earlier of the date of the enactment into law of an Act that specifically amends the date specified in this section or May 31, 2012" and inserting "September 30, 2016".

SEC. 343. MANDATORY PURCHASE.

(a) AUTHORITY TO TEMPORARILY SUSPEND MANDATORY PURCHASE REQUIREMENT.—

(1) IN GENERAL.—Section 102 of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4012a) is amended by adding at the end the following new subsection:

"(i) AUTHORITY TO TEMPORARILY SUSPEND MANDATORY PURCHASE REQUIREMENT.—

"(1) FINDING BY ADMINISTRATOR THAT AREA IS AN ELIGIBLE AREA.—For any area, upon a request submitted to the Administrator by a local government authority having jurisdiction over any portion of the area, the Administrator shall make a finding of whether the area is an eligible area under paragraph (3). If the Administrator finds that such area is an eligible area, the Administrator shall, in the discretion of the Administrator, designate a period during which such finding shall be effective, which shall not be longer in duration than 12 months.

"(2) SUSPENSION OF MANDATORY PURCHASE REQUIREMENT.—If the Administrator makes a finding under paragraph (1) that an area is an eligible area under paragraph (3), during the period specified in the finding, the designation of such eligible area as an area having special flood hazards shall not be

effective for purposes of subsections (a), (b), and (e) of this section, and section 202(a) of this Act. Nothing in this paragraph may be construed to prevent any lender, servicer, regulated lending institution, Federal agency lender, the Federal National Mortgage Association, or the Federal Home Loan Mortgage Corporation, at the discretion of such entity, from requiring the purchase of flood insurance coverage in connection with the making, increasing, extending, or renewing of a loan secured by improved real estate or a mobile home located or to be located in such eligible area during such period or a lender or servicer from purchasing coverage on behalf of a borrower pursuant to subsection (e).

"(3) ELIGIBLE AREAS.—An eligible area under this paragraph is an area that is designated or will, pursuant to any issuance, revision, updating, or other change in flood insurance maps that takes effect on or after the date of the enactment of the Flood Insurance Reform Act of 2012, become designated as an area having special flood hazards and that meets any one of the following 3 requirements:

"(A) AREAS WITH NO HISTORY OF SPECIAL FLOOD HAZARDS.—The area does not include any area that has ever previously been designated as an area having special flood hazards.

"(B) AREAS WITH FLOOD PROTECTION SYSTEMS UNDER IMPROVEMENTS.—The area was intended to be protected by a flood protection system—

"(i) that has been decertified, or is required to be certified, as providing protection for the 100-year frequency flood standard;

"(ii) that is being improved, constructed, or reconstructed; and

"(iii) for which the Administrator has determined measurable progress toward completion of such improvement, construction, reconstruction is being made and toward securing financial commitments sufficient to fund such completion.

"(C) AREAS FOR WHICH APPEAL HAS BEEN FILED.—An area for which a community has appealed designation of the area as having special flood hazards in a timely manner under section 1363.

"(4) EXTENSION OF DELAY.—Upon a request submitted by a local government authority having jurisdiction over any portion of the eligible area, the Administrator may extend the period during which a finding under paragraph (1) shall be effective, except that—

"(A) each such extension under this paragraph shall not be for a period exceeding 12 months; and

"(B) for any area, the cumulative number of such extensions may not exceed 2.

"(5) ADDITIONAL EXTENSION FOR COMMUNITIES MAKING MORE THAN ADEQUATE PROGRESS ON FLOOD PROTECTION SYSTEM.—

"(A) EXTENSION.—

"(i) AUTHORITY.—Except as provided in subparagraph (B), in the case of an eligible area for which the Administrator has, pursuant to paragraph (4), extended the period of effectiveness of the finding under paragraph (1) for the area, upon a request submitted by a local government authority having jurisdiction over any portion of the eligible area, if the Administrator finds that more than adequate progress has been made on the construction of a flood protection system for such area, as determined in accordance with the last sentence of section 1307(e) of the National Flood Insurance Act of 1968 (42 U.S.C. 4014(e)), the Administrator may, in the discretion of the Administrator, further extend the period during which the finding under paragraph (1) shall be effective for such area for an additional 12 months.

"(ii) LIMIT.— For any eligible area, the cumulative number of extensions under this subparagraph may not exceed 2.

"(B) EXCLUSION FOR NEW MORTGAGES.—

"(i) EXCLUSION.—Any extension under subparagraph (A) of this paragraph of a finding under paragraph (1) shall not be effective with respect to any excluded property after the origination, increase, extension, or renewal of the loan referred to in clause (ii)(II) for the property.

"(ii) EXCLUDED PROPERTIES.—For purposes of this subparagraph, the term 'excluded property' means any improved real estate or mobile home—

"(I) that is located in an eligible area; and

"(II) for which, during the period that any extension under subparagraph (A) of this paragraph of a finding under paragraph (1) is otherwise in effect for the eligible area in which such property is located—

"(aa) a loan that is secured by the property is originated; or

"(bb) any existing loan that is secured by the property is increased, extended, or renewed.

"(6) RULE OF CONSTRUCTION.—Nothing in this subsection may be construed to affect the applicability of a designation of any area as an area having special flood hazards for purposes of the availability of flood insurance coverage, criteria for land management and use, notification of flood hazards, eligibility for mitigation assistance, or any other purpose or provision not specifically referred to in paragraph (2).

"(7) REPORTS.—The Administrator shall, in each annual report submitted pursuant to section 1320, include information identifying each finding under paragraph (1) by the Administrator during the preceding year that an area is an area having special flood hazards, the basis for each such finding, any extensions pursuant to paragraph (4) of the periods of effectiveness of such findings, and the reasons for such extensions.".

(2) NO REFUNDS.—Nothing in this subsection or the amendments made by this subsection may be construed to authorize or require any payment or refund for flood insurance coverage purchased for any property that covered any period during which such coverage is not required for the property pursuant to the applicability of the amendment made by paragraph (1).

(b) TERMINATION OF FORCE-PLACED INSURANCE.—Section 102(e) of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4012a(e)) is amended—

(1) in paragraph (2), by striking "insurance." and inserting "insurance, including premiums or fees incurred for coverage beginning on the date on which flood insurance coverage lapsed or did not provide a sufficient coverage amount.";

(2) by redesignating paragraphs (3) and (4) as paragraphs (5) and 6), respectively; and

(3) by inserting after paragraph (2) the following new paragraphs:

"(3) TERMINATION OF FORCE-PLACED INSURANCE.—Within 30 days of receipt by the lender or servicer of a confirmation of a borrower's existing flood insurance coverage, the lender or servicer shall—

"(A) terminate the force-placed insurance; and

"(B) refund to the borrower all force-placed insurance premiums paid by the borrower during any period during which the borrower's flood insurance coverage and the force-placed flood insurance coverage were each in effect, and any related fees charged to the borrower with respect to the force-placed insurance during such period.

"(4) SUFFICIENCY OF DEMONSTRATION.—For purposes of confirming a borrower's existing flood insurance coverage, a lender or servicer for a loan shall accept from the borrower an insurance policy declarations page that includes the existing flood insurance policy number and the identity of, and contact information for, the insurance company or agent.".

(c) USE OF PRIVATE INSURANCE TO SATISFY MANDATORY PURCHASE REQUIREMENT.—Section 102(b) of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4012a(b)) is amended—

(1) in paragraph (1)—

(A) by striking "lending institutions not to make" and inserting "lending institutions—

"(A) not to make";

(B) in subparagraph (A), as designated by subparagraph (A) of this paragraph, by striking "less." and inserting "less; and"; and

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

"(B) to accept private flood insurance as satisfaction of the flood insurance coverage requirement under subparagraph (A) if the coverage provided by such private flood insurance meets the requirements for coverage under such subparagraph.";

(2) in paragraph (2), by inserting after "provided in paragraph (1)." the following new sentence: "Each Federal agency

lender shall accept private flood insurance as satisfaction of the flood insurance coverage requirement under the preceding sentence if the flood insurance coverage provided by such private flood insurance meets the requirements for coverage under such sentence.";

(3) in paragraph (3), in the matter following subparagraph (B), by adding at the end the following new sentence: "The Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation shall accept private flood insurance as satisfaction of the flood insurance coverage requirement under the preceding sentence if the flood insurance coverage provided by such private flood insurance meets the requirements for coverage under such sentence."; and

(4) by adding at the end the following new paragraph:

"(5) PRIVATE FLOOD INSURANCE DEFINED.—In this subsection, the term 'private flood insurance' means a contract for flood insurance coverage allowed for sale under the laws of any State.".

SEC. 344. REFORMS OF COVERAGE TERMS.

(a) MINIMUM DEDUCTIBLES FOR CLAIMS.—Section 1312 of the National Flood Insurance Act of 1968 (42 U.S.C. 4019) is amended—

(1) by striking "The Director is" and inserting the following: "(a) IN GENERAL.—The Administrator is"; and

(2) by adding at the end the following:

"(b) MINIMUM ANNUAL DEDUCTIBLES.—

"(1) SUBSIDIZED RATE PROPERTIES.—For any structure that is covered by flood insurance under this title, and for which the chargeable rate for such coverage is less than the applicable estimated risk premium rate under section 1307(a)(1) for the area (or subdivision thereof) in which such structure is located, the minimum annual deductible for damage to or loss of such structure shall be $2,000.

"(2) ACTUARIAL RATE PROPERTIES.—For any structure that is covered by flood insurance under this title, for which the chargeable rate for such coverage is not less than the applicable estimated risk premium rate under section 1307(a)(1) for the area (or subdivision thereof) in which such structure is located, the minimum annual deductible for damage to or loss of such structure shall be $1,000.".

(b) CLARIFICATION OF RESIDENTIAL AND COMMERCIAL COVERAGE LIMITS.—Section 1306(b) of the National Flood Insurance Act of 1968 (42 U.S.C. 4013(b)) is amended—

(1) in paragraph (2)—

(A) by striking "in the case of any residential property" and inserting "in the case of any residential building designed for the occupancy of from one to four families"; and

(B) by striking "shall be made available to every insured upon renewal and every applicant for insurance so as to enable such insured or applicant to receive coverage up to a total amount (including such limits specified in paragraph (1)(A)(i)) of $250,000" and inserting "shall be made available, with respect to any single such building,

up to an aggregate liability (including such limits specified in paragraph (1)(A)(i)) of $250,000"; and

(2) in paragraph (4)—

(A) by striking "in the case of any nonresidential property, including churches," and inserting "in the case of any nonresidential building, including a church,"; and

(B) by striking "shall be made available to every insured upon renewal and every applicant for insurance, in respect to any single structure, up to a total amount (including such limit specified in subparagraph (B) or (C) of paragraph (1), as applicable) of $500,000 for each structure and $500,000 for any contents related to each structure" and inserting "shall be made available with respect to any single such building, up to an aggregate liability (including such limits specified in subparagraph (B) or (C) of paragraph (1), as applicable) of $500,000, and coverage shall be made available up to a total of $500,000 aggregate liability for contents owned by the building owner and $500,000 aggregate liability for each unit within the building for contents owned by the tenant".

(c) INDEXING OF MAXIMUM COVERAGE LIMITS.—Subsection (b) of section 1306 of the National Flood Insurance Act of 1968 (42 U.S.C. 4013(b)) is amended—

(1) in paragraph (4), by striking "and" at the end;

(2) in paragraph (5), by striking the period at the end and inserting "; and";

(3) by redesignating paragraph (5) as paragraph (7); and

(4) by adding at the end the following new paragraph:

"(8) each of the dollar amount limitations under paragraphs (2), (3), (4), (5), and (6) shall be adjusted effective on the date of the enactment of the Flood Insurance Reform Act of 2012, such adjustments shall be calculated using the percentage change, over the period beginning on September 30, 1994, and ending on such date of enactment, in such inflationary index as the Administrator shall, by regulation, specify, and the dollar amount of such adjustment shall be rounded to the next lower dollar; and the Administrator shall cause to be published in the Federal Register the adjustments under this paragraph to such dollar amount limitations; except that in the case of coverage for a property that is made available, pursuant to this paragraph, in an amount that exceeds the limitation otherwise applicable to such coverage as specified in paragraph (2), (3), (4), (5), or (6), the total of such coverage shall be made available only at chargeable rates that are not less than the estimated premium rates for such coverage determined in accordance with section 1307(a)(1).".

(d) OPTIONAL COVERAGE FOR LOSS OF USE OF PERSONAL RESIDENCE AND BUSINESS INTERRUPTION.—Subsection (b) of section 1306 of the National Flood Insurance Act of 1968 (42 U.S.C. 4013(b)), as amended by the preceding provisions of this section, is further amended by inserting after paragraph (4) the following new paragraphs:

"(5) the Administrator may provide that, in the case of any residential property, each renewal or new contract for flood in-

surance coverage may provide not more than $5,000 aggregate liability per dwelling unit for any necessary increases in living expenses incurred by the insured when losses from a flood make the residence unfit to live in, except that—

"(A) purchase of such coverage shall be at the option of the insured;

"(B) any such coverage shall be made available only at chargeable rates that are not less than the estimated premium rates for such coverage determined in accordance with section 1307(a)(1); and

"(C) the Administrator may make such coverage available only if the Administrator makes a determination and causes notice of such determination to be published in the Federal Register that—

"(i) a competitive private insurance market for such coverage does not exist; and

"(ii) the national flood insurance program has the capacity to make such coverage available without borrowing funds from the Secretary of the Treasury under section 1309 or otherwise;

"(6) the Administrator may provide that, in the case of any commercial property or other residential property, including multifamily rental property, coverage for losses resulting from any partial or total interruption of the insured's business caused by damage to, or loss of, such property from a flood may be made available to every insured upon renewal and every applicant, up to a total amount of $20,000 per property, except that—

"(A) purchase of such coverage shall be at the option of the insured;

"(B) any such coverage shall be made available only at chargeable rates that are not less than the estimated premium rates for such coverage determined in accordance with section 1307(a)(1); and

"(C) the Administrator may make such coverage available only if the Administrator makes a determination and causes notice of such determination to be published in the Federal Register that—

"(i) a competitive private insurance market for such coverage does not exist; and

"(ii) the national flood insurance program has the capacity to make such coverage available without borrowing funds from the Secretary of the Treasury under section 1309 or otherwise;".

(e) PAYMENT OF PREMIUMS IN INSTALLMENTS FOR RESIDENTIAL PROPERTIES.—Section 1306 of the National Flood Insurance Act of 1968 (42 U.S.C. 4013) is amended by adding at the end the following new subsection:

"(d) PAYMENT OF PREMIUMS IN INSTALLMENTS FOR RESIDENTIAL PROPERTIES.—

"(1) AUTHORITY.—In addition to any other terms and conditions under subsection (a), such regulations shall provide that, in the case of any residential property, premiums for

flood insurance coverage made available under this title for such property may be paid in installments.

"(2) LIMITATIONS.—In implementing the authority under paragraph (1), the Administrator may establish increased chargeable premium rates and surcharges, and deny coverage and establish such other sanctions, as the Administrator considers necessary to ensure that insureds purchase, pay for, and maintain coverage for the full term of a contract for flood insurance coverage or to prevent insureds from purchasing coverage only for periods during a year when risk of flooding is comparatively higher or canceling coverage for periods when such risk is comparatively lower.".

(f) EFFECTIVE DATE OF POLICIES COVERING PROPERTIES AFFECTED BY FLOODS IN PROGRESS.—Paragraph (1) of section 1306(c) of the National Flood Insurance Act of 1968 (42 U.S.C. 4013(c)) is amended by adding after the period at the end the following: "With respect to any flood that has commenced or is in progress before the expiration of such 30-day period, such flood insurance coverage for a property shall take effect upon the expiration of such 30-day period and shall cover damage to such property occurring after the expiration of such period that results from such flood, but only if the property has not suffered damage or loss as a result of such flood before the expiration of such 30-day period.".

SEC. 345. REFORMS OF PREMIUM RATES.

(a) INCREASE IN ANNUAL LIMITATION ON PREMIUM INCREASES.—Section 1308(e) of the National Flood Insurance Act of 1968 (42 U.S.C. 4015(e)) is amended by striking "10 percent" and inserting "20 percent".

(b) PHASE-IN OF RATES FOR CERTAIN PROPERTIES IN NEWLY MAPPED AREAS.—

(1) IN GENERAL.—Section 1308 of the National Flood Insurance Act of 1968 (42 U.S.C. 4015) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by inserting "or notice" after "prescribe by regulation";

(B) in subsection (c), by inserting "and subsection (g)" before the first comma; and

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

"(g) 5-YEAR PHASE-IN OF FLOOD INSURANCE RATES FOR CERTAIN PROPERTIES IN NEWLY MAPPED AREAS.—

"(1) 5-YEAR PHASE-IN PERIOD.—Notwithstanding subsection (c) or any other provision of law relating to chargeable risk premium rates for flood insurance coverage under this title, in the case of any area that was not previously designated as an area having special flood hazards and that, pursuant to any issuance, revision, updating, or other change in flood insurance maps, becomes designated as such an area, during the 5-year period that begins, except as provided in paragraph (2), upon the date that such maps, as issued, revised, updated, or otherwise changed, become effective, the chargeable premium rate for flood insurance under this title with respect to any covered property that is located within such area shall be the rate described in paragraph (3).

"(2) APPLICABILITY TO PREFERRED RISK RATE AREAS.—In the case of any area described in paragraph (1) that consists of or includes an area that, as of date of the effectiveness of the flood insurance maps for such area referred to in paragraph (1) as so issued, revised, updated, or changed, is eligible for any reason for preferred risk rate method premiums for flood insurance coverage and was eligible for such premiums as of the enactment of the Flood Insurance Reform Act of 2012, the 5-year period referred to in paragraph (1) for such area eligible for preferred risk rate method premiums shall begin upon the expiration of the period during which such area is eligible for such preferred risk rate method premiums.

"(3) PHASE-IN OF FULL ACTUARIAL RATES.—With respect to any area described in paragraph (1), the chargeable risk premium rate for flood insurance under this title for a covered property that is located in such area shall be—

"(A) for the first year of the 5-year period referred to in paragraph (1), the greater of—

"(i) 20 percent of the chargeable risk premium rate otherwise applicable under this title to the property; and

"(ii) in the case of any property that, as of the beginning of such first year, is eligible for preferred risk rate method premiums for flood insurance coverage, such preferred risk rate method premium for the property;

"(B) for the second year of such 5-year period, 40 percent of the chargeable risk premium rate otherwise applicable under this title to the property;

"(C) for the third year of such 5-year period, 60 percent of the chargeable risk premium rate otherwise applicable under this title to the property;

"(D) for the fourth year of such 5-year period, 80 percent of the chargeable risk premium rate otherwise applicable under this title to the property; and

"(E) for the fifth year of such 5-year period, 100 percent of the chargeable risk premium rate otherwise applicable under this title to the property.

"(4) COVERED PROPERTIES.—For purposes of the subsection, the term 'covered property' means any residential property occupied by its owner or a bona fide tenant as a primary residence.".

(2) REGULATION OR NOTICE.—The Administrator of the Federal Emergency Management Agency shall issue an interim final rule or notice to implement this subsection and the amendments made by this subsection as soon as practicable after the date of the enactment of this Act.

(c) PHASE-IN OF ACTUARIAL RATES FOR CERTAIN PROPERTIES.—

(1) IN GENERAL.—Section 1308(c) of the National Flood Insurance Act of 1968 (42 U.S.C. 4015(c)) is amended—

(A) by redesignating paragraph (2) as paragraph (7); and

(B) by inserting after paragraph (1) the following new paragraphs:

"(2) COMMERCIAL PROPERTIES.—Any nonresidential property.

"(3) SECOND HOMES AND VACATION HOMES.—Any residential property that is not the primary residence of any individual.

"(4) HOMES SOLD TO NEW OWNERS.—Any single family property that—

"(A) has been constructed or substantially improved and for which such construction or improvement was started, as determined by the Administrator, before December 31, 1974, or before the effective date of the initial rate map published by the Administrator under paragraph (2) of section 1360(a) for the area in which such property is located, whichever is later; and

"(B) is purchased after the effective date of this paragraph, pursuant to section 345(c)(3)(A) of the Flood Insurance Reform Act of 2012.

"(5) HOMES DAMAGED OR IMPROVED.—Any property that, on or after the date of the enactment of the Flood Insurance Reform Act of 2012, has experienced or sustained—

"(A) substantial flood damage exceeding 50 percent of the fair market value of such property; or

"(B) substantial improvement exceeding 30 percent of the fair market value of such property.

"(6) HOMES WITH MULTIPLE CLAIMS.—Any severe repetitive loss property (as such term is defined in section 1366(j)).".

(2) TECHNICAL AMENDMENTS.—Section 1308 of the National Flood Insurance Act of 1968 (42 U.S.C. 4015) is amended—

(A) in subsection (c)—

(i) in the matter preceding paragraph (1), by striking "the limitations provided under paragraphs (1) and (2)" and inserting "subsection (e)"; and

(ii) in paragraph (1), by striking ", except" and all that follows through "subsection (e)"; and

(B) in subsection (e), by striking "paragraph (2) or (3)" and inserting "paragraph (7)".

(3) EFFECTIVE DATE AND TRANSITION.—

(A) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply beginning upon the expiration of the 12-month period that begins on the date of the enactment of this Act, except as provided in subparagraph (B) of this paragraph.

(B) TRANSITION FOR PROPERTIES COVERED BY FLOOD INSURANCE UPON EFFECTIVE DATE.—

(i) INCREASE OF RATES OVER TIME.—In the case of any property described in paragraph (2), (3), (4), (5), or (6) of section 1308(c) of the National Flood Insurance Act of 1968, as amended by paragraph (1) of this subsection, that, as of the effective date under subparagraph (A) of this paragraph, is covered under a policy for flood insurance made available under the national flood insurance program for which the chargeable premium rates are less than the applicable estimated risk

premium rate under section 1307(a)(1) of such Act for the area in which the property is located, the Administrator of the Federal Emergency Management Agency shall increase the chargeable premium rates for such property over time to such applicable estimated risk premium rate under section 1307(a)(1).

(ii) AMOUNT OF ANNUAL INCREASE.—Such increase shall be made by increasing the chargeable premium rates for the property (after application of any increase in the premium rates otherwise applicable to such property), once during the 12-month period that begins upon the effective date under subparagraph (A) of this paragraph and once every 12 months thereafter until such increase is accomplished, by 20 percent (or such lesser amount as may be necessary so that the chargeable rate does not exceed such applicable estimated risk premium rate or to comply with clause (iii)).

(iii) PROPERTIES SUBJECT TO PHASE-IN AND ANNUAL INCREASES.—In the case of any pre-FIRM property (as such term is defined in section 578(b) of the National Flood Insurance Reform Act of 1974), the aggregate increase, during any 12-month period, in the chargeable premium rate for the property that is attributable to this subparagraph or to an increase described in section 1308(e) of the National Flood Insurance Act of 1968 may not exceed 20 percent.

(iv) FULL ACTUARIAL RATES.—The provisions of paragraphs (2), (3), (4), (5), and (6) of such section 1308(c) shall apply to such a property upon the accomplishment of the increase under this subparagraph and thereafter.

(d) PROHIBITION OF EXTENSION OF SUBSIDIZED RATES TO LAPSED POLICIES.—Section 1308 of the National Flood Insurance Act of 1968 (42 U.S.C. 4015), as amended by the preceding provisions of this subtitle, is further amended—

(1) in subsection (e), by inserting "or subsection (h)" after "subsection (c)"; and

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

"(h) PROHIBITION OF EXTENSION OF SUBSIDIZED RATES TO LAPSED POLICIES.—Notwithstanding any other provision of law relating to chargeable risk premium rates for flood insurance coverage under this title, the Administrator shall not provide flood insurance coverage under this title for any property for which a policy for such coverage for the property has previously lapsed in coverage as a result of the deliberate choice of the holder of such policy, at a rate less than the applicable estimated risk premium rates for the area (or subdivision thereof) in which such property is located.".

(e) RECOGNITION OF STATE AND LOCAL FUNDING FOR CONSTRUCTION, RECONSTRUCTION, AND IMPROVEMENT OF FLOOD PROTECTION SYSTEMS IN DETERMINATION OF RATES.—

(1) IN GENERAL.—Section 1307 of the National Flood Insurance Act of 1968 (42 U.S.C. 4014) is amended—

(A) in subsection (e)—

(i) in the first sentence, by striking "construction of a flood protection system" and inserting "construction, reconstruction, or improvement of a flood protection system (without respect to the level of Federal investment or participation)"; and

(ii) in the second sentence—

(I) by striking "construction of a flood protection system" and inserting "construction, reconstruction, or improvement of a flood protection system"; and

(II) by inserting "based on the present value of the completed system" after "has been expended"; and

(B) in subsection (f)—

(i) in the first sentence in the matter preceding paragraph (1), by inserting "(without respect to the level of Federal investment or participation)" before the period at the end;

(ii) in the third sentence in the matter preceding paragraph (1), by inserting ", whether coastal or riverine," after "special flood hazard"; and

(iii) in paragraph (1), by striking "a Federal agency in consultation with the local project sponsor" and inserting "the entity or entities that own, operate, maintain, or repair such system".

(2) REGULATIONS.—The Administrator of the Federal Emergency Management Agency shall promulgate regulations to implement this subsection and the amendments made by this subsection as soon as practicable, but not more than 18 months after the date of the enactment of this Act. Paragraph (3) may not be construed to annul, alter, affect, authorize any waiver of, or establish any exception to, the requirement under the preceding sentence.

SEC. 346. TECHNICAL MAPPING ADVISORY COUNCIL.

(a) ESTABLISHMENT.—There is established a council to be known as the Technical Mapping Advisory Council (in this section referred to as the "Council").

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Council shall consist of—

(A) the Administrator of the Federal Emergency Management Agency (in this section referred to as the "Administrator"), or the designee thereof;

(B) the Director of the United States Geological Survey of the Department of the Interior, or the designee thereof;

(C) the Under Secretary of Commerce for Oceans and Atmosphere, or the designee thereof;

(D) the commanding officer of the United States Army Corps of Engineers, or the designee thereof;

(E) the chief of the Natural Resources Conservation Service of the Department of Agriculture, or the designee thereof;

(F) the Director of the United States Fish and Wildlife Service of the Department of the Interior, or the designee thereof;

(G) the Assistant Administrator for Fisheries of the National Oceanic and Atmospheric Administration of the Department of Commerce, or the designee thereof; and

(H) 14 additional members to be appointed by the Administrator of the Federal Emergency Management Agency, who shall be—

(i) an expert in data management;

(ii) an expert in real estate;

(iii) an expert in insurance;

(iv) a member of a recognized regional flood and storm water management organization;

(v) a representative of a State emergency management agency or association or organization for such agencies;

(vi) a member of a recognized professional surveying association or organization;

(vii) a member of a recognized professional mapping association or organization;

(viii) a member of a recognized professional engineering association or organization;

(ix) a member of a recognized professional association or organization representing flood hazard determination firms;

(x) a representative of State national flood insurance coordination offices;

(xi) representatives of two local governments, at least one of whom is a local levee flood manager or executive, designated by the Federal Emergency Management Agency as Cooperating Technical Partners; and

(xii) representatives of two State governments designated by the Federal Emergency Management Agency as Cooperating Technical States.

(2) QUALIFICATIONS.—Members of the Council shall be appointed based on their demonstrated knowledge and competence regarding surveying, cartography, remote sensing, geographic information systems, or the technical aspects of preparing and using flood insurance rate maps. In appointing members under paragraph (1)(H), the Administrator shall ensure that the membership of the Council has a balance of Federal, State, local, and private members, and includes an adequate number of representatives from the States with coastline on the Gulf of Mexico and other States containing areas identified by the Administrator of the Federal Emergency Management Agency as at high-risk for flooding or special flood hazard areas.

(c) DUTIES.—

(1) NEW MAPPING STANDARDS.—Not later than the expiration of the 12-month period beginning upon the date of the enactment of this Act, the Council shall develop and submit to the Administrator and the Congress proposed new mapping

standards for 100-year flood insurance rate maps used under the national flood insurance program under the National Flood Insurance Act of 1968. In developing such proposed standards the Council shall—

(A) ensure that the flood insurance rate maps reflect true risk, including graduated risk that better reflects the financial risk to each property; such reflection of risk should be at the smallest geographic level possible (but not necessarily property-by-property) to ensure that communities are mapped in a manner that takes into consideration different risk levels within the community;

(B) ensure the most efficient generation, display, and distribution of flood risk data, models, and maps where practicable through dynamic digital environments using spatial database technology and the Internet;

(C) ensure that flood insurance rate maps reflect current hydrologic and hydraulic data, current land use, and topography, incorporating the most current and accurate ground and bathymetric elevation data;

(D) determine the best ways to include in such flood insurance rate maps levees, decertified levees, and areas located below dams, including determining a methodology for ensuring that decertified levees and other protections are included in flood insurance rate maps and their corresponding flood zones reflect the level of protection conferred;

(E) consider how to incorporate restored wetlands and other natural buffers into flood insurance rate maps, which may include wetlands, groundwater recharge areas, erosion zones, meander belts, endangered species habitat, barrier islands and shoreline buffer features, riparian forests, and other features;

(F) consider whether to use vertical positioning (as defined by the Administrator) for flood insurance rate maps;

(G) ensure that flood insurance rate maps differentiate between a property that is located in a flood zone and a structure located on such property that is not at the same risk level for flooding as such property due to the elevation of the structure;

(H) ensure that flood insurance rate maps take into consideration the best scientific data and potential future conditions (including projections for sea level rise); and

(I) consider how to incorporate the new standards proposed pursuant to this paragraph in existing mapping efforts.

(2) ONGOING DUTIES.—The Council shall, on an ongoing basis, review the mapping protocols developed pursuant to paragraph (1), and make recommendations to the Administrator when the Council determines that mapping protocols should be altered.

(3) MEETINGS.—In carrying out its duties under this section, the Council shall consult with stakeholders through at least 4 public meetings annually, and shall seek input of all stakeholder interests including State and local representatives,

environmental and conservation organizations, insurance industry representatives, advocacy groups, planning organizations, and mapping organizations.

(d) PROHIBITION ON COMPENSATION.—Members of the Council shall receive no additional compensation by reason of their service on the Council.

(e) CHAIRPERSON.—The Administrator shall serve as the Chairperson of the Council.

(f) STAFF.—

(1) FEMA.—Upon the request of the Council, the Administrator may detail, on a nonreimbursable basis, personnel of the Federal Emergency Management Agency to assist the Council in carrying out its duties.

(2) OTHER FEDERAL AGENCIES.—Upon request of the Council, any other Federal agency that is a member of the Council may detail, on a non-reimbursable basis, personnel to assist the Council in carrying out its duties.

(g) POWERS.—In carrying out this section, the Council may hold hearings, receive evidence and assistance, provide information, and conduct research, as the Council considers appropriate.

(h) TERMINATION.—The Council shall terminate upon the expiration of the 5-year period beginning on the date of the enactment of this Act.

(i) MORATORIUM ON FLOOD MAP CHANGES.—

(1) MORATORIUM.—Except as provided in paragraph (2) and notwithstanding any other provision of this subtitle, the National Flood Insurance Act of 1968, or the Flood Disaster Protection Act of 1973, during the period beginning upon the date of the enactment of this Act and ending upon the submission by the Council to the Administrator and the Congress of the proposed new mapping standards required under subsection (c)(1), the Administrator may not make effective any new or updated rate maps for flood insurance coverage under the national flood insurance program that were not in effect for such program as of such date of enactment, or otherwise revise, update, or change the flood insurance rate maps in effect for such program as of such date.

(2) LETTERS OF MAP CHANGE.—During the period described in paragraph (1), the Administrator may revise, update, and change the flood insurance rate maps in effect for the national flood insurance program only pursuant to a letter of map change (including a letter of map amendment, letter of map revision, and letter of map revision based on fill).

SEC. 347. FEMA INCORPORATION OF NEW MAPPING PROTOCOLS.

(a) NEW RATE MAPPING STANDARDS.—Not later than the expiration of the 6-month period beginning upon submission by the Technical Mapping Advisory Council under section 346 of the proposed new mapping standards for flood insurance rate maps used under the national flood insurance program developed by the Council pursuant to section 346(c), the Administrator of the Federal Emergency Management Agency (in this section referred to as the "Administrator") shall establish new standards for such rate maps based on such proposed new standards and the recommendations of the Council.

(b) REQUIREMENTS.—The new standards for flood insurance rate maps established by the Administrator pursuant to subsection (a) shall—

(1) delineate and include in any such rate maps—

(A) all areas located within the 100-year flood plain; and

(B) areas subject to graduated and other risk levels, to the maximum extent possible;

(2) ensure that any such rate maps—

(A) include levees, including decertified levees, and the level of protection they confer;

(B) reflect current land use and topography and incorporate the most current and accurate ground level data;

(C) take into consideration the impacts and use of fill and the flood risks associated with altered hydrology;

(D) differentiate between a property that is located in a flood zone and a structure located on such property that is not at the same risk level for flooding as such property due to the elevation of the structure;

(E) identify and incorporate natural features and their associated flood protection benefits into mapping and rates; and

(F) identify, analyze, and incorporate the impact of significant changes to building and development throughout any river or costal water system, including all tributaries, which may impact flooding in areas downstream; and

(3) provide that such rate maps are developed on a watershed basis.

(c) REPORT.—If, in establishing new standards for flood insurance rate maps pursuant to subsection (a) of this section, the Administrator does not implement all of the recommendations of the Council made under the proposed new mapping standards developed by the Council pursuant to section 346(c), upon establishment of the new standards the Administrator shall submit a report to the Committee on Financial Services of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate specifying which such recommendations were not adopted and explaining the reasons such recommendations were not adopted.

(d) IMPLEMENTATION.—The Administrator shall, not later than the expiration of the 6-month period beginning upon establishment of the new standards for flood insurance rate maps pursuant to subsection (a) of this section, commence use of the new standards and updating of flood insurance rate maps in accordance with the new standards. Not later than the expiration of the 10-year period beginning upon the establishment of such new standards, the Administrator shall complete updating of all flood insurance rate maps in accordance with the new standards, subject to the availability of sufficient amounts for such activities provided in appropriation Acts.

(e) TEMPORARY SUSPENSION OF MANDATORY PURCHASE REQUIREMENT FOR CERTAIN PROPERTIES.—

(1) SUBMISSION OF ELEVATION CERTIFICATE.—Subject to paragraphs (2) and (3) of this subsection, subsections (a), (b), and (e) of section 102 of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4012a), and section 202(a) of such Act, shall not apply to a property located in an area designated as having a special flood hazard if the owner of such property submits to the Administrator an elevation certificate for such property showing that the lowest level of the primary residence on such property is at an elevation that is at least three feet higher than the elevation of the 100-year flood plain.

(2) REVIEW OF CERTIFICATE.—The Administrator shall accept as conclusive each elevation certificate submitted under paragraph (1) unless the Administrator conducts a subsequent elevation survey and determines that the lowest level of the primary residence on the property in question is not at an elevation that is at least three feet higher than the elevation of the 100-year flood plain. The Administrator shall provide any such subsequent elevation survey to the owner of such property.

(3) DETERMINATIONS FOR PROPERTIES ON BORDERS OF SPECIAL FLOOD HAZARD AREAS.—

(A) EXPEDITED DETERMINATION.—In the case of any survey for a property submitted to the Administrator pursuant to paragraph (1) showing that a portion of the property is located within an area having special flood hazards and that a structure located on the property is not located within such area having special flood hazards, the Administrator shall expeditiously process any request made by an owner of the property for a determination pursuant to paragraph (2) or a determination of whether the structure is located within the area having special flood hazards.

(B) PROHIBITION OF FEE.—If the Administrator determines pursuant to subparagraph (A) that the structure on the property is not located within the area having special flood hazards, the Administrator shall not charge a fee for reviewing the flood hazard data and shall not require the owner to provide any additional elevation data.

(C) SIMPLIFICATION OF REVIEW PROCESS.—The Administrator shall collaborate with private sector flood insurers to simplify the review process for properties described in subparagraph (A) and to ensure that the review process provides for accurate determinations.

(4) TERMINATION OF AUTHORITY.—This subsection shall cease to apply to a property on the date on which the Administrator updates the flood insurance rate map that applies to such property in accordance with the requirements of subsection (d).

SEC. 348. TREATMENT OF LEVEES.

Section 1360 of the National Flood Insurance Act of 1968 (42 U.S.C. 4101) is amended by adding at the end the following new subsection:

"(k) TREATMENT OF LEVEES.—The Administrator may not issue flood insurance maps, or make effective updated flood insurance maps, that omit or disregard the actual protection afforded by an

existing levee, floodwall, pump or other flood protection feature, regardless of the accreditation status of such feature.".

SEC. 349. PRIVATIZATION INITIATIVES.

(a) FEMA AND GAO REPORTS.—Not later than the expiration of the 18-month period beginning on the date of the enactment of this Act, the Administrator of the Federal Emergency Management Agency and the Comptroller General of the United States shall each conduct a separate study to assess a broad range of options, methods, and strategies for privatizing the national flood insurance program and shall each submit a report to the Committee on Financial Services of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate with recommendations for the best manner to accomplish such privatization.

(b) PRIVATE RISK-MANAGEMENT INITIATIVES.—

(1) AUTHORITY.—The Administrator of the Federal Emergency Management Agency may carry out such private risk-management initiatives under the national flood insurance program as the Administrator considers appropriate to determine the capacity of private insurers, reinsurers, and financial markets to assist communities, on a voluntary basis only, in managing the full range of financial risks associated with flooding.

(2) ASSESSMENT.—Not later than the expiration of the 12-month period beginning on the date of the enactment of this Act, the Administrator shall assess the capacity of the private reinsurance, capital, and financial markets by seeking proposals to assume a portion of the program's insurance risk and submit to the Congress a report describing the response to such request for proposals and the results of such assessment.

(3) PROTOCOL FOR RELEASE OF DATA.—The Administrator shall develop a protocol to provide for the release of data sufficient to conduct the assessment required under paragraph (2).

(c) REINSURANCE.—The National Flood Insurance Act of 1968 is amended—

(1) in section 1331(a)(2) (42 U.S.C. 4051(a)(2)), by inserting ", including as reinsurance of insurance coverage provided by the flood insurance program" before ", on such terms";

(2) in section 1332(c)(2) (42 U.S.C. 4052(c)(2)), by inserting "or reinsurance" after "flood insurance coverage";

(3) in section 1335(a) (42 U.S.C. 4055(a))—

(A) by inserting "(1)" after "(a)"; and

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

"(2) The Administrator is authorized to secure reinsurance coverage of coverage provided by the flood insurance program from private market insurance, reinsurance, and capital market sources at rates and on terms determined by the Administrator to be reasonable and appropriate in an amount sufficient to maintain the ability of the program to pay claims and that minimizes the likelihood that the program will utilize the borrowing authority provided under section 1309.";

(4) in section 1346(a) (12 U.S.C. 4082(a))—

(A) in the matter preceding paragraph (1), by inserting ", or for purposes of securing reinsurance of insurance coverage provided by the program," before "of any or all of";

(B) in paragraph (1)—

(i) by striking "estimating" and inserting "Estimating"; and

(ii) by striking the semicolon at the end and inserting a period;

(C) in paragraph (2)—

(i) by striking "receiving" and inserting "Receiving"; and

(ii) by striking the semicolon at the end and inserting a period;

(D) in paragraph (3)—

(i) by striking "making" and inserting "Making"; and

(ii) by striking "; and" and inserting a period;

(E) in paragraph (4)—

(i) by striking "otherwise" and inserting "Otherwise"; and

(ii) by redesignating such paragraph as paragraph (5); and

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

"(4) Placing reinsurance coverage on insurance provided by such program."; and

(5) in section 1370(a)(3) (42 U.S.C. 4121(a)(3)), by inserting before the semicolon at the end the following: ", is subject to the reporting requirements of the Securities Exchange Act of 1934, pursuant to section 13(a) or 15(d) of such Act (15 U.S.C. 78m(a), 78o(d)), or is authorized by the Administrator to assume reinsurance on risks insured by the flood insurance program".

(d) ASSESSMENT OF CLAIMS-PAYING ABILITY.—

(1) ASSESSMENT.—Not later than September 30 of each year, the Administrator of the Federal Emergency Management Agency shall conduct an assessment of the claims-paying ability of the national flood insurance program, including the program's utilization of private sector reinsurance and reinsurance equivalents, with and without reliance on borrowing authority under section 1309 of the National Flood Insurance Act of 1968 (42 U.S.C. 4016). In conducting the assessment, the Administrator shall take into consideration regional concentrations of coverage written by the program, peak flood zones, and relevant mitigation measures.

(2) REPORT.—The Administrator shall submit a report to the Congress of the results of each such assessment, and make such report available to the public, not later than 30 days after completion of the assessment.

SEC. 350. FEMA ANNUAL REPORT ON INSURANCE PROGRAM.

Section 1320 of the National Flood Insurance Act of 1968 (42 U.S.C. 4027) is amended—

(1) in the section heading, by striking "REPORT TO THE PRESIDENT" and inserting "ANNUAL REPORT TO CONGRESS";

(2) in subsection (a)—

(A) by striking "biennially";

(B) by striking "the President for submission to"; and

(C) by inserting "not later than June 30 of each year" before the period at the end;

(3) in subsection (b), by striking "biennial" and inserting "annual"; and

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

"(c) FINANCIAL STATUS OF PROGRAM.—The report under this section for each year shall include information regarding the financial status of the national flood insurance program under this title, including a description of the financial status of the National Flood Insurance Fund and current and projected levels of claims, premium receipts, expenses, and borrowing under the program.".

SEC. 351. MITIGATION ASSISTANCE.

(a) MITIGATION ASSISTANCE GRANTS.—Section 1366 of the National Flood Insurance Act of 1968 (42 U.S.C. 4104c) is amended—

(1) in subsection (a), by striking the last sentence and inserting the following: "Such financial assistance shall be made available—

"(1) to States and communities in the form of grants under this section for carrying out mitigation activities;

"(2) to States and communities in the form of grants under this section for carrying out mitigation activities that reduce flood damage to severe repetitive loss structures; and

"(3) to property owners in the form of direct grants under this section for carrying out mitigation activities that reduce flood damage to individual structures for which 2 or more claim payments for losses have been made under flood insurance coverage under this title if the Administrator, after consultation with the State and community, determines that neither the State nor community in which such a structure is located has the capacity to manage such grants.".

(2) by striking subsection (b);

(3) in subsection (c)—

(A) by striking "flood risk" and inserting "multi-hazard";

(B) by striking "provides protection against" and inserting "examines reduction of"; and

(C) by redesignating such subsection as subsection (b);

(4) by striking subsection (d);

(5) in subsection (e)—

(A) in paragraph (1), by striking the paragraph designation and all that follows through the end of the first sentence and inserting the following:

"(1) REQUIREMENT OF CONSISTENCY WITH APPROVED MITIGATION PLAN.—Amounts provided under this section may be used only for mitigation activities that are consistent with mitigation plans that are approved by the Administrator and identified under subparagraph (4).";

(B) by striking paragraphs (2), (3), and (4) and inserting the following new paragraphs:

"(2) REQUIREMENTS OF TECHNICAL FEASIBILITY, COST EFFECTIVENESS, AND INTEREST OF NFIF.—The Administrator may approve only mitigation activities that the Administrator determines are technically feasible and cost-effective and in the interest of, and represent savings to, the National Flood Insur-

ance Fund. In making such determinations, the Administrator shall take into consideration recognized benefits that are difficult to quantify.

"(3) PRIORITY FOR MITIGATION ASSISTANCE.—In providing grants under this section for mitigation activities, the Administrator shall give priority for funding to activities that the Administrator determines will result in the greatest savings to the National Flood Insurance Fund, including activities for—

"(A) severe repetitive loss structures;

"(B) repetitive loss structures; and

"(C) other subsets of structures as the Administrator may establish.";

(C) in paragraph (5)—

(i) by striking all of the matter that precedes subparagraph (A) and inserting the following:

"(4) ELIGIBLE ACTIVITIES.—Eligible activities may include—";

(ii) by striking subparagraphs (E) and (H);

(iii) by redesignating subparagraphs (D), (F), and (G) as subparagraphs (E), (G), and (H);

(iv) by inserting after subparagraph (C) the following new subparagraph:

"(D) elevation, relocation, and floodproofing of utilities (including equipment that serve structures);";

(v) by inserting after subparagraph (E), as so redesignated by clause (iii) of this subparagraph, the following new subparagraph:

"(F) the development or update of State, local, or Indian tribal mitigation plans which meet the planning criteria established by the Administrator, except that the amount from grants under this section that may be used under this subparagraph may not exceed $50,000 for any mitigation plan of a State or $25,000 for any mitigation plan of a local government or Indian tribe;";

(vi) in subparagraph (H); as so redesignated by clause (iii) of this subparagraph, by striking "and" at the end; and

(vii) by adding at the end the following new subparagraphs:

"(I) other mitigation activities not described in subparagraphs (A) through (G) or the regulations issued under subparagraph (H), that are described in the mitigation plan of a State, community, or Indian tribe; and

"(J) personnel costs for State staff that provide technical assistance to communities to identify eligible activities, to develop grant applications, and to implement grants awarded under this section, not to exceed $50,000 per State in any Federal fiscal year, so long as the State applied for and was awarded at least $1,000,000 in grants available under this section in the prior Federal fiscal year; the requirements of subsections (d)(1) and (d)(2) shall not apply to the activity under this subparagraph.";

(D) by adding at the end the following new paragraph:

"(6) ELIGIBILITY OF DEMOLITION AND REBUILDING OF PROPERTIES.—The Administrator shall consider as an eligible activity the demolition and rebuilding of properties to at least base flood elevation or greater, if required by the Administrator or if required by any State regulation or local ordinance, and in accordance with criteria established by the Administrator."; and

(E) by redesignating such subsection as subsection (c);

(6) by striking subsections (f), (g), and (h) and inserting the following new subsection:

"(d) MATCHING REQUIREMENT.—The Administrator may provide grants for eligible mitigation activities as follows:

"(1) SEVERE REPETITIVE LOSS STRUCTURES.—In the case of mitigation activities to severe repetitive loss structures, in an amount up to 100 percent of all eligible costs.

"(2) REPETITIVE LOSS STRUCTURES.—In the case of mitigation activities to repetitive loss structures, in an amount up to 90 percent of all eligible costs.

"(3) OTHER MITIGATION ACTIVITIES.— In the case of all other mitigation activities, in an amount up to 75 percent of all eligible costs.";

(7) in subsection (i)—

(A) in paragraph (2)—

(i) by striking "certified under subsection (g)" and inserting "required under subsection (d)"; and

(ii) by striking "3 times the amount" and inserting "the amount"; and

(B) by redesignating such subsection as subsection (e);

(8) in subsection (j)—

(A) by striking "Riegle Community Development and Regulatory Improvement Act of 1994" and inserting "Flood Insurance Reform Act of 2012";

(B) by redesignating such subsection as subsection (f); and

(9) by striking subsections (k) and (m) and inserting the following new subsections:

"(g) FAILURE TO MAKE GRANT AWARD WITHIN 5 YEARS.—For any application for a grant under this section for which the Administrator fails to make a grant award within 5 years of the date of application, the grant application shall be considered to be denied and any funding amounts allocated for such grant applications shall remain in the National Flood Mitigation Fund under section 1367 of this title and shall be made available for grants under this section.

"(h) LIMITATION ON FUNDING FOR MITIGATION ACTIVITIES FOR SEVERE REPETITIVE LOSS STRUCTURES.—The amount used pursuant to section 1310(a)(8) in any fiscal year may not exceed $40,000,000 and shall remain available until expended.

"(i) DEFINITIONS.—For purposes of this section, the following definitions shall apply:

"(1) COMMUNITY.—The term 'community' means—

"(A) a political subdivision that—

"(i) has zoning and building code jurisdiction over a particular area having special flood hazards, and

"(ii) is participating in the national flood insurance program; or

"(B) a political subdivision of a State, or other authority, that is designated by political subdivisions, all of which meet the requirements of subparagraph (A), to administer grants for mitigation activities for such political subdivisions.

"(2) REPETITIVE LOSS STRUCTURE.—The term 'repetitive loss structure' has the meaning given such term in section 1370.

"(3) SEVERE REPETITIVE LOSS STRUCTURE.—The term 'severe repetitive loss structure' means a structure that—

"(A) is covered under a contract for flood insurance made available under this title; and

"(B) has incurred flood-related damage—

"(i) for which 4 or more separate claims payments have been made under flood insurance coverage under this title, with the amount of each such claim exceeding $15,000, and with the cumulative amount of such claims payments exceeding $60,000; or

"(ii) for which at least 2 separate claims payments have been made under such coverage, with the cumulative amount of such claims exceeding the value of the insured structure.".

(b) ELIMINATION OF GRANTS PROGRAM FOR REPETITIVE INSURANCE CLAIMS PROPERTIES.—Chapter I of the National Flood Insurance Act of 1968 is amended by striking section 1323 (42 U.S.C. 4030).

(c) ELIMINATION OF PILOT PROGRAM FOR MITIGATION OF SEVERE REPETITIVE LOSS PROPERTIES.—Chapter III of the National Flood Insurance Act of 1968 is amended by striking section 1361A (42 U.S.C. 4102a).

(d) NATIONAL FLOOD INSURANCE FUND.—Section 1310(a) of the National Flood Insurance Act of 1968 (42 U.S.C. 4017(a)) is amended—

(1) in paragraph (7), by inserting "and" after the semicolon; and

(2) by striking paragraphs (8) and (9).

(e) NATIONAL FLOOD MITIGATION FUND.—Section 1367 of the National Flood Insurance Act of 1968 (42 U.S.C. 4104d) is amended—

(1) in subsection (b)—

(A) by striking paragraph (1) and inserting the following new paragraph:

"(1) in each fiscal year, from the National Flood Insurance Fund in amounts not exceeding $90,000,000 to remain available until expended, of which—

"(A) not more than $40,000,000 shall be available pursuant to subsection (a) of this section only for assistance described in section 1366(a)(1);

"(B) not more than $40,000,000 shall be available pursuant to subsection (a) of this section only for assistance described in section 1366(a)(2); and

"(C) not more than $10,000,000 shall be available pursuant to subsection (a) of this section only for assistance described in section 1366(a)(3).".

(B) in paragraph (3), by striking "section 1366(i)" and inserting "section 1366(e)";

(2) in subsection (c), by striking "sections 1366 and 1323" and inserting "section 1366";

(3) by redesignating subsections (d) and (e) as subsections (f) and (g), respectively; and

(4) by inserting after subsection (c) the following new subsections:

"(d) PROHIBITION ON OFFSETTING COLLECTIONS.—Notwithstanding any other provision of this title, amounts made available pursuant to this section shall not be subject to offsetting collections through premium rates for flood insurance coverage under this title.

"(e) CONTINUED AVAILABILITY AND REALLOCATION.—Any amounts made available pursuant to subparagraph (A), (B), or (C) of subsection (b)(1) that are not used in any fiscal year shall continue to be available for the purposes specified in such subparagraph of subsection (b)(1) pursuant to which such amounts were made available, unless the Administrator determines that reallocation of such unused amounts to meet demonstrated need for other mitigation activities under section 1366 is in the best interest of the National Flood Insurance Fund.".

(f) INCREASED COST OF COMPLIANCE COVERAGE.—Section 1304(b)(4) of the National Flood Insurance Act of 1968 (42 U.S.C. 4011(b)(4)) is amended—

(1) by striking subparagraph (B); and

(2) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively.

SEC. 352. NOTIFICATION TO HOMEOWNERS REGARDING MANDATORY PURCHASE REQUIREMENT APPLICABILITY AND RATE PHASE-INS.

Section 201 of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4105) is amended by adding at the end the following new subsection:

"(f) ANNUAL NOTIFICATION.—The Administrator, in consultation with affected communities, shall establish and carry out a plan to notify residents of areas having special flood hazards, on an annual basis—

"(1) that they reside in such an area;

"(2) of the geographical boundaries of such area;

"(3) of whether section 1308(g) of the National Flood Insurance Act of 1968 applies to properties within such area;

"(4) of the provisions of section 102 requiring purchase of flood insurance coverage for properties located in such an area, including the date on which such provisions apply with respect to such area, taking into consideration section 102(i); and

"(5) of a general estimate of what similar homeowners in similar areas typically pay for flood insurance coverage, taking into consideration section 1308(g) of the National Flood Insurance Act of 1968.".

SEC. 353. NOTIFICATION TO MEMBERS OF CONGRESS OF FLOOD MAP REVISIONS AND UPDATES.

Section 1360 of the National Flood Insurance Act of 1968 (42 U.S.C. 4101), as amended by the preceding provisions of this subtitle, is further amended by adding at the end the following new subsection:

"(l) NOTIFICATION TO MEMBERS OF CONGRESS OF MAP MODERNIZATION.—Upon any revision or update of any floodplain area or flood-risk zone pursuant to subsection (f), any decision pursuant to subsection (f)(1) that such revision or update is necessary, any issuance of preliminary maps for such revision or updating, or any other significant action relating to any such revision or update, the Administrator shall notify the Senators for each State affected, and each Member of the House of Representatives for each congressional district affected, by such revision or update in writing of the action taken.".

SEC. 354. NOTIFICATION AND APPEAL OF MAP CHANGES; NOTIFICATION TO COMMUNITIES OF ESTABLISHMENT OF FLOOD ELEVATIONS.

Section 1363 of the National Flood Insurance Act of 1968 (42 U.S.C. 4104) is amended by striking the section designation and all that follows through the end of subsection (a) and inserting the following:

"SEC. 1363. (a) In establishing projected flood elevations for land use purposes with respect to any community pursuant to section 1361, the Administrator shall first propose such determinations—

"(1) by providing the chief executive officer of each community affected by the proposed elevations, by certified mail, with a return receipt requested, notice of the elevations, including a copy of the maps for the elevations for such community and a statement explaining the process under this section to appeal for changes in such elevations;

"(2) by causing notice of such elevations to be published in the Federal Register, which notice shall include information sufficient to identify the elevation determinations and the communities affected, information explaining how to obtain copies of the elevations, and a statement explaining the process under this section to appeal for changes in the elevations;

"(3) by publishing in a prominent local newspaper the elevations, a description of the appeals process for flood determinations, and the mailing address and telephone number of a person the owner may contact for more information or to initiate an appeal;

"(4) by providing written notification, by first class mail, to each owner of real property affected by the proposed elevations of—

"(A) the status of such property, both prior to and after the effective date of the proposed determination, with respect to flood zone and flood insurance requirements under this Act and the Flood Disaster Protection Act of 1973;

"(B) the process under this section to appeal a flood elevation determination; and

"(C) the mailing address and phone number of a person the owner may contact for more information or to initiate an appeal; and".

SEC. 355. NOTIFICATION TO TENANTS OF AVAILABILITY OF CONTENTS INSURANCE.

The National Flood Insurance Act of 1968 is amended by inserting after section 1308 (42 U.S.C. 4015) the following new section:

"SEC. 1308A. NOTIFICATION TO TENANTS OF AVAILABILITY OF CONTENTS INSURANCE.

"(a) IN GENERAL.—The Administrator shall, upon entering into a contract for flood insurance coverage under this title for any property—

"(1) provide to the insured sufficient copies of the notice developed pursuant to subsection (b); and

"(2) require the insured to provide a copy of the notice, or otherwise provide notification of the information under subsection (b) in the manner that the manager or landlord deems most appropriate, to each such tenant and to each new tenant upon commencement of such a tenancy.

"(b) NOTICE.—Notice to a tenant of a property in accordance with this subsection is written notice that clearly informs a tenant—

"(1) whether the property is located in an area having special flood hazards;

"(2) that flood insurance coverage is available under the national flood insurance program under this title for contents of the unit or structure leased by the tenant;

"(3) of the maximum amount of such coverage for contents available under this title at that time; and

"(4) of where to obtain information regarding how to obtain such coverage, including a telephone number, mailing address, and Internet site of the Administrator where such information is available.".

SEC. 356. NOTIFICATION TO POLICY HOLDERS REGARDING DIRECT MANAGEMENT OF POLICY BY FEMA.

Part C of chapter II of the National Flood Insurance Act of 1968 (42 U.S.C. 4081 et seq.) is amended by adding at the end the following new section:

"SEC. 1349. NOTIFICATION TO POLICY HOLDERS REGARDING DIRECT MANAGEMENT OF POLICY BY FEMA.

"(a) NOTIFICATION.—Not later than 60 days before the date on which a transferred flood insurance policy expires, and annually thereafter until such time as the Federal Emergency Management Agency is no longer directly administering such policy, the Administrator shall notify the holder of such policy that—

"(1) the Federal Emergency Management Agency is directly administering the policy;

"(2) such holder may purchase flood insurance that is directly administered by an insurance company; and

"(3) purchasing flood insurance offered under the National Flood Insurance Program that is directly administered by an insurance company will not alter the coverage provided or the

premiums charged to such holder that otherwise would be provided or charged if the policy was directly administered by the Federal Emergency Management Agency.

"(b) DEFINITION.—In this section, the term 'transferred flood insurance policy' means a flood insurance policy that—

"(1) was directly administered by an insurance company at the time the policy was originally purchased by the policy holder; and

"(2) at the time of renewal of the policy, direct administration of the policy was or will be transferred to the Federal Emergency Management Agency.".

SEC. 357. NOTICE OF AVAILABILITY OF FLOOD INSURANCE AND ESCROW IN RESPA GOOD FAITH ESTIMATE.

Subsection (c) of section 5 of the Real Estate Settlement Procedures Act of 1974 (12 U.S.C. 2604(c)) is amended by adding at the end the following new sentence: "Each such good faith estimate shall include the following conspicuous statements and information: (1) that flood insurance coverage for residential real estate is generally available under the national flood insurance program whether or not the real estate is located in an area having special flood hazards and that, to obtain such coverage, a home owner or purchaser should contact the national flood insurance program; (2) a telephone number and a location on the Internet by which a home owner or purchaser can contact the national flood insurance program; and (3) that the escrowing of flood insurance payments is required for many loans under section 102(d) of the Flood Disaster Protection Act of 1973, and may be a convenient and available option with respect to other loans.".

SEC. 358. REIMBURSEMENT FOR COSTS INCURRED BY HOMEOWNERS AND COMMUNITIES OBTAINING LETTERS OF MAP AMENDMENT OR REVISION.

(a) IN GENERAL.—Section 1360 of the National Flood Insurance Act of 1968 (42 U.S.C. 4101), as amended by the preceding provisions of this subtitle, is further amended by adding at the end the following new subsection:

"(m) REIMBURSEMENT.—

"(1) REQUIREMENT UPON BONA FIDE ERROR.—If an owner of any property located in an area described in section 102(i)(3) of the Flood Disaster Protection Act of 1973, or a community in which such a property is located, obtains a letter of map amendment, or a letter of map revision, due to a bona fide error on the part of the Administrator of the Federal Emergency Management Agency, the Administrator shall reimburse such owner, or such entity or jurisdiction acting on such owner's behalf, or such community, as applicable, for any reasonable costs incurred in obtaining such letter.

"(2) REASONABLE COSTS.—The Administrator shall, by regulation or notice, determine a reasonable amount of costs to be reimbursed under paragraph (1), except that such costs shall not include legal or attorneys fees. In determining the reasonableness of costs, the Administrator shall only consider the actual costs to the owner or community, as applicable, of utilizing the services of an engineer, surveyor, or similar services.".

(b) REGULATIONS.—Not later than 90 days after the date of the enactment of this Act, the Administrator of the Federal Emergency Management Agency shall issue the regulations or notice required under section 1360(m)(2) of the National Flood Insurance Act of 1968, as added by the amendment made by subsection (a) of this section.

SEC. 359. ENHANCED COMMUNICATION WITH CERTAIN COMMUNITIES DURING MAP UPDATING PROCESS.

Section 1360 of the National Flood Insurance Act of 1968 (42 U.S.C. 4101), as amended by the preceding provisions of this subtitle, is further amended by adding at the end the following new subsection:

"(n) ENHANCED COMMUNICATION WITH CERTAIN COMMUNITIES DURING MAP UPDATING PROCESS.—In updating flood insurance maps under this section, the Administrator shall communicate with communities located in areas where flood insurance rate maps have not been updated in 20 years or more and the appropriate State emergency agencies to resolve outstanding issues, provide technical assistance, and disseminate all necessary information to reduce the prevalence of outdated maps in flood-prone areas.".

SEC. 360. NOTIFICATION TO RESIDENTS NEWLY INCLUDED IN FLOOD HAZARD AREAS.

Section 1360 of the National Flood Insurance Act of 1968 (42 U.S.C. 4101), as amended by the preceding provisions of this subtitle, is further amended by adding at the end the following new subsection:

"(o) NOTIFICATION TO RESIDENTS NEWLY INCLUDED IN FLOOD HAZARD AREA.—In revising or updating any areas having special flood hazards, the Administrator shall provide to each owner of a property to be newly included in such a special flood hazard area, at the time of issuance of such proposed revised or updated flood insurance maps, a copy of the proposed revised or updated flood insurance maps together with information regarding the appeals process under section 1363 (42 U.S.C. 4104).".

SEC. 361. TREATMENT OF SWIMMING POOL ENCLOSURES OUTSIDE OF HURRICANE SEASON.

Chapter I of the National Flood Insurance Act of 1968 (42 U.S.C. 4001 et seq.) is amended by adding at the end the following new section:

"SEC. 1325. TREATMENT OF SWIMMING POOL ENCLOSURES OUTSIDE OF HURRICANE SEASON.

"In the case of any property that is otherwise in compliance with the coverage and building requirements of the national flood insurance program, the presence of an enclosed swimming pool located at ground level or in the space below the lowest floor of a building after November 30 and before June 1 of any year shall have no effect on the terms of coverage or the ability to receive coverage for such building under the national flood insurance program established pursuant to this title, if the pool is enclosed with nonsupporting breakaway walls.".

SEC. 362. INFORMATION REGARDING MULTIPLE PERILS CLAIMS.

Section 1345 of the National Flood Insurance Act of 1968 (42 U.S.C. 4081) is amended by adding at the end the following new subsection:

"(d) INFORMATION REGARDING MULTIPLE PERILS CLAIMS.—

"(1) IN GENERAL.—Subject to paragraph (2), if an insured having flood insurance coverage under a policy issued under the program under this title by the Administrator or a company, insurer, or entity offering flood insurance coverage under such program (in this subsection referred to as a 'participating company') has wind or other homeowners coverage from any company, insurer, or other entity covering property covered by such flood insurance, in the case of damage to such property that may have been caused by flood or by wind, the Administrator and the participating company, upon the request of the insured, shall provide to the insured, within 30 days of such request—

"(A) a copy of the estimate of structure damage;

"(B) proofs of loss;

"(C) any expert or engineering reports or documents commissioned by or relied upon by the Administrator or participating company in determining whether the damage was caused by flood or any other peril; and

"(D) the Administrator's or the participating company's final determination on the claim.

"(2) TIMING.—Paragraph (1) shall apply only with respect to a request described in such paragraph made by an insured after the Administrator or the participating company, or both, as applicable, have issued a final decision on the flood claim involved and resolution of all appeals with respect to such claim.".

SEC. 363. FEMA AUTHORITY TO REJECT TRANSFER OF POLICIES.

Section 1345 of the National Flood Insurance Act of 1968 (42 U.S.C. 4081) is amended by adding at the end the following new subsection:

"(e) FEMA AUTHORITY TO REJECT TRANSFER OF POLICIES.—Notwithstanding any other provision of this Act, the Administrator may, at the discretion of the Administrator, refuse to accept the transfer of the administration of policies for coverage under the flood insurance program under this title that are written and administered by any insurance company or other insurer, or any insurance agent or broker.".

SEC. 364. APPEALS.

(a) TELEVISION AND RADIO ANNOUNCEMENT.—Section 1363 of the National Flood Insurance Act of 1968 (42 U.S.C. 4104), as amended by the preceding provisions of this subtitle, is further amended—

(1) in subsection (a), by adding at the end the following new paragraph:

"(5) by notifying a local television and radio station,"; and

(2) in the first sentence of subsection (b), by inserting before the period at the end the following: "and shall notify a

local television and radio station at least once during the same 10-day period".

(b) EXTENSION OF APPEALS PERIOD.—Subsection (b) of section 1363 of the National Flood Insurance Act of 1968 (42 U.S.C. 4104(b)) is amended—

(1) by striking "(b) The Director" and inserting "(b)(1) The Administrator"; and

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

"(2) The Administrator shall grant an extension of the 90-day period for appeals referred to in paragraph (1) for 90 additional days if an affected community certifies to the Administrator, after the expiration of at least 60 days of such period, that the community—

"(A) believes there are property owners or lessees in the community who are unaware of such period for appeals; and

"(B) will utilize the extension under this paragraph to notify property owners or lessees who are affected by the proposed flood elevation determinations of the period for appeals and the opportunity to appeal the determinations proposed by the Administrator.".

(c) APPLICABILITY.—The amendments made by subsections (a) and (b) shall apply with respect to any flood elevation determination for any area in a community that has not, as of the date of the enactment of this Act, been issued a Letter of Final Determination for such determination under the flood insurance map modernization process.

SEC. 365. RESERVE FUND.

(a) ESTABLISHMENT.—Chapter I of the National Flood Insurance Act of 1968 is amended by inserting after section 1310 (42 U.S.C. 4017) the following new section:

"SEC. 1310A. RESERVE FUND.

"(a) ESTABLISHMENT OF RESERVE FUND.—In carrying out the flood insurance program authorized by this title, the Administrator shall establish in the Treasury of the United States a National Flood Insurance Reserve Fund (in this section referred to as the 'Reserve Fund') which shall—

"(1) be an account separate from any other accounts or funds available to the Administrator; and

"(2) be available for meeting the expected future obligations of the flood insurance program.

"(b) RESERVE RATIO.—Subject to the phase-in requirements under subsection (d), the Reserve Fund shall maintain a balance equal to—

"(1) 1 percent of the sum of the total potential loss exposure of all outstanding flood insurance policies in force in the prior fiscal year; or

"(2) such higher percentage as the Administrator determines to be appropriate, taking into consideration any circumstance that may raise a significant risk of substantial future losses to the Reserve Fund.

"(c) MAINTENANCE OF RESERVE RATIO.—

"(1) IN GENERAL.—The Administrator shall have the authority to establish, increase, or decrease the amount of aggre-

gate annual insurance premiums to be collected for any fiscal year necessary—

"(A) to maintain the reserve ratio required under subsection (b); and

"(B) to achieve such reserve ratio, if the actual balance of such reserve is below the amount required under subsection (b).

"(2) CONSIDERATIONS.—In exercising the authority under paragraph (1), the Administrator shall consider—

"(A) the expected operating expenses of the Reserve Fund;

"(B) the insurance loss expenditures under the flood insurance program;

"(C) any investment income generated under the flood insurance program; and

"(D) any other factor that the Administrator determines appropriate.

"(3) LIMITATIONS.—In exercising the authority under paragraph (1), the Administrator shall be subject to all other provisions of this Act, including any provisions relating to chargeable premium rates and annual increases of such rates.

"(d) PHASE-IN REQUIREMENTS.—The phase-in requirements under this subsection are as follows:

"(1) IN GENERAL.—Beginning in fiscal year 2012 and not ending until the fiscal year in which the ratio required under subsection (b) is achieved, in each such fiscal year the Administrator shall place in the Reserve Fund an amount equal to not less than 7.5 percent of the reserve ratio required under subsection (b).

"(2) AMOUNT SATISFIED.—As soon as the ratio required under subsection (b) is achieved, and except as provided in paragraph (3), the Administrator shall not be required to set aside any amounts for the Reserve Fund.

"(3) EXCEPTION.—If at any time after the ratio required under subsection (b) is achieved, the Reserve Fund falls below the required ratio under subsection (b), the Administrator shall place in the Reserve Fund for that fiscal year an amount equal to not less than 7.5 percent of the reserve ratio required under subsection (b).

"(e) LIMITATION ON RESERVE RATIO.—In any given fiscal year, if the Administrator determines that the reserve ratio required under subsection (b) cannot be achieved, the Administrator shall submit a report to the Congress that—

"(1) describes and details the specific concerns of the Administrator regarding such consequences;

"(2) demonstrates how such consequences would harm the long-term financial soundness of the flood insurance program; and

"(3) indicates the maximum attainable reserve ratio for that particular fiscal year.

"(f) AVAILABILITY OF AMOUNTS.—The reserve ratio requirements under subsection (b) and the phase-in requirements under subsection (d) shall be subject to the availability of amounts in the

National Flood Insurance Fund for transfer under section 1310(a)(10), as provided in section 1310(f).".

(b) FUNDING.—Subsection (a) of section 1310 of the National Flood Insurance Act of 1968 (42 U.S.C. 4017(a)), as amended by the preceding provisions of this Act, is further amended by adding at the end the following new paragraph:

"(10) for transfers to the National Flood Insurance Reserve Fund under section 1310A, in accordance with such section.".

SEC. 366. CDBG ELIGIBILITY FOR FLOOD INSURANCE OUTREACH ACTIVITIES AND COMMUNITY BUILDING CODE ADMINISTRATION GRANTS.

Section 105(a) of the Housing and Community Development Act of 1974 (42 U.S.C. 5305(a)) is amended—

(1) in paragraph (24), by striking "and" at the end;

(2) in paragraph (25), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

"(26) supplementing existing State or local funding for administration of building code enforcement by local building code enforcement departments, including for increasing staffing, providing staff training, increasing staff competence and professional qualifications, and supporting individual certification or departmental accreditation, and for capital expenditures specifically dedicated to the administration of the building code enforcement department, except that, to be eligible to use amounts as provided in this paragraph—

"(A) a building code enforcement department shall provide matching, non-Federal funds to be used in conjunction with amounts used under this paragraph in an amount—

"(i) in the case of a building code enforcement department serving an area with a population of more than 50,000, equal to not less than 50 percent of the total amount of any funds made available under this title that are used under this paragraph;

"(ii) in the case of a building code enforcement department serving an area with a population of between 20,001 and 50,000, equal to not less than 25 percent of the total amount of any funds made available under this title that are used under this paragraph; and

"(iii) in the case of a building code enforcement department serving an area with a population of less than 20,000, equal to not less than 12.5 percent of the total amount of any funds made available under this title that are used under this paragraph,

except that the Secretary may waive the matching fund requirements under this subparagraph, in whole or in part, based upon the level of economic distress of the jurisdiction in which is located the local building code enforcement department that is using amounts for purposes under this paragraph, and shall waive such matching fund requirements in whole for any recipient jurisdiction that has dedicated all building code permitting fees to the conduct of local building code enforcement; and

"(B) any building code enforcement department using funds made available under this title for purposes under this paragraph shall empanel a code administration and enforcement team consisting of at least 1 full-time building code enforcement officer, a city planner, and a health planner or similar officer; and

"(27) provision of assistance to local governmental agencies responsible for floodplain management activities (including such agencies of Indians tribes, as such term is defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)) in communities that participate in the national flood insurance program under the National Flood Insurance Act of 1968 (42 U.S.C. 4001 et seq.), only for carrying out outreach activities to encourage and facilitate the purchase of flood insurance protection under such Act by owners and renters of properties in such communities and to promote educational activities that increase awareness of flood risk reduction; except that—

"(A) amounts used as provided under this paragraph shall be used only for activities designed to—

"(i) identify owners and renters of properties in communities that participate in the national flood insurance program, including owners of residential and commercial properties;

"(ii) notify such owners and renters when their properties become included in, or when they are excluded from, an area having special flood hazards and the effect of such inclusion or exclusion on the applicability of the mandatory flood insurance purchase requirement under section 102 of the Flood Disaster Protection Act of 1973 (42 U.S.C. 4012a) to such properties;

"(iii) educate such owners and renters regarding the flood risk and reduction of this risk in their community, including the continued flood risks to areas that are no longer subject to the flood insurance mandatory purchase requirement;

"(iv) educate such owners and renters regarding the benefits and costs of maintaining or acquiring flood insurance, including, where applicable, lower-cost preferred risk policies under this title for such properties and the contents of such properties;

"(v) encourage such owners and renters to maintain or acquire such coverage;

"(vi) notify such owners of where to obtain information regarding how to obtain such coverage, including a telephone number, mailing address, and Internet site of the Administrator of the Federal Emergency Management Agency (in this paragraph referred to as the 'Administrator') where such information is available; and

"(vii) educate local real estate agents in communities participating in the national flood insurance program regarding the program and the availability of

coverage under the program for owners and renters of properties in such communities, and establish coordination and liaisons with such real estate agents to facilitate purchase of coverage under the National Flood Insurance Act of 1968 and increase awareness of flood risk reduction;

"(B) in any fiscal year, a local governmental agency may not use an amount under this paragraph that exceeds 3 times the amount that the agency certifies, as the Secretary, in consultation with the Administrator, shall require, that the agency will contribute from non-Federal funds to be used with such amounts used under this paragraph only for carrying out activities described in subparagraph (A); and for purposes of this subparagraph, the term 'non-Federal funds' includes State or local government agency amounts, in-kind contributions, any salary paid to staff to carry out the eligible activities of the local governmental agency involved, the value of the time and services contributed by volunteers to carry out such services (at a rate determined by the Secretary), and the value of any donated material or building and the value of any lease on a building;

"(C) a local governmental agency that uses amounts as provided under this paragraph may coordinate or contract with other agencies and entities having particular capacities, specialties, or experience with respect to certain populations or constituencies, including elderly or disabled families or persons, to carry out activities described in subparagraph (A) with respect to such populations or constituencies; and

"(D) each local government agency that uses amounts as provided under this paragraph shall submit a report to the Secretary and the Administrator, not later than 12 months after such amounts are first received, which shall include such information as the Secretary and the Administrator jointly consider appropriate to describe the activities conducted using such amounts and the effect of such activities on the retention or acquisition of flood insurance coverage.".

SEC. 367. TECHNICAL CORRECTIONS.

(a) FLOOD DISASTER PROTECTION ACT OF 1973.—The Flood Disaster Protection Act of 1973 (42 U.S.C. 4002 et seq.) is amended—

(1) by striking "Director" each place such term appears, except in section 102(f)(3) (42 U.S.C. 4012a(f)(3)), and inserting "Administrator"; and

(2) in section 201(b) (42 U.S.C. 4105(b)), by striking "Director's" and inserting "Administrator's".

(b) NATIONAL FLOOD INSURANCE ACT OF 1968.—The National Flood Insurance Act of 1968 (42 U.S.C. 4001 et seq.) is amended—

(1) by striking "Director" each place such term appears and inserting "Administrator"; and

(2) in section 1363 (42 U.S.C. 4104), by striking "Director's" each place such term appears and inserting "Administrator's".

(c) FEDERAL FLOOD INSURANCE ACT OF 1956.—Section 15(e) of the Federal Flood Insurance Act of 1956 (42 U.S.C. 2414(e)) is amended by striking "Director" each place such term appears and inserting "Administrator".

SEC. 368. REQUIRING COMPETITION FOR NATIONAL FLOOD INSURANCE PROGRAM POLICIES.

(a) REPORT.—Not later than the expiration of the 90-day period beginning upon the date of the enactment of this Act, the Administrator of the Federal Emergency Management Agency, in consultation with insurance companies, insurance agents and other organizations with which the Administrator has contracted, shall submit to the Congress a report describing procedures and policies that the Administrator shall implement to limit the percentage of policies for flood insurance coverage under the national flood insurance program that are directly managed by the Agency to not more than 10 percent of the aggregate number of flood insurance policies in force under such program.

(b) IMPLEMENTATION.—Upon submission of the report under subsection (a) to the Congress, the Administrator shall implement the policies and procedures described in the report. The Administrator shall, not later than the expiration of the 12-month period beginning upon submission of such report, reduce the number of policies for flood insurance coverage that are directly managed by the Agency, or by the Agency's direct servicing contractor that is not an insurer, to not more than 10 percent of the aggregate number of flood insurance policies in force as of the expiration of such 12-month period.

(c) CONTINUATION OF CURRENT AGENT RELATIONSHIPS.—In carrying out subsection (b), the Administrator shall ensure that—

(1) agents selling or servicing policies described in such subsection are not prevented from continuing to sell or service such policies; and

(2) insurance companies are not prevented from waiving any limitation such companies could otherwise enforce to limit any such activity.

SEC. 369. STUDIES OF VOLUNTARY COMMUNITY-BASED FLOOD INSURANCE OPTIONS.

(a) STUDIES.—The Administrator of the Federal Emergency Management Agency and the Comptroller General of the United States shall each conduct a separate study to assess options, methods, and strategies for offering voluntary community-based flood insurance policy options and incorporating such options into the national flood insurance program. Such studies shall take into consideration and analyze how the policy options would affect communities having varying economic bases, geographic locations, flood hazard characteristics or classifications, and flood management approaches.

(b) REPORTS.—Not later than the expiration of the 18-month period beginning on the date of the enactment of this Act, the Administrator of the Federal Emergency Management Agency and the Comptroller General of the United States shall each submit a report to the Committee on Financial Services of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate on the results and conclusions of the study

such agency conducted under subsection (a), and each such report shall include recommendations for the best manner to incorporate voluntary community-based flood insurance options into the national flood insurance program and for a strategy to implement such options that would encourage communities to undertake flood mitigation activities.

SEC. 370. REPORT ON INCLUSION OF BUILDING CODES IN FLOODPLAIN MANAGEMENT CRITERIA.

Not later than the expiration of the 6-month period beginning on the date of the enactment of this Act, the Administrator of the Federal Emergency Management Agency shall conduct a study and submit a report to the Committee on Financial Services of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate regarding the impact, effectiveness, and feasibility of amending section 1361 of the National Flood Insurance Act of 1968 (42 U.S.C. 4102) to include widely used and nationally recognized building codes as part of the floodplain management criteria developed under such section, and shall determine—

(1) the regulatory, financial, and economic impacts of such a building code requirement on homeowners, States and local communities, local land use policies, and the Federal Emergency Management Agency;

(2) the resources required of State and local communities to administer and enforce such a building code requirement;

(3) the effectiveness of such a building code requirement in reducing flood-related damage to buildings and contents;

(4) the impact of such a building code requirement on the actuarial soundness of the National Flood Insurance Program;

(5) the effectiveness of nationally recognized codes in allowing innovative materials and systems for flood-resistant construction;

(6) the feasibility and effectiveness of providing an incentive in lower premium rates for flood insurance coverage under such Act for structures meeting whichever of such widely used and nationally recognized building code or any applicable local building code provides greater protection from flood damage;

(7) the impact of such a building code requirement on rural communities with different building code challenges than more urban environments; and

(8) the impact of such a building code requirement on Indian reservations.

SEC. 371. STUDY ON GRADUATED RISK.

(a) STUDY.—The National Academy of Sciences shall conduct a study exploring methods for understanding graduated risk behind levees and the associated land development, insurance, and risk communication dimensions, which shall—

(1) research, review, and recommend current best practices for estimating direct annualized flood losses behind levees for residential and commercial structures;

(2) rank such practices based on their best value, balancing cost, scientific integrity, and the inherent uncertainties associated with all aspects of the loss estimate, including

geotechnical engineering, flood frequency estimates, economic value, and direct damages;

(3) research, review, and identify current best floodplain management and land use practices behind levees that effectively balance social, economic, and environmental considerations as part of an overall flood risk management strategy;

(4) identify examples where such practices have proven effective and recommend methods and processes by which they could be applied more broadly across the United States, given the variety of different flood risks, State and local legal frameworks, and evolving judicial opinions;

(5) research, review, and identify a variety of flood insurance pricing options for flood hazards behind levees which are actuarially sound and based on the flood risk data developed using the top three best value approaches identified pursuant to paragraph (1);

(6) evaluate and recommend methods to reduce insurance costs through creative arrangements between insureds and insurers while keeping a clear accounting of how much financial risk is being borne by various parties such that the entire risk is accounted for, including establishment of explicit limits on disaster aid or other assistance in the event of a flood; and

(7) taking into consideration the recommendations pursuant to paragraphs (1) through (3), recommend approaches to communicating the associated risks to community officials, homeowners, and other residents.

(b) REPORT.—Not later than the expiration of the 12-month period beginning on the date of the enactment of this Act, the National Academy of Sciences shall submit a report to the Committees on Financial Services and Science, Space, and Technology of the House of Representatives and the Committees on Banking, Housing, and Urban Affairs and Commerce, Science and Transportation of the Senate on the study under subsection (a) including the information and recommendations required under such subsection.

SEC. 372. REPORT ON FLOOD-IN-PROGRESS DETERMINATION.

The Administrator of the Federal Emergency Management Agency shall review the processes and procedures for determining that a flood event has commenced or is in progress for purposes of flood insurance coverage made available under the national flood insurance program under the National Flood Insurance Act of 1968 and for providing public notification that such an event has commenced or is in progress. In such review, the Administrator shall take into consideration the effects and implications that weather conditions, such as rainfall, snowfall, projected snowmelt, existing water levels, and other conditions have on the determination that a flood event has commenced or is in progress. Not later than the expiration of the 6-month period beginning upon the date of the enactment of this Act, the Administrator shall submit a report to the Congress setting forth the results and conclusions of the review undertaken pursuant to this section and any actions undertaken or proposed actions to be taken to provide for a more precise and technical determination that a flooding event has commenced or is in progress.

SEC. 373. STUDY ON REPAYING FLOOD INSURANCE DEBT.

Not later than the expiration of the 6-month period beginning on the date of the enactment of this Act, the Administrator of the Federal Emergency Management Agency shall submit a report to the Congress setting forth a plan for repaying within 10 years all amounts, including any amounts previously borrowed but not yet repaid, owed pursuant to clause (2) of subsection (a) of section 1309 of the National Flood Insurance Act of 1968 (42 U.S.C. 4016(a)(2)).

SEC. 374. NO CAUSE OF ACTION.

No cause of action shall exist and no claim may be brought against the United States for violation of any notification requirement imposed upon the United States by this subtitle or any amendment made by this subtitle.

SEC. 375. AUTHORITY FOR THE CORPS OF ENGINEERS TO PROVIDE SPECIALIZED OR TECHNICAL SERVICES.

(a) IN GENERAL.—Notwithstanding any other provision of law, upon the request of a State or local government, the Secretary of the Army may evaluate a levee system that was designed or constructed by the Secretary for the purposes of the National Flood Insurance Program established under chapter 1 of the National Flood Insurance Act of 1968 (42 U.S.C. 4011 et seq.).

(b) REQUIREMENTS.—A levee system evaluation under subsection (a) shall—

(1) comply with applicable regulations related to areas protected by a levee system;

(2) be carried out in accordance with such procedures as the Secretary, in consultation with the Administrator of the Federal Emergency Management Agency, may establish; and

(3) be carried out only if the State or local government agrees to reimburse the Secretary for all cost associated with the performance of the activities.

Subtitle E—Repeal of the Office of Financial Research

SEC. 381. REPEAL OF THE OFFICE OF FINANCIAL RESEARCH.

(a) IN GENERAL.—Subtitle B of title I of the Dodd-Frank Wall Street Reform and Consumer Protection Act is hereby repealed.

(b) CONFORMING AMENDMENTS TO THE DODD-FRANK ACT.—The Dodd-Frank Wall Street Reform and Consumer Protection Act is amended—

(1) in section 102(a), by striking paragraph (5);

(2) in section 111—

(A) in subsection (b)(2)—

(i) by striking subparagraph (A); and

(ii) by redesignating subparagraphs (B), (C), (D), and (E) as subparagraphs (A), (B), (C), and (D), respectively;

(B) in subsection (c)(1), by striking "subparagraphs (C), (D), and (E)" and inserting "subparagraphs (B), (C), and (D)";

(3) in section 112—

(A) in subsection (a)(2)—

(i) in subparagraph (A), by striking "direct the Office of Financial Research to";

(ii) by striking subparagraph (B); and

(iii) by redesignating subparagraphs (C), (D), (E), (F), (G), (H), (I), (J), (K), (L), (M), and (N) as subparagraphs (B), (C), (D), (E), (F), (G), (H), (I), (J), (K), (L), and (M), respectively; and

(B) in subsection (d)—

(i) in paragraph (1), by striking "the Office of Financial Research, member agencies, and" and inserting "member agencies and";

(ii) in paragraph (2), by striking "the Office of Financial Research, any member agency, and" and inserting "any member agency and";

(iii) in paragraph (3)—

(I) by striking ", acting through the Office of Financial Research," each place it appears; and

(II) in subparagraph (B), by striking "the Office of Financial Research or"; and

(iv) in paragraph (5)(A), by striking ", the Office of Financial Research,";

(4) in section 116, by striking ", acting through the Office of Financial Research," each place it appears; and

(5) by striking section 118.

(c) CONFORMING AMENDMENT TO THE PAPERWORK REDUCTION ACT.—Effective as of the date specified in section 1100H of the Dodd-Frank Wall Street Reform and Consumer Protection Act, section 1100D(a) of such Act is amended to read as follows:

"(a) DESIGNATION AS AN INDEPENDENT AGENCY.—Section 3502(5) of subchapter I of chapter 35 of title 44, United States Code (commonly known as the Paperwork Reduction Act) is amended by inserting 'the Bureau of Consumer Financial Protection,' after 'the Securities and Exchange Commission,'.".

(d) TECHNICAL AMENDMENTS.—The table of contents for the Dodd-Frank Wall Street Reform and Consumer Protection Act is amended—

(1) by striking the item relating to section 118; and

(2) by striking the items relating to subtitle B of title I.

TITLE IV—COMMITTEE ON THE JUDICIARY

SEC. 401. SHORT TITLE.

This title may be cited as the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011".

SEC. 402. 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 ex-

ceed 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. 403. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this title shall limit 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. 404. 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. 405. 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 applicable 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 maintaining 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. 406. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

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

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

SEC. 407. DEFINITIONS.

In this title:

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

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

(3) 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 noneconomic damages, as such terms are defined in this section.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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.

(10) 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.

(11) 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.

(12) 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.

(13) 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)), respectively, including any component or raw material used therein, but excluding health care services.

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

(15) PUNITIVE DAMAGES.—The term "punitive damages" means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

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

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

SEC. 408. 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 title does not affect the application of the rule of law to such an action; and

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

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

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title 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. 409. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title preempt, subject to subsections

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

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

(2) prohibits the introduction of evidence regarding collateral source benefits, 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 title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This title 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 title or create a cause of action.

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

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 303(a); or

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

SEC. 410. APPLICABILITY; EFFECTIVE DATE.

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

TITLE V—COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

SEC. 501. RETIREMENT CONTRIBUTIONS.

(a) CIVIL SERVICE RETIREMENT SYSTEM.—

(1) INDIVIDUAL CONTRIBUTIONS.—Section 8334(c) of title 5, United States Code, is amended—

(A) by striking "(c) Each" and inserting "(c)(1) Each"; and

(B) by adding at the end the following:

"(2) Notwithstanding any other provision of this subsection, the applicable percentage of basic pay under this subsection shall—

"(A) except as provided in subparagraph (B) or (C), for purposes of computing an amount—

"(i) for a period in calendar year 2013, be equal to the applicable percentage under this subsection for calendar year 2012, plus an additional 1.5 percentage points;

"(ii) for a period in calendar year 2014, be equal to the applicable percentage under this subsection for calendar year 2013 (as determined under clause (i)), plus an additional 0.5 percentage point;

"(iii) for a period in calendar year 2015, 2016, or 2017, be equal to the applicable percentage under this subsection for the preceding calendar year (as determined under clause (ii) or this clause, as the case may be), plus an additional 1.0 percentage point; and

"(iv) for a period in any calendar year after 2017, be equal to the applicable percentage under this subsection for calendar year 2017 (as determined under clause (iii));

"(B) for purposes of computing an amount with respect to a Member for Member service—

"(i) for a period in calendar year 2013, be equal to the applicable percentage under this subsection for calendar year 2012, plus an additional 2.5 percentage points;

"(ii) for a period in calendar year 2014, 2015, 2016, or 2017, be equal to the applicable percentage under this subsection for the preceding calendar year (as determined under clause (i) or this clause, as the case may be), plus an additional 1.5 percentage points; and

"(iii) for a period in any calendar year after 2017, be equal to the applicable percentage under this subsection for calendar year 2017 (as determined under clause (ii)); and

"(C) for purposes of computing an amount with respect to a Member or employee for Congressional employee service—

"(i) for a period in calendar year 2013, be equal to the applicable percentage under this subsection for calendar year 2012, plus an additional 2.5 percentage points;

"(ii) for a period in calendar year 2014, 2015, 2016, or 2017, be equal to the applicable percentage under this subsection for the preceding calendar year (as determined under clause (i) or this clause, as the case may be), plus an additional 1.5 percentage points; and

"(iii) for a period in any calendar year after 2017, be equal to the applicable percentage under this subsection for calendar year 2017 (as determined under clause (ii)).".

(2) GOVERNMENT CONTRIBUTIONS.—Section 8334(a)(1)(B) of title 5, United States Code, is amended—

(A) in clause (i), by striking "Except as provided in clause (ii)," and inserting "Except as provided in clause (ii) or (iii),"; and

(B) by adding at the end the following:

"(iii) The amount to be contributed under clause (i) shall, with respect to a period in any year beginning after December 31, 2012, be equal to—

"(I) the amount which would otherwise apply under clause (i) with respect to such period, reduced by

"(II) the amount by which, with respect to such period, the withholding under subparagraph (A) exceeds the amount which would otherwise have been withheld from the basic pay of the employee or elected official involved under subparagraph (A) based on the percentage applicable under subsection (c) for calendar year 2012.".

(b) FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—Section 8422(a)(3) of title 5, United States Code, is amended—

(1) by redesignating subparagraph (B) as subparagraph (C);

(2) by inserting after subparagraph (A) the following:

"(B) Notwithstanding any other provision of this paragraph, the applicable percentage under this paragraph shall—

"(i) except as provided in clause (ii) or (iii), for purposes of computing an amount—

"(I) for a period in calendar year 2013, be equal to the applicable percentage under this paragraph for calendar year 2012, plus an additional 1.5 percentage points;

"(II) for a period in calendar year 2014, be equal to the applicable percentage under this paragraph for calendar year 2013 (as determined under subclause (I)), plus an additional 0.5 percentage point;

"(III) for a period in calendar year 2015, 2016, or 2017, be equal to the applicable percentage under this paragraph for the preceding calendar year (as determined under subclause (II) or this subclause, as the case may be), plus an additional 1.0 percentage point; and

"(IV) for a period in any calendar year after 2017, be equal to the applicable percentage under this paragraph for calendar year 2017 (as determined under subclause (III));

"(ii) for purposes of computing an amount with respect to a Member—

"(I) for a period in calendar year 2013, be equal to the applicable percentage under this paragraph for calendar year 2012, plus an additional 2.5 percentage points;

"(II) for a period in calendar year 2014, 2015, 2016, or 2017, be equal to the applicable percentage under this paragraph for the preceding calendar year (as determined under subclause (I) or this subclause, as the case may be), plus an additional 1.5 percentage points; and

"(III) for a period in any calendar year after 2017, be equal to the applicable percentage under this paragraph for calendar year 2017 (as determined under subclause (II)); and

"(iii) for purposes of computing an amount with respect to a Congressional employee—

"(I) for a period in calendar year 2013, 2014, 2015, 2016, or 2017, be equal to the applicable percentage under this paragraph for the preceding calendar year (including as increased under this subclause, if applicable), plus an additional 1.5 percentage points; and

"(II) for a period in any calendar year after 2017, be equal to the applicable percentage under this paragraph for calendar year 2017 (as determined under subclause (I)).."; and

(3) in subparagraph (C) (as so redesignated by paragraph (1))—

(A) by striking "9.3" each place it appears and inserting "12"; and

(B) by striking "9.8" each place it appears and inserting "12.5".

SEC. 502. ANNUITY SUPPLEMENT.

Section 8421(a) of title 5, United States Code, is amended—

(1) in paragraph (1), by striking "paragraph (3)" and inserting "paragraphs (3) and (4)";

(2) in paragraph (2), by striking "paragraph (3)" and inserting "paragraphs (3) and (4)"; and

(3) by adding at the end the following:

"(4)(A) Except as provided in subparagraph (B), no annuity supplement under this section shall be payable in the case of an individual who first becomes subject to this chapter after December 31, 2012.

"(B) Nothing in this paragraph applies in the case of an individual separating under subsection (d) or (e) of section 8412.".

SEC. 503. CONTRIBUTIONS TO THRIFT SAVINGS FUND OF PAYMENTS FOR ACCRUED OR ACCUMULATED LEAVE.

(a) AMENDMENTS RELATING TO CSRS.—Section 8351(b) of title 5, United States Code, is amended—

(1) by striking paragraph (2)(A) and inserting the following:

"(2)(A) An employee or Member may contribute to the Thrift Savings Fund in any pay period any amount of such employee's or Member's basic pay for such pay period, and may contribute (by direct transfer to the Fund) any part of any payment that the employee or Member receives for accumulated and accrued annual or vacation leave under section 5551 or 5552. Notwithstanding section 2105(e), in this paragraph the term 'employee' includes an employee of the United States Postal Service or of the Postal Regulatory Commission.";

(2) by striking subparagraph (B) of paragraph (2); and

(3) by redesignating subparagraph (C) of paragraph (2) as subparagraph (B).

(b) AMENDMENTS RELATING TO FERS.—Section 8432(a) of title 5, United States Code, is amended—

(1) by striking all that precedes paragraph (3) and inserting the following:

"(a)(1) An employee or Member—

"(A) may contribute to the Thrift Savings Fund in any pay period, pursuant to an election under subsection (b), any amount of such employee's or Member's basic pay for such pay period; and

"(B) may contribute (by direct transfer to the Fund) any part of any payment that the employee or Member receives for

accumulated and accrued annual or vacation leave under section 5551 or 5552.

"(2) Contributions made under paragraph (1)(A) pursuant to an election under subsection (b) shall, with respect to each pay period for which such election remains in effect, be made in accordance with a program of regular contributions provided in regulations prescribed by the Executive Director."; and

(2) by adding at the end the following:

"(4) Notwithstanding section 2105(e), in this subsection the term 'employee' includes an employee of the United States Postal Service or of the Postal Regulatory Commission.".

(c) REGULATIONS.—The Executive Director of the Federal Retirement Thrift Investment Board shall promulgate regulations to carry out the amendments made by this section.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect 1 year after the date of the enactment of this Act.

TITLE VI—COMMITTEE ON WAYS AND MEANS

Subtitle A—Recapture of Overpayments Resulting From Certain Federally-subsidized Health Insurance

SEC. 601. RECAPTURE OF OVERPAYMENTS RESULTING FROM CERTAIN FEDERALLY-SUBSIDIZED HEALTH INSURANCE.

(a) IN GENERAL.—Paragraph (2) of section 36B(f) of the Internal Revenue Code of 1986 is amended by striking subparagraph (B).

(b) CONFORMING AMENDMENT.—So much of paragraph (2) of section 36B(f) of such Code, as amended by subsection (a), as precedes "advance payments" is amended to read as follows:

"(2) EXCESS ADVANCE PAYMENTS.—If the".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

Subtitle B—Social Security Number Required to Claim the Refundable Portion of the Child Tax Credit

SEC. 611. SOCIAL SECURITY NUMBER REQUIRED TO CLAIM THE REFUNDABLE PORTION OF THE CHILD TAX CREDIT.

(a) IN GENERAL.—Subsection (d) of section 24 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(5) IDENTIFICATION REQUIREMENT WITH RESPECT TO TAXPAYER.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any taxpayer for any taxable year unless the taxpayer in-

cludes the taxpayer's Social Security number on the return of tax for such taxable year.

"(B) JOINT RETURNS.—In the case of a joint return, the requirement of subparagraph (A) shall be treated as met if the Social Security number of either spouse is included on such return.

"(C) LIMITATION.—Subparagraph (A) shall not apply to the extent the tentative minimum tax (as defined in section 55(b)(1)(A)) exceeds the credit allowed under section 32.".

(b) OMISSION TREATED AS MATHEMATICAL OR CLERICAL ERROR.—Subparagraph (I) of section 6213(g)(2) of such Code is amended to read as follows:

"(I) an omission of a correct Social Security number required under section 24(d)(5) (relating to refundable portion of child tax credit), or a correct TIN under section 24(e) (relating to child tax credit), to be included on a return,".

(c) CONFORMING AMENDMENT.—Subsection (e) of section 24 of such Code is amended by inserting "WITH RESPECT TO QUALIFYING CHILDREN" after "IDENTIFICATION REQUIREMENT" in the heading thereof.

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

Subtitle C—Human Resources Provisions

SEC. 621. REPEAL OF THE PROGRAM OF BLOCK GRANTS TO STATES FOR SOCIAL SERVICES.

(a) REPEALS.—Sections 2001 through 2007 of the Social Security Act (42 U.S.C. 1397–1397f) are repealed.

(b) CONFORMING AMENDMENTS.—

(1) Section 404(d) of the Social Security Act (42 U.S.C. 604(d)) is amended—

(A) in paragraph (1), by striking "any or all of the following provisions of law:" and all that follows through "The" and inserting "the";

(B) in paragraph (3)—

(i) by striking "RULES" and all that follows through "any amount paid" and inserting "RULES.—Any amount paid";

(ii) by striking "a provision of law specified in paragraph (1)" and inserting "the Child Care and Development Block Grant Act of 1990"; and

(iii) by striking subparagraph (B); and

(C) by striking paragraph (2) and redesignating paragraph (3) as paragraph (2).

(2) Section 422(b) of the Social Security Act (42 U.S.C. 622(b)) is amended—

(A) in paragraph (1)(A)—

(i) by striking "administers or supervises" and inserting "administered or supervised"; and

(ii) by striking "subtitle 1 of title XX" and inserting "subtitle A of title XX (as in effect before the repeal of such subtitle)"; and

(B) in paragraph (2), by striking "under subtitle 1 of title XX,".

(3) Section 471(a) of the Social Security Act (42 U.S.C. 671(a)) is amended—

(A) in paragraph (4), by striking ", under subtitle 1 of title XX of this Act,"; and

(B) in paragraph (8), by striking "XIX, or XX" and inserting "or XIX".

(4) Section 472(h)(1) of the Social Security Act (42 U.S.C. 672(h)(1)) is amended by striking the 2nd sentence.

(5) Section 473(b) of the Social Security Act (42 U.S.C. 673(b)) is amended—

(A) in paragraph (1), by striking "(3)" and inserting "(2)";

(B) in paragraph (4), by striking "paragraphs (1) and (2)" and inserting "paragraph (1)"; and

(C) by striking paragraph (2) and redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(6) Section 504(b)(6) of the Social Security Act (42 U.S.C. 704(b)(6)) is amended in each of subparagraphs (A) and (B) by striking "XIX, or XX" and inserting "or XIX".

(7) Section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) is amended by striking the penultimate sentence.

(8) Section 1128(h) of the Social Security Act (42 U.S.C. 1320a-7(h)) is amended—

(A) by adding "or" at the end of paragraph (2); and

(B) by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(9) Section 1128A(i)(1) of the Social Security Act (42 U.S.C. 1320a-7a(i)(1)) is amended by striking "or subtitle 1 of title XX".

(10) Section 1132(a)(1) of the Social Security Act (42 U.S.C. 1320b-2(a)(1)) is amended by striking "XIX, or XX" and inserting "or XIX".

(11) Section 1902(e)(13)(F)(iii) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F)(iii)) is amended—

(A) by striking "EXCLUSIONS" and inserting "EXCLUSION"; and

(B) by striking "an agency that determines eligibility for a program established under the Social Services Block Grant established under title XX or".

(12) The heading for title XX of the Social Security Act is amended by striking "BLOCK GRANTS TO STATES FOR SOCIAL SERVICES" and inserting "HEALTH PROFESSIONS DEMONSTRATIONS AND ENVIRONMENTAL HEALTH CONDITION DETECTION".

(13) The heading for subtitle A of title XX of the Social Security Act is amended by striking "**Block Grants to States for Social Services**" and inserting "**Health Professions Demonstrations and Environmental Health Condition Detection**".

(14) Section 16(k)(5)(B)(i) of the Food and Nutrition Act of 2008 (7 U.S.C. 2025(k)(5)(B)(i)) is amended by striking ", or title XX,".

(15) Section 402(b)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(3)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(16) Section 245A(h)(4)(I) of the Immigration Reform and Control Act of 1986 (8 U.S.C. 1255a(h)(4)(I)) is amended by striking ", XVI, and XX" and inserting "and XVI".

(17) Section 17 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766) is amended—

(A) in subsection (a)(2)—

(i) in subparagraph (B)—

(I) by striking "—" and all that follows through "(i)";

(II) by striking "or" at the end of clause (i); and

(III) by striking clause (ii); and

(ii) in subparagraph (D)(ii), by striking "or title XX"; and

(B) in subsection (o)(2)(B)—

(i) by striking "or title XX" each place it appears; and

(ii) by striking "or XX".

(18) Section 201(b) of the Indian Child Welfare Act of 1978 (25 U.S.C. 1931(b)) is amended by striking "titles IV–B and XX" each place it appears and inserting "part B of title IV".

(19) Section 3803(c)(2)(C) of title 31, United States Code, is amended by striking clause (vi) and redesignating clauses (vii) through (xvi) as clauses (vi) through (xv), respectively.

(20) Section 14502(d)(3) of title 40, United States Code, is amended—

(A) by striking "and title XX"; and

(B) by striking ", 1397 et seq.".

(21) Section 2006(a)(15) of the Public Health Service Act (42 U.S.C. 300z-5(a)(15)) is amended by striking "and title XX".

(22) Section 203(b)(3) of the Older Americans Act of 1965 (42 U.S.C. 3013(b)(3)) is amended by striking "XIX, and XX" and inserting "and XIX".

(23) Section 213 of the Older Americans Act of 1965 (42 U.S.C. 3020d) is amended by striking "or title XX".

(24) Section 306(d) of the Older Americans Act of 1965 (42 U.S.C. 3026(d)) is amended in each of paragraphs (1) and (2) by striking "titles XIX and XX" and inserting "title XIX".

(25) Section 2605 of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8624) is amended in each of subsections (b)(4) and (j) by striking "under title XX of the Social Security Act,".

(26) Section 602 of the Child Development Associate Scholarship Assistance Act of 1985 (42 U.S.C. 10901) is repealed.

(27) Section 3(d)(1) of the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14402(d)(1)) is amended by

striking subparagraph (C) and redesignating subparagraphs (D) through (K) as subparagraphs (C) through (J), respectively.

(c) EFFECTIVE DATE.—The repeals and amendments made by this section shall take effect on October 1, 2012.

○