To replace automatic spending cuts with targeted reforms, and for other purposes.

IN THE SENATE OF THE UNITED STATES

AUGUST 1, 2012

Mr. INHOFE introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To replace automatic spending cuts with targeted reforms, and for other purposes.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Sequestration Prevention Act of 2012”.

(b) Table of Contents.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—FULLY REPEAL THE SEQUESTRATION PROVISION OF ROUND 2 OF THE BUDGET CONTROL ACT

Sec. 101. Repeal.

TITLE II—REPEAL OF HEALTH CARE LAW
Sec. 201. Short title.
Sec. 203. Budgetary effects of this Act.

TITLE III—NUTRITION ASSISTANCE BLOCK GRANT PROGRAM

Sec. 301. Nutrition assistance block grant program.
Sec. 302. Funding.
Sec. 303. Repeals.
Sec. 304. Baseline.

TITLE IV—BLOCK GRANT THE MEDICAID PROGRAM

Sec. 401. Medical assistance block grant program.
Sec. 402. Funding.
Sec. 403. Termination of mandatory funding.
Sec. 404. Miscellaneous.
Sec. 405. Baseline.
Sec. 406. Definitions.

TITLE V—REDUCTION OF FEDERAL WORKFORCE

Sec. 501. Reduction in the number of Federal employees.

TITLE VI—PROHIBITION ON CLIMATE CHANGE AND GLOBAL WARMING FUNDING

Sec. 601. No funding for climate change or global warming.

TITLE VII—PROTECTING ACCESS TO HEALTH CARE

Sec. 700. Short title.

Subtitle A—HEALTH Act

Sec. 701. Short title.
Sec. 702. Purpose.
Sec. 703. Encouraging speedy resolution of claims.
Sec. 704. Compensating patient injury.
Sec. 705. Maximizing patient recovery.
Sec. 706. Punitive damages.
Sec. 707. Authorization of payment of future damages to claimants in health care lawsuits.
Sec. 708. Definitions.
Sec. 709. Effect on other laws.
Sec. 710. State flexibility and protection of States’ rights.
Sec. 711. Applicability; effective date.

Subtitle B—Health Care Safety Net Enhancement

Sec. 721. Short title.
Sec. 722. Protection for emergency and related services furnished pursuant to EMTALA.
Sec. 723. Constitutional authority.

Subtitle C—Restoring the Application of Antitrust Laws to Health Sector Insurers
Sec. 731. Short title.
Sec. 732. Application of the antitrust laws to the business of health insurance.
Subtitle D—Protections for Good Samaritan Health Professionals
Sec. 741. Short title.
Sec. 742. Limitation on liability for volunteer health care professionals.

TITLE VIII—BUDGET CONTROL ACT SPENDING CAP ADJUSTMENTS
Sec. 801. Budget Control Act spending cap adjustments.

1 TITLE I—FULLY REPEAL THE SEQUESTRATION PROVISION OF ROUND 2 OF THE BUDGET CONTROL ACT

SEC. 101. REPEAL.
Section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985 is repealed.

TITLE II—REPEAL OF HEALTH CARE LAW

SEC. 201. SHORT TITLE.
This title may be cited as the “Repealing the Job-Killing Health Care Law Act”.
(a) JOB-KILLING HEALTH CARE LAW.—Effective as of the enactment of Public Law 111–148, such Act is repealed, and the provisions of law amended or repealed by
such Act are restored or revived as if such Act had not been enacted.

(b) **Health Care-Related Provisions in the Health Care and Education Reconciliation Act of 2010.**—Effective as of the enactment of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), title I and subtitle B of title II of such Act are repealed, and the provisions of law amended or repealed by such title or subtitle, respectively, are restored or revived as if such title and subtitle had not been enacted.

**SEC. 203. BUDGETARY EFFECTS OF THIS ACT.**

The budgetary effects of this title, for the purpose of complying with the Statutory Pay-As-You-Go Act of 2010, shall be determined by reference to the latest statement titled “Budgetary Effects of PAYGO Legislation” for this title, submitted for printing in the Congressional Record by the Chairman of the Committee on the Budget of the House of Representatives, as long as such statement has been submitted prior to the vote on passage of this Act.
TITLE III—NUTRITION ASSISTANCE BLOCK GRANT PROGRAM

SEC. 301. NUTRITION ASSISTANCE BLOCK GRANT PROGRAM.

(a) In General.—For each of fiscal years 2014 through 2022, the Secretary shall establish a nutrition assistance block grant program under which the Secretary shall make annual grants to each participating State that establishes a nutrition assistance program in the State and submits to the Secretary annual reports under subsection (d).

(b) Requirements.—As a requirement of receiving grants under this section, the Governor of each participating State shall certify that the State nutrition assistance program includes—

(1) work requirements;

(2) mandatory drug testing; and

(3) limitations on the eligible uses of benefits that are at least as restrictive as the limitations in place for the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.) as of May 31, 2012.
(c) AMOUNT OF GRANT.—For each fiscal year, the
Secretary shall make a grant to each participating State
in an amount equal to the product of—

(1) the amount made available under section
302 for the applicable fiscal year; and

(2) the proportion that—

(A) the number of legal residents in the
State whose income does not exceed 100 per-
cent of the poverty line (as defined in section
673(2) of the Community Services Block Grant
Act (42 U.S.C. 9902(2), including any revision
required by such section)) applicable to a family
of the size involved; bears to

(B) the number of such individuals in all
participating States for the applicable fiscal
year, based on data for the most recent fiscal
year for which data is available.

(d) ANNUAL REPORT REQUIREMENTS.—

(1) IN GENERAL.—Not later than January 1 of
each year, each State that receives a grant under
this section shall submit to the Secretary a report
that shall include, for the year covered by the re-
port—

(A) a description of the structure and de-
sign of the nutrition assistance program of the
State, including the manner in which residents of the State qualify for the program;

(B) the cost the State incurs to administer the program;

(C) whether the State has established a rainy day fund for the nutrition assistance program of the State; and

(D) general statistics about participation in the nutrition assistance program.

(2) AUDIT.—Each year, the Comptroller General of the United States shall—

(A) conduct an audit on the effectiveness of the nutritional assistance block grant program and the manner in which each participating State is implementing the program; and

(B) not later than June 30, submit to the appropriate committees of Congress a report describing—

(i) the results of the audit; and

(ii) the manner in which the State will carry out the supplemental nutrition assistance program in the State, including eligibility and fraud prevention requirements.

(e) USE OF FUNDS.—
(1) IN GENERAL.—A State that receives a grant under this section may use the grant in any manner determined to be appropriate by the State to provide nutrition assistance to the legal residents of the State.

(2) AVAILABILITY OF FUNDS.—Grant funds made available to a State under this section shall—

(A) remain available to the State for a period of 5 years; and

(B) after that period, shall—

(i) revert to the Federal Government to be deposited in the Treasury and used for Federal budget deficit reduction; or

(ii) if there is no Federal budget deficit, be used to reduce the Federal debt in such manner as the Secretary of the Treasury considers appropriate.

SEC. 302. FUNDING.

There is authorized to be appropriated to carry out this title—

(1) for fiscal year 2014, $44,400,000,000;

(2) for fiscal year 2015, $45,500,000,000;

(3) for fiscal year 2016, $46,600,000,000;

(4) for fiscal year 2017, $47,800,000,000;

(5) for fiscal year 2018, $49,000,000,000;
(6) for fiscal year 2019, $50,200,000,000;
(7) for fiscal year 2020, $51,500,000,000;
(8) for fiscal year 2021, $52,800,000,000; and
(9) for fiscal year 2022, $54,100,000,000.

SEC. 303. REPEALS.
(a) In General.—Effective September 30, 2013, the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.) is repealed.
(b) Repeal of Mandatory Funding.—
(1) In General.—Notwithstanding any other provision of law, effective September 30, 2013, the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.) (as in effect prior to that date) shall cease to be a program funded through direct spending (as defined in section 250(e) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)) prior to the amendment made by paragraph (2)).
(2) Direct Spending.—Effective September 30, 2013, section 250(e)(8) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(e)(8)) is amended—
(A) in subparagraph (A), by adding “and” at the end;
(B) in subparagraph (B), by striking “; and” at the end and inserting a period; and

(C) by striking subparagraph (C).

(3) **ENTITLEMENT AUTHORITY.**—Effective September 30, 2013, section 3(9) of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 622(9)) is amended—

(A) by striking “means—” and all that follows through “the authority to make” and inserting “means the authority to make”;  
(B) by striking “; and” and inserting a period; and  
(C) by striking subparagraph (B).

(4) **OTHER DIRECT SPENDING.**—Effective September 30, 2013, section 1026(5) of the Congressional Budget and Impoundment Control Act of 1974 (2 U.S.C. 691e(5)) is amended—

(A) in subparagraph (A), by adding “and” at the end;  
(B) in subparagraph (B), by striking “; and” at the end and inserting a period; and  
(C) by striking subparagraph (C).

(e) **RELATIONSHIP TO OTHER LAW.**—Any reference in this title, an amendment made by this title, or any other law to the supplemental nutrition assistance program shall
be considered to be a reference to the nutrition assistance block grant program under this title.

SEC. 304. BASELINE.

Notwithstanding section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 907), the baseline shall assume that, on and after September 30, 2013, no benefits shall be provided under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.) (as in effect prior to that date).

TITLE IV—BLOCK GRANT THE MEDICAID PROGRAM

SEC. 401. MEDICAL ASSISTANCE BLOCK GRANT PROGRAM.

(a) In General.—For each of fiscal years 2014 through 2022, the Secretary shall establish a Medicaid block grant program under which the Secretary shall make annual grants to each participating State that establishes a medical assistance program for individuals in the State and submits to the Secretary annual reports under subsection (d).

(b) Amount of Grant.—For each fiscal year, the Secretary shall make a grant to each participating State in an amount equal to the product of—

(1) the amount made available under section 402 for the applicable fiscal year; and
(2) the proportion that—

(A) the number of legal residents in the State whose income does not exceed 185 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2), including any revision required by such section)) applicable to a family of the size involved; bears to

(B) the number of such individuals in all participating States for the applicable fiscal year, based on data for the most recent fiscal year for which data is available.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A State that receives a grant under this section may use the grant in any manner determined to be appropriate by the State to provide medical assistance to legal residents of the State.

(2) AVAILABILITY OF FUNDS.—Grant funds made available to a State under this section shall—

(A) remain available to the State for a period of 5 years; and

(B) after that period, shall—
(i) revert to the Federal Government to be deposited in the Treasury and used for Federal budget deficit reduction; or
(ii) if there is no Federal budget deficit, be used to reduce the Federal debt in such manner as the Secretary of the Treasury considers appropriate.

(d) **Annual Report Requirements.—**

(1) **In general.**—Not later than January 1 of each year, each State that receives a grant under this section shall submit to the Secretary a report that shall include, for the year covered by the report—

(A) a description of the structure and design of the Medicaid program of the State, including the manner in which residents of the State qualify for the program;

(B) the cost the State incurs to administer the program;

(C) whether the State has established a rainy day fund for the Medicaid program of the State; and

(D) general statistics about participation in Medicaid program.
(2) AUDIT.—Each year, the Comptroller General of the United States shall—

(A) conduct an audit on the effectiveness of the Medicaid block grant program and the manner in which each participating State is implementing the program; and

(B) not later than June 30, submit to the appropriate committees of Congress a report describing—

(i) the results of the audit; and

(ii) the manner in which the State will carry out the Medicaid program in the State, including eligibility and fraud prevention requirements.

SEC. 402. FUNDING.

There is authorized to be appropriated to carry out this title—

(1) for fiscal year 2014, $304,000,000,000;

(2) for fiscal year 2015, $311,000,000,000;

(3) for fiscal year 2016, $317,000,000,000;

(4) for fiscal year 2017, $334,000,000,000;

(5) for fiscal year 2018, $345,000,000,000;

(6) for fiscal year 2019, $355,000,000,000;

(7) for fiscal year 2020, $370,000,000,000;

(8) for fiscal year 2021, $382,000,000,000; and
SEC. 403. TERMINATION OF MANDATORY FUNDING.

(a) In General.—Effective October 1, 2013, title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) are repealed.

(b) Elimination of Mandatory Funding.—Notwithstanding any other provision of law, effective October 1, 2013, the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) shall cease to be a program funded through direct spending (as defined in section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

SEC. 404. MISCELLANEOUS.

(a) Relationship to Other Law.—Any reference in this Act, an amendment made by this Act, or any other Act to the Medicaid program or to title XIX of the Social Security Act shall be considered to be a reference to the Medicaid block grant program established under this title.

(b) Nonentitlement.—Nothing in this title shall be construed as providing—

(1) an individual with an entitlement to medical assistance provided under a grant made under this title; or
(2) as an obligation of the Federal Government
to provide payments to States to carry out this title
other than to the extent funds are made available
for that purpose through an appropriations Act.

(c) WAIVERS.—

(1) IN GENERAL.—In the case of a State con-
ducting an experimental, pilot, or demonstration
project under section 1115 of the Social Security
Act (42 U.S.C. 1315) or other authority relating to
the Medicaid program under title XIX of the Social
Security Act that is in effect on the date of enact-
ment of this Act, the waiver shall terminate on Sep-
tember 30, 2013, unless the State submits a request,
not later than July 1, 2013, to the Secretary to con-
tinue the project. The Secretary may approve the re-
quest of a State to continue with such a project only
if the total amount of Federal funds paid to the
State to conduct the project will not exceed the
amount of Federal funds that would be paid to the
State under this title if the project were not contin-
ued.

(2) NO WAIVER AUTHORITY.—The Secretary
may not waive any provision of this title under sec-
tion 1115 of the Social Security Act (42 U.S.C.
1315).
(d) **Hold Harmless Provisions.**—

(1) **CHIP.**—The State children’s health insurance program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) shall continue to be operated in accordance with the provisions of that title.

(2) **Child Support and Foster Care Payments.**—The Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) (as in effect on September 30, 2013) shall continue to apply to payments to States under parts D and E of title IV of the Social Security Act (42 U.S.C. 651 et seq.; 670 et seq.). Notwithstanding the repeal of title XIX of the Social Security Act under section 403(a), the Secretary shall annually determine and promulgate the Federal medical assistance percentage for each State in accordance with the provisions of section 1101(a)(8)(B) of the Social Security Act (42 U.S.C. 1301(a)(8)(B)).

(3) **Vaccines for Children Program.**—The program for the distribution of pediatric vaccines established under section 1928 of the Social Security Act (42 U.S.C. 1396s) shall continue to be operated
in accordance with the provisions of that section (as
in effect on September 30, 2013).

(c) TECHNICAL ASSISTANCE.—The Secretary shall
provide technical assistance and guidance to States to co-
ordinate the transition to the Medicaid block grant pro-
gram established under this title.

SEC. 405. BASELINE.

Notwithstanding section 257 of the Balanced Budget
and Emergency Deficit Control Act of 1985 (2 U.S.C.
907), the baseline shall assume that after September 30,
2013, no payments shall be provided under section 1903

SEC. 406. DEFINITIONS.

In this title:

(1) MEDICAL ASSISTANCE.—The term “medical
assistance” means payment for part or all of the
cost of providing, or arranging for the provision of
(including through the purchase of health insurance
coverage), health benefits.

(2) SECRETARY.—The term “Secretary” means
the Secretary of Health and Human Services.

(3) STATE.—The term “State” means each of
the 50 States, the District of Columbia, Puerto Rico,
the United States Virgin Islands, Guam, the North-
ern Mariana Islands, and American Samoa.
TITLE V—REDUCTION OF FEDERAL WORKFORCE

SEC. 501. REDUCTION IN THE NUMBER OF FEDERAL EMPLOYEES.

(a) Definition.—In this section, the term “agency” has the meaning given the term “Executive agency” under section 105 of title 5, United States Code.

(b) Determination of Number of Employees.—Not later than 60 days after the date of enactment of this Act, the Director of the Office of Management and Budget shall determine the number of full-time employees employed in each agency. The head of each agency shall cooperate with the Director of the Office of Management and Budget in making the determinations.

(c) Replacement Hire Rate.—

(1) In general.—During the period described under paragraph (2), the head of each agency may hire no more than 2 employees in that agency for every 3 employees who leave employment in that agency.

(2) Period of replacement hire rate.—Paragraph (1) shall apply to each agency during the period beginning 60 days after the date of enactment of this Act through the date on which the Director of the Office of Management and Budget
makes a determination that the number of full-time
employees employed in that agency is 10 percent less
than the number of full-time employees employed in
that agency determined under subsection (a).

(d) WAIVERS.—This section may be waived upon a
determination by the President that—

(1) the existence of a state of war or other na-
tional security concern so requires; or

(2) the existence of an extraordinary emergency
threatening life, health, public safety, property, or
the environment so requires.

TITLE VI—PROHIBITION ON CLIMATE CHANGE AND GLOBAL WARMING FUNDING

SEC. 601. NO FUNDING FOR CLIMATE CHANGE OR GLOBAL WARMING.

On and after the date of enactment of this Act, no
Federal funds may be expended for any activity relating
to climate change or global warming.

TITLE VII—PROTECTING ACCESS TO HEALTH CARE

SEC. 700. SHORT TITLE.

This title may be cited as the “Protecting Access to
Health Care Act”.

S 3473 IS
Subtitle A—HEALTH Act

SEC. 701. SHORT TITLE.
This subtitle may be cited as the “Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2012”.

SEC. 702. 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 unun-
tended injury and improve patient care.

SEC. 703. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care law-
suit 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. 704. 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.
judgment, and such reduction shall be made before ac-
counting 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 re-
duced 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 sepa-
rate 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 propor-
tion of responsibility of each party for the claimant’s
harm.

**SEC. 705. MAXIMIZING PATIENT RECOVERY.**

(a) **Court Supervision of Share of Damages
Actually Paid to Claimants.**—In any health care law-
suit, the court shall supervise the arrangements for pay-
ment of damages to protect against conflicts of interest
that may have the effect of reducing the amount of dam-
ages awarded that are actually paid to claimants. In par-
ticular, 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 require-
ment for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 706. 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 li-
censure by the Food and Drug Administra-
tion with respect to the safety of the for-
mulation 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 ap-
proved, cleared, or licensed; or

(ii) such medical product is generally
recognized among qualified experts as safe
and effective pursuant to conditions estab-
lished by the Food and Drug Administra-
tion and applicable Food and Drug Admin-
istration regulations, including without
limitation those related to packaging and
labeling, unless the Food and Drug Admin-
istration has determined that such medical
product was not manufactured or distrib-
uted in substantial compliance with appli-
cable Food and Drug Administration stat-
utes and regulations.

(B) RULE OF CONSTRUCTION.—Subpara-
graph (A) may not be construed as establishing
the obligation of the Food and Drug Adminis-
tration to demonstrate affirmatively that a
manufacturer, distributor, or supplier referred
to in such subparagraph meets any of the con-
ditions described in such subparagraph.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—
A health care provider who prescribes, or who dis-
penses 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 li-
ability 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 regula-
tions of the Secretary of Health and Human Serv-
ices (including labeling regulations related to such
packaging), the manufacturer or product seller of
the drug shall not be held liable for punitive dam-
ages 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

SEC. 707. 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. 708. 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 man-
ner 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, includ-
ing 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 as-
serted or such an action is brought, whether de-
ceased, 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 med-
ical products, such as past and future medical ex-
penses, loss of past and future earnings, cost of ob-
taining domestic services, loss of employment, and
loss of business or employment opportunities, dam-
ages for physical and emotional pain, suffering, in-
convenience, physical impairment, mental anguish,
disfigurement, loss of enjoyment of life, loss of soci-
ety and companionship, loss of consortium (other
than loss of domestic service), hedonic damages, in-
jury to reputation, and all other nonpecuniary losses
of any kind or nature. The term “compensatory damages” includes economic damages and non-economic damages, as such terms are defined in this section.

(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 require-
ment 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)), re-
spectively, 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 Is-
lands, the Trust Territory of the Pacific Islands, and
any other territory or possession of the United
States, or any political subdivision thereof.

SEC. 709. 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-re-
lated injury or death—

(A) this subtitle does not affect the appli-
cation of the rule of law to such an action; and

(B) any rule of law prescribed by this sub-
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
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. 710. 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 title) 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 704(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.
SEC. 711. 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 title, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Health Care Safety Net Enhancement

SEC. 721. SHORT TITLE.

This subtitle may be cited as the “Health Care Safety Net Enhancement Act of 2012”.

SEC. 722. PROTECTION FOR EMERGENCY AND RELATED SERVICES FURNISHED PURSUANT TO EMTALA.

Section 224(g) of the Public Health Service Act (42 U.S.C. 233(g)) is amended—

(1) in paragraph (4), by striking “An entity” and inserting “Subject to paragraph (6), an entity”; and

(2) by adding at the end the following:

“(6)(A) For purposes of this section—

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“(i) an entity described in subparagraph (B) shall be considered to be an entity described in paragraph (4); and

“(ii) the provisions of this section shall apply to an entity described in subparagraph (B) in the same manner as such provisions apply to an entity described in paragraph (4), except that—

“(I) notwithstanding paragraph (1)(B), the deeming of any entity described in subparagraph (B), or of an officer, governing board member, employee, contractor, or on-call provider of such an entity, to be an employee of the Public Health Service for purposes of this section shall apply only with respect to items and services that are furnished to an individual pursuant to section 1867 of the Social Security Act and to post stabilization services (as defined in subparagraph (D)) furnished to such an individual;

“(II) nothing in paragraph (1)(D) shall be construed as preventing a physician or physician group described in subparagraph (B)(ii) from making the appli-
cation referred to in such paragraph or as conditioning the deeming of a physician or physician group that makes such an application upon receipt by the Secretary of an application from the hospital or emergency department that employs or contracts with the physician or group, or enlists the physician or physician group as an on-call provider;

“(III) notwithstanding paragraph (3), this paragraph shall apply only with respect to causes of action arising from acts or omissions that occur on or after January 1, 2012;

“(IV) paragraph (5) shall not apply to a physician or physician group described in subparagraph (B)(ii);

“(V) the Attorney General, in consultation with the Secretary, shall make separate estimates under subsection (k)(1) with respect to entities described in subparagraph (B) and entities described in paragraph (4) (other than those described in subparagraph (B)), and the Secretary shall establish separate funds under sub-
section (k)(2) with respect to such groups of entities, and any appropriations under this subsection for entities described in subparagraph (B) shall be separate from the amounts authorized by subsection (k)(2);

“(VI) notwithstanding subsection (k)(2), the amount of the fund established by the Secretary under such subsection with respect to entities described in subparagraph (B) may exceed a total of $10,000,000 for a fiscal year; and

“(VII) subsection (m) shall not apply to entities described in subparagraph (B).

“(B) An entity described in this subparagraph is—

“(i) a hospital or an emergency department to which section 1867 of the Social Security Act applies; and

“(ii) a physician or physician group that is employed by, is under contract with, or is an on-call provider of such hospital or emergency department, to furnish items and services to individuals under such section.
“(C) For purposes of this paragraph, the term ‘on-call provider’ means a physician or physician group that—

“(i) has full, temporary, or locum tenens staff privileges at a hospital or emergency department to which section 1867 of the Social Security Act applies; and

“(ii) is not employed by or under contract with such hospital or emergency department, but agrees to be ready and available to provide services pursuant to section 1867 of the Social Security Act or post-stabilization services to individuals being treated in the hospital or emergency department with or without compensation from the hospital or emergency department.

“(D) For purposes of this paragraph, the term ‘post stabilization services’ means, with respect to an individual who has been treated by an entity described in subparagraph (B) for purposes of complying with section 1867 of the Social Security Act, services that are—

“(i) related to the condition that was so treated; and

“(ii) provided after the individual is stabilized in order to maintain the stabilized condi-
tion or to improve or resolve the condition of
the individual.

“(E)(i) Nothing in this paragraph (or in any
other provision of this section as such provision ap-
plies to entities described in subparagraph (B) by
operation of subparagraph (A)) shall be construed as
authorizing or requiring the Secretary to make pay-
ments to such entities, the budget authority for
which is not provided in advance by appropriation
Acts.

“(ii) The Secretary shall limit the total amount
of payments under this paragraph for a fiscal year
to the total amount appropriated in advance by ap-
propriation Acts for such purpose for such fiscal
year. If the total amount of payments that would
otherwise be made under this paragraph for a fiscal
year exceeds such total amount appropriated, the
Secretary shall take such steps as may be necessary
to ensure that the total amount of payments under
this paragraph for such fiscal year does not exceed
such total amount appropriated.”.

SEC. 723. CONSTITUTIONAL AUTHORITY.

The constitutional authority upon which this subtitle
rests is the power of the Congress to provide for the gen-
eral welfare, to regulate commerce, and to make all laws
which shall be necessary and proper for carrying into exec-
ution Federal powers, as enumerated in Section 8 of Arti-
cle I of the Constitution of the United States.

Subtitle C—Restoring the Application of Antitrust Laws to Health Sector Insurers

SEC. 731. SHORT TITLE.

This subtitle may be cited as the “Health Insurance Industry Fair Competition Act of 2012”.

SEC. 732. APPLICATION OF THE ANTITRUST LAWS TO THE BUSINESS OF HEALTH INSURANCE.

(a) Amendment to McCarran-Ferguson Act.—

Section 3 of the Act of March 9, 1945 (15 U.S.C. 1013), commonly known as the McCarran-Ferguson Act, is amended by adding at the end the following:

“(c) Nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance. For purposes of the preceding sentence, the term ‘antitrust laws’ has the meaning given it in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition. For the purposes of this subsection, the term ‘business of health insurance’ shall—
“(1) mean ‘health insurance coverage’ offered by a ‘health insurance issuer’ as those terms are defined in section 9001 of the Patient Protection and Affordable Care Act, which incorporates by reference and utilizes the definitions included in section 9832 of the Internal Revenue Code (26 U.S.C. 9832); and

“(2) not include—

“(A) life insurance and annuities;

“(B) property or casualty insurance, including but not limited to, automobile, medical malpractice or workers’ compensation insurance; or

“(C) any insurance or benefits defined as ‘excepted benefits’ under section 9832(c) of the Internal Revenue Code (26 U.S.C. 9832(c)), whether offered separately or in combination with products described in subparagraph (A).”.

(b) RELATED PROVISION.—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, section 3(c) of the McCarran-Ferguson Act shall apply with respect to the business of health insurance without regard to whether such business is carried on for profit, notwithstanding the definition of “Corporation’

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contained in section 4 of the Federal Trade Commission Act.

(c) LIMITATION ON CLASS ACTIONS.—

(1) LIMITATION.—No class action may be heard in a Federal or State court on a claim against a person engaged in the business of health insurance for a violation of any of the antitrust laws (as defined in section 3(c) of the Act of March 9, 1945 (15 U.S.C. 1013), commonly known as the McCarran-Ferguson Act).

(2) EXEMPTION.—Paragraph (1) shall not apply with respect to any action commenced—

(A) by the United States or any State; or

(B) by a named claimant for an injury only to itself.

Subtitle D—Protections for Good Samaritan Health Professionals

SEC. 741. SHORT TITLE.

This subtitle may be cited as the “Good Samaritan Health Professionals Act of 2012”.

SEC. 742. LIMITATION ON LIABILITY FOR VOLUNTEER HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by inserting after section 224 the following:
"SEC. 224A. LIMITATION ON LIABILITY FOR VOLUNTEER HEALTH CARE PROFESSIONALS.

"(a) LIMITATION ON LIABILITY.—Except as provided in subsection (b), a health care professional shall not be liable under Federal or State law for any harm caused by an act or omission of the professional if—

"(1) the professional is serving as a volunteer for purposes of responding to a disaster; and

"(2) the act or omission occurs—

"(A) during the period of the disaster, as determined under the laws listed in subsection (e)(1);

"(B) in the health care professional’s capacity as such a volunteer; and

"(C) in a good faith belief that the individual being treated is in need of health care services.

"(b) EXCEPTIONS.—Subsection (a) does not apply if—

"(1) the harm was caused by an act or omission constituting willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious flagrant indifference to the rights or safety of the individual harmed by the health care professional; or

"(2) the health care professional rendered the health care services under the influence (as deter-
mined pursuant to applicable State law) of intoxicating alcohol or an intoxicating drug.

“(c) STANDARD OF PROOF.—In any civil action or proceeding against a health care professional claiming that the limitation in subsection (a) applies, the plaintiff shall have the burden of proving by clear and convincing evidence the extent to which limitation does not apply.

“(d) PREEMPTION.—

“(1) IN GENERAL.—This section preempts the laws of a State or any political subdivision of a State to the extent that such laws are inconsistent with this section, unless such laws provide greater protection from liability.

“(2) VOLUNTEER PROTECTION ACT.—Protections afforded by this section are in addition to those provided by the Volunteer Protection Act of 1997.

“(e) DEFINITIONS.—In this section:

“(1) The term ‘disaster’ means—

“(A) a national emergency declared by the President under the National Emergencies Act;

“(B) an emergency or major disaster declared by the President under the Robert T. Stafford Disaster Relief and Emergency Assistance Act; or
“(C) a public health emergency determined
by the Secretary under section 319 of this Act.
“(2) The term ‘harm’ includes physical, non-
physical, economic, and noneconomic losses.
“(3) The term ‘health care professional’ means
an individual who is licensed, certified, or authorized
in one or more States to practice a health care pro-
fession.
“(4) The term ‘State’ includes each of the sev-
eral States, the District of Columbia, the Common-
wealth of Puerto Rico, the Virgin Islands, Guam,
American Samoa, the Northern Mariana Islands,
and any other territory or possession of the United
States.
“(5)(A) The term ‘volunteer’ means a health
care professional who, with respect to the health
care services rendered, does not receive—
“(i) compensation; or
“(ii) any other thing of value in lieu of
compensation, in excess of $500 per year.
“(B) For purposes of subparagraph (A), the
term ‘compensation’—
“(i) includes payment under any insurance
policy or health plan, or under any Federal or
State health benefits program; and
“(ii) excludes—

“(I) reasonable reimbursement or allowance for expenses actually incurred;

“(II) receipt of paid leave; and

“(III) receipt of items to be used exclusively for rendering the health services in the health care professional’s capacity as a volunteer described in subsection (a)(1).”.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—This subtitle and the amendment made by subsection (a) shall take effect 90 days after the date of the enactment of this title.

(2) APPLICATION.—This subtitle applies to any claim for harm caused by an act or omission of a health care professional where the claim is filed on or after the effective date of this subtitle, but only if the harm that is the subject of the claim or the conduct that caused such harm occurred on or after such effective date.
TITLE VIII—BUDGET CONTROL
ACT SPENDING CAP ADJUSTMENTS

SEC. 801. BUDGET CONTROL ACT SPENDING CAP ADJUSTMENTS.

(a) REENACTMENT.—Section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985 is reenacted as in effect on January 15, 2012.

(b) NEW CAPS.—The Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in section 250(c)(4), by striking subparagraph (B) and inserting the following:

“(B) The term ‘security category’ means discretionary appropriations in budget function 050.”; and

(2) in section 251(c), by striking paragraphs (2) through (10) and inserting the following:

“(2) with respect to fiscal year 2013—

“(A) for the security category, $546,000,000,000; and

“(B) for the nonsecurity category, $430,700,000,000;”

“(3) with respect to fiscal year 2014—

“(A) for the security category, $566,800,000,000; and

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“(B) for the nonsecurity category,

$769,100,000,000;

“(4) with respect to fiscal year 2015—

“(A) for the security category,

$620,400,000,000; and

“(B) for the nonsecurity category,

$777,200,000,000;

“(5) with respect to fiscal year 2016—

“(A) for the security category,

$657,700,000,000; and

“(B) for the nonsecurity category,

$784,300,000,000;

“(6) with respect to fiscal year 2017—

“(A) for the security category,

$702,000,000,000; and

“(B) for the nonsecurity category,

$802,000,000,000;

“(7) with respect to fiscal year 2018—

“(A) for the security category,

$736,800,000,000; and

“(B) for the nonsecurity category,

$824,400,000,000;

“(8) with respect to fiscal year 2019—

“(A) for the security category,

$780,900,000,000; and
“(B) for the nonsecurity category, $845,700,000,000;
“(9) with respect to fiscal year 2020—
“(A) for the security category, $828,100,000,000; and
“(B) for the nonsecurity category, $872,100,000,000;
“(10) with respect to fiscal year 2021—
“(A) for the security category, $865,300,000,000; and
“(B) for the nonsecurity category, $894,400,000,000; and
“(11) with respect to fiscal year 2022—
“(A) for the security category, $990,800,000,000; and
“(B) for the nonsecurity category: $925,300,000,000.”.

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