

111TH CONGRESS
1ST SESSION

S. 1324

To ensure that every American has a health insurance plan that they can afford, own, and keep.

IN THE SENATE OF THE UNITED STATES

JUNE 23, 2009

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

A BILL

To ensure that every American has a health insurance plan that they can afford, own, and keep.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Health Care Freedom
5 Act of 2009”.

1 **TITLE I—ACCESS TO COVERAGE**
 2 **FOR EVERY AMERICAN**
 3 **Subtitle A—Tax Code Equity**

4 **SEC. 101. REFUNDABLE CREDIT FOR HEALTH INSURANCE**
 5 **COVERAGE.**

6 (a) IN GENERAL.—Subpart C of part IV of sub-
 7 chapter A of chapter 1 of the Internal Revenue Code of
 8 1986 is amended by inserting after section 36A the fol-
 9 lowing new section:

10 **“SEC. 36B. QUALIFIED HEALTH INSURANCE CREDIT.**

11 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
 12 dividual, there shall be allowed as a credit against the tax
 13 imposed by this chapter for the taxable year so much of
 14 the qualified health insurance costs of the taxpayer as does
 15 not exceed the sum of the monthly limitations determined
 16 under subsection (b).

17 “(b) MONTHLY LIMITATION.—

18 “(1) IN GENERAL.—The monthly limitation for
 19 each month during the taxable year is $\frac{1}{12}$ th of—

20 “(A) \$2,000, in the case of an individual
 21 purchasing individual coverage for an eligible
 22 individual, and

23 “(B) \$5,000, in the case of an individual
 24 purchasing family coverage for 2 or more eligi-
 25 ble individuals.

1 “(2) LIMITATION.—In no case shall the annual
2 sum of the monthly limitations with respect to any
3 taxpayer exceed \$5,000.

4 “(3) NO CREDIT FOR INELIGIBLE MONTHS.—
5 With respect to any individual, the monthly limita-
6 tion shall be zero for any month for which such indi-
7 vidual is not an eligible individual.

8 “(c) ELIGIBLE INDIVIDUAL.—For purposes of this
9 section—

10 “(1) IN GENERAL.—The term ‘eligible indi-
11 vidual’ means, with respect to any month, an indi-
12 vidual who—

13 “(A) is the taxpayer, the taxpayer’s
14 spouse, or the taxpayer’s dependent,

15 “(B) is covered under qualified health in-
16 surance as of the 1st day of such month, and

17 “(C) is not covered under employer-pro-
18 vided health insurance as of the 1st day of such
19 month.

20 “(2) COVERAGE UNDER MEDICARE, MEDICAID,
21 SCHIP, MILITARY COVERAGE.—The term ‘eligible in-
22 dividual’ shall not include any individual for a month
23 if, as of the first day of such month, such individual
24 is—

1 “(A) entitled to benefits under part A of
2 title XVIII of the Social Security Act or en-
3 rolled under part B of such title, and the indi-
4 vidual is not a participant or beneficiary in a
5 group health plan or large group health plan
6 that is a primary plan (as defined in section
7 1862(b)(2)(A) of such Act),

8 “(B) in the case of a State that has not
9 made the election described in section
10 1939(a)(1)(B) of the Social Security Act, en-
11 rolled in the program under title XIX of such
12 Act (other than under section 1928 of such
13 Act), or

14 “(C) entitled to benefits under chapter 55
15 of title 10, United States Code.

16 “(3) IDENTIFICATION REQUIREMENTS.—The
17 term ‘eligible individual’ shall not include any indi-
18 vidual for any month unless the policy number asso-
19 ciated with the qualified health insurance and the
20 TIN of each eligible individual covered under such
21 health insurance for such month are included on the
22 return of tax for the taxable year in which such
23 month occurs.

24 “(4) PRISONERS.—The term ‘eligible individual’
25 shall not include any individual for a month if, as

1 of the first day of such month, such individual is im-
2 prisoned under Federal, State, or local authority.

3 “(5) ALIENS.—The term ‘eligible individual’
4 shall not include any alien individual for a month if,
5 as of the first day of such month, such individual is
6 not a lawful permanent resident of the United
7 States.

8 “(d) QUALIFIED HEALTH INSURANCE COSTS.—For
9 purposes of this section, the term ‘qualified health insur-
10 ance costs’ means the sum of the amounts paid during
11 the taxable year to obtain qualified health insurance for
12 1 or more eligible individuals.

13 “(e) QUALIFIED HEALTH INSURANCE.—For pur-
14 poses of this section, the term ‘qualified health insurance’
15 includes a high deductible health plan within the meaning
16 of section 223(c)(2), but shall not include any insurance
17 if a substantial portion of its benefits are excepted benefits
18 (as defined in section 9832(e)).

19 “(f) OTHER DEFINITIONS.—For purposes of this sec-
20 tion—

21 “(1) DEPENDENT.—The term ‘dependent’ has
22 the meaning given such term by section 152 (deter-
23 mined without regard to subsections (b)(1), (b)(2),
24 and (d)(1)(B) thereof). An individual who is a child
25 to whom section 152(e) applies shall be treated as

1 a dependent of the custodial parent for a coverage
2 month unless the custodial and noncustodial parent
3 agree otherwise.

4 “(2) CHILD.—The term ‘child’ means a quali-
5 fying child (as defined in section 152(e)).

6 “(g) SPECIAL RULES.—

7 “(1) COORDINATION WITH MEDICAL DEDUC-
8 TION, ETC.—Any amount paid by a taxpayer for in-
9 surance to which subsection (a) applies shall not be
10 taken into account in computing the amount allow-
11 able to the taxpayer as a credit under section 35 or
12 as a deduction under section 213(a).

13 “(2) MEDICAL AND HEALTH SAVINGS AC-
14 COUNTS.—The amounts taken into account as quali-
15 fied health insurance costs for any taxable year shall
16 be reduced by the aggregate amounts, if any, distrib-
17 uted from Archer MSAs (as defined in section
18 220(d)) and health savings accounts (as defined in
19 section 223(d)) which are excludable from gross in-
20 come for such taxable year by reason of being used
21 to pay premiums for coverage of an individual under
22 qualified health insurance for any month during
23 such taxable year.

24 “(3) DENIAL OF CREDIT TO DEPENDENTS.—No
25 credit shall be allowed under this section to any indi-

1 vidual with respect to whom a deduction under sec-
2 tion 151 is allowable to another taxpayer for a tax-
3 able year beginning in the calendar year in which
4 such individual's taxable year begins.

5 “(4) MARRIED COUPLES MUST FILE JOINT RE-
6 TURN.—

7 “(A) IN GENERAL.—If the taxpayer is
8 married at the close of the taxable year, the
9 credit shall be allowed under subsection (a) only
10 if the taxpayer and his spouse file a joint return
11 for the taxable year.

12 “(B) MARITAL STATUS; CERTAIN MARRIED
13 INDIVIDUALS LIVING APART.—Rules similar to
14 the rules of paragraphs (3) and (4) of section
15 21(e) shall apply for purposes of this para-
16 graph.

17 “(5) VERIFICATION OF COVERAGE, ETC.—No
18 credit shall be allowed under this section with re-
19 spect to any individual unless such individual's cov-
20 erage (and such related information as the Secretary
21 may require) is verified in such manner as the Sec-
22 retary may prescribe.

23 “(6) INSURANCE WHICH COVERS OTHER INDI-
24 VIDUALS; TREATMENT OF PAYMENTS.—Rules similar

1 to the rules of paragraphs (7) and (8) of section
2 35(g) shall apply for purposes of this section.

3 “(7) PARTICIPANTS IN HEALTH CARE SHARING
4 MINISTRIES.—

5 “(A) IN GENERAL.—In the case of a tax-
6 payer who is a participant or contributor to a
7 health care sharing ministry during a month in
8 the taxable year, and who is not covered under
9 qualified health insurance during such month—

10 “(i) such taxpayer (and such tax-
11 payer’s spouse and dependents, if such in-
12 dividuals are covered by such health care
13 sharing ministry) shall be considered to be
14 eligible individuals for purposes of sub-
15 section (c)(1) for such month,

16 “(ii) the amount of such taxpayer’s
17 contribution to such health care sharing
18 ministry in such month shall be considered
19 to be qualified health insurance costs in
20 such month,

21 “(iii) subsection (c)(3) shall apply to
22 such taxpayer (and such taxpayer’s spouse
23 and dependents, if such individuals are
24 covered by such ministry) without regard
25 to the policy number requirement, and

1 “(iv) the Secretary may require such
2 information under paragraph (5) of this
3 subsection as may be necessary to verify
4 such taxpayer’s contribution to such min-
5 istry.

6 “(B) HEALTH CARE SHARING MINISTRY.—
7 For purposes of this paragraph, the term
8 ‘health care sharing ministry’ means any health
9 care cost sharing arrangement among persons
10 of similar beliefs that is not in the trade or
11 business of providing health insurance.

12 “(C) CREDIT DENIED IN THE CASE OF
13 CHARITABLE CONTRIBUTIONS.—This paragraph
14 shall not apply in the case of any contribution
15 for which a deduction is allowable under section
16 170.

17 “(h) ELECTION TO FORGO OTHER FEDERAL
18 HEALTH BENEFIT PROGRAMS.—

19 “(1) IN GENERAL.—An individual who is a par-
20 ticipant in, or is entitled to benefits under, any pro-
21 gram described in subsection (c)(2) in any month
22 may elect to forgo such individual’s participation in
23 or entitlement to benefits under such program in
24 such month. If such election is made with respect to
25 any month, such month shall not fail to be deemed

1 a coverage month with respect to such individual
 2 solely because such individual would, but for such
 3 election, be a participant in or be entitled to benefits
 4 under a program described in subsection (c)(2).

5 “(2) MANNER AND REPORTING OF ELEC-
 6 TION.—The election described in paragraph (1) shall
 7 be made in a form and manner specified by the Sec-
 8 retary of Health and Human Services, in consulta-
 9 tion with the Secretary of the Treasury, and a dec-
 10 laration of such election shall be attached to the tax-
 11 payer’s return of tax for the taxable year, in a man-
 12 ner specified by the Secretary of the Treasury.

13 “(3) PROSPECTIVE AND YEAR-LONG ELEC-
 14 TION.—Each election described in paragraph (1)—

15 “(A) shall not be made with respect to any
 16 month beginning before the date of such elec-
 17 tion, and

18 “(B) shall be effective for such period (not
 19 less than 1 calendar year) as shall be specified
 20 by the Secretary of Health and Human Serv-
 21 ices, in consultation with the Secretary of the
 22 Treasury.

23 “(i) CREDIT IN EXCESS OF ALLOWABLE CREDIT DE-
 24 POSITED IN TAX-FAVORED HEALTH CARE ACCOUNTS.—

25 “(1) IN GENERAL.—The excess, if any, of—

1 “(A) the monthly limitation applicable to
2 the individual under subsection (b), multiplied
3 by the number of coverage months of the indi-
4 vidual for the taxable year, over

5 “(B) the credit allowed in such taxable
6 year with respect to such individual under sub-
7 section (a),

8 shall be paid by the Secretary into the designated
9 account of the individual.

10 “(2) DESIGNATED ACCOUNTS.—

11 “(A) DESIGNATED ACCOUNT.—For pur-
12 poses of this subsection, the term ‘designated
13 account’ means any health savings account
14 under section 223 or any Archer MSA under
15 section 220 established and maintained by the
16 provider of the individual’s qualified health in-
17 surance—

18 “(i) which is designated by the indi-
19 vidual (in such form and manner as the
20 Secretary may provide) on the return of
21 tax for the taxable year, and

22 “(ii) which, under the terms of the ac-
23 count, accepts the payment described in
24 paragraph (1) on behalf of the individual.

1 “(B) TREATMENT OF PAYMENT.—Any
2 payment under this subsection to a designated
3 account—

4 “(i) shall not be taken into account
5 with respect to any dollar limitation which
6 applies with respect to contributions to
7 such account (or to tax benefits with re-
8 spect to such contributions),

9 “(ii) shall be included in gross income
10 of the taxpayer for the taxable year in
11 which the payment is made (except as pro-
12 vided in clause (iii)), and

13 “(iii) shall be taken into account in
14 determining any deduction or exclusion
15 from gross income in the same manner as
16 if such contribution were made by the tax-
17 payer.

18 “(j) COORDINATION WITH ADVANCE PAYMENTS.—

19 “(1) REDUCTION IN CREDIT FOR ADVANCE PAY-
20 MENTS.—With respect to any taxable year, the
21 amount which would (but for this subsection, and
22 without regard to subsection (i)) be allowed as a
23 credit to the taxpayer under subsection (a) shall be
24 reduced (but not below zero) by the aggregate
25 amount paid on behalf of such taxpayer under sec-

1 tion 7527A for months beginning in such taxable
2 year.

3 “(2) RECAPTURE OF EXCESS ADVANCE PAY-
4 MENTS.—If the aggregate amount paid on behalf of
5 the taxpayer under section 7527A for months begin-
6 ning in the taxable year exceeds the sum of the
7 monthly limitations under subsection (b) for such
8 taxable year, then the tax imposed by this chapter
9 for such taxable year shall be increased by the sum
10 of—

11 “(A) such excess, plus

12 “(B) interest on such excess determined at
13 the underpayment rate established under sec-
14 tion 6621 for the period from the date of the
15 payment under section 7527A to the date such
16 excess is paid.

17 For purposes of subparagraph (B), an equal part of
18 the aggregate amount of the excess shall be deemed
19 to be attributable to payments made under section
20 7527A on the first day of each month beginning in
21 such taxable year, unless the taxpayer establishes
22 the date on which each such payment giving rise to
23 such excess occurred, in which case subparagraph
24 (B) shall be applied with respect to each date so es-
25 tablished.

1 “(k) REGULATIONS.—The Secretary shall prescribe
2 regulations for the administration of this section to ensure
3 that no portion of the amounts taken into account as
4 qualified health insurance costs are amounts for which an-
5 other credit, deduction, or exclusion is allowed under this
6 subtitle, including through a health flexible spending ar-
7 rangement.”.

8 (b) ADVANCE PAYMENT OF CREDIT.—Chapter 77 of
9 the Internal Revenue Code of 1986 is amended by insert-
10 ing after section 7527 the following new section:

11 **“SEC. 7527A. ADVANCE PAYMENT OF QUALIFIED HEALTH**
12 **INSURANCE CREDIT.**

13 “(a) IN GENERAL.—The Secretary shall establish a
14 program for making payments on behalf of taxpayers who
15 are eligible individuals within the meaning of section
16 36B(c) to providers of qualified health insurance (as de-
17 fined in section 36B(e)) or to health care sharing min-
18 istries (as defined in section 36B(g)(7)(B)) for such indi-
19 viduals.

20 “(b) LIMITATION.—The Secretary may make pay-
21 ments under subsection (a) only to the extent that the Sec-
22 retary determines that the amount of such payments made
23 on behalf of any taxpayer for any month does not exceed
24 the monthly limitation in effect under section 36B(b) for
25 the taxpayer for such month.”.

1 (c) INFORMATION REPORTING.—

2 (1) IN GENERAL.—Subpart B of part III of
3 subchapter A of chapter 61 of the Internal Revenue
4 Code of 1986 is amended by inserting after section
5 6050W the following new section:

6 **“SEC. 6050X. RETURNS RELATING TO QUALIFIED HEALTH**
7 **INSURANCE CREDIT.**

8 “(a) REQUIREMENT OF REPORTING.—Every person
9 who is entitled to receive payments for any month of any
10 calendar year under section 7527A (relating to advance
11 payment of qualified health insurance credit) with respect
12 to any individual shall, at such time as the Secretary may
13 prescribe, make the return described in subsection (b) with
14 respect to each such individual.

15 “(b) FORM AND MANNER OF RETURNS.—A return
16 is described in this subsection if such return—

17 “(1) is in such form as the Secretary may pre-
18 scribe, and

19 “(2) contains, with respect to each individual
20 referred to in subsection (a)—

21 “(A) the name, address, and TIN of each
22 such individual,

23 “(B) the months for which amounts pay-
24 ments under section 7527A were received,

25 “(C) the amount of each such payment,

1 “(D) the type of insurance coverage pro-
2 vided by such person with respect to such indi-
3 vidual and the policy number associated with
4 such coverage, if applicable,

5 “(E) the name, address, and TIN of the
6 spouse and each dependent covered under such
7 coverage, and

8 “(F) such other information as the Sec-
9 retary may prescribe.

10 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
11 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
12 QUIRED.—Every person required to make a return under
13 subsection (a) shall furnish to each individual whose name
14 is required to be set forth in such return a written state-
15 ment showing—

16 “(1) the name and address of the person re-
17 quired to make such return and the phone number
18 of the information contact for such person, and

19 “(2) the information required to be shown on
20 the return with respect to such individual.

21 The written statement required under the preceding sen-
22 tence shall be furnished on or before January 31 of the
23 year following the calendar year for which the return
24 under subsection (a) is required to be made.

1 “(d) RETURNS WHICH WOULD BE REQUIRED TO BE
2 MADE BY 2 OR MORE PERSONS.—Except to the extent
3 provided in regulations prescribed by the Secretary, in the
4 case of any amount received by any person on behalf of
5 another person, only the person first receiving such
6 amount shall be required to make the return under sub-
7 section (a).”.

8 (2) ASSESSABLE PENALTIES.—

9 (A) Subparagraph (B) of section
10 6724(d)(1) of such Code is amended by striking
11 “or” at the end of clause (xxii), by striking
12 “and” at the end of clause (xxiii) and inserting
13 “or”, and by inserting after clause (xxiii) the
14 following new clause:

15 “(xxiv) section 6050X (relating to re-
16 turns relating to qualified health insurance
17 credit), and”.

18 (B) Paragraph (2) of section 6724(d) of
19 such Code is amended by striking “or” at the
20 end of subparagraph (EE), by striking the pe-
21 riod at the end of subparagraph (FF) and in-
22 serting “, or”, and by inserting after subpara-
23 graph (FF) the following new subparagraph:

24 “(GG) section 6050X (relating to returns
25 relating to qualified health insurance credit).”.

1 (d) CONFORMING AMENDMENTS.—

2 (1) Paragraph (2) of section 1324(b) of title
3 31, United States Code, is amended by inserting
4 “36B,” after “36A,”.

5 (2) The table of sections for subpart C of part
6 IV of subchapter A of chapter 1 of the Internal Rev-
7 enue Code of 1986 is amended by inserting after the
8 item relating to section 36A the following new item:

“Sec. 36B. Qualified health insurance credit.”.

9 (3) The table of sections for chapter 77 of such
10 Code is amended by inserting after the item relating
11 to section 7527 the following new item:

“Sec. 7527A. Advance payment of qualified health insurance credit.”.

12 (4) The table of sections for subpart B of part
13 III of subchapter A of chapter 61 of such Code is
14 amended by adding at the end the following new
15 item:

“Sec. 6050X. Returns relating to qualified health insurance credit.”.

16 (e) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 December 31, 2009.

1 **Subtitle B—Improvements to**
2 **Health Savings Accounts**

3 **SEC. 111. PURCHASE OF HEALTH INSURANCE FROM HSA**
4 **AND ARCHER MSA ACCOUNTS.**

5 (a) **HEALTH SAVINGS ACCOUNTS.**—Paragraph (2) of
6 section 223(d) of the Internal Revenue Code of 1986 is
7 amended to read as follows:

8 “(2) **QUALIFIED MEDICAL EXPENSES.**—

9 “(A) **IN GENERAL.**—The term ‘qualified
10 medical expenses’ means, with respect to an ac-
11 count beneficiary, amounts paid by such bene-
12 ficiary for medical care (as defined in section
13 213(d)) for any individual covered by a high de-
14 ductible health plan of the account beneficiary,
15 but only to the extent such amounts are not
16 compensated for by insurance or otherwise.

17 “(B) **HEALTH INSURANCE MAY NOT BE**
18 **PURCHASED FROM ACCOUNT.**—Except as pro-
19 vided in subparagraph (C), subparagraph (A)
20 shall not apply to any payment for insurance.

21 “(C) **EXCEPTIONS.**—Subparagraph (B)
22 shall not apply to any expense for coverage
23 under—

1 “(i) a health plan during any period
2 of continuation coverage required under
3 any Federal law,

4 “(ii) a qualified long-term care insur-
5 ance contract (as defined in section
6 7702B(b)),

7 “(iii) a health plan during any period
8 in which the individual is receiving unem-
9 ployment compensation under any Federal
10 or State law,

11 “(iv) a high deductible health plan, or

12 “(v) any health insurance under title
13 XVIII of the Social Security Act, other
14 than a Medicare supplemental policy (as
15 defined in section 1882 of such Act).”.

16 (b) ARCHER MSAS.—Subparagraph (B) of section
17 220(d)(2) of the Internal Revenue Code of 1986 is amend-
18 ed to read as follows:

19 “(B) HEALTH INSURANCE MAY NOT BE
20 PURCHASED FROM ACCOUNT.—

21 “(i) IN GENERAL.—Subparagraph (A)
22 shall not apply to any payment for insur-
23 ance.

1 “(ii) EXCEPTIONS.—Clause (i) shall
2 not apply to any expense for coverage
3 under—

4 “(I) a health plan during any pe-
5 riod of continuation coverage required
6 under any Federal law,

7 “(II) a qualified long-term care
8 insurance contract (as defined in sec-
9 tion 7702B(b)),

10 “(III) a health plan during any
11 period in which the individual is re-
12 ceiving unemployment compensation
13 under any Federal or State law,

14 “(IV) a high deductible health
15 plan, or

16 “(V) any health insurance under
17 title XVIII of the Social Security Act,
18 other than a Medicare supplemental
19 policy (as defined in section 1882 of
20 such Act).”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply with respect to insurance pur-
23 chased after the date of the enactment of this Act in tax-
24 able years beginning after such date.

1 **Subtitle C—Medical Care Access**
2 **Protection**

3 **SEC. 121. SHORT TITLE.**

4 This subtitle may be cited as the “Medical Care Ac-
5 cess Protection Act of 2009” or the “MCAP Act”.

6 **SEC. 122. FINDINGS AND PURPOSE.**

7 (a) FINDINGS.—

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

19 (2) EFFECT ON INTERSTATE COMMERCE.—

20 Congress finds that the health care and insurance
21 industries are industries affecting interstate com-
22 merce and the health care liability litigation systems
23 existing throughout the United States are activities
24 that affect interstate commerce by contributing to
25 the high costs of health care and premiums for

1 health care liability insurance purchased by health
2 care system providers.

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

8 (A) the large number of individuals who
9 receive health care benefits under programs op-
10 erated or financed by the Federal Government;

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

15 (C) the large number of health care pro-
16 viders who provide items or services for which
17 the Federal Government makes payments.

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

21 (1) improve the availability of health care serv-
22 ices in cases in which health care liability actions
23 have been shown to be a factor in the decreased
24 availability of services;

1 (2) reduce the incidence of “defensive medi-
2 cine” and lower the cost of health care liability in-
3 surance, all of which contribute to the escalation of
4 health care costs;

5 (3) ensure that persons with meritorious health
6 care injury claims receive fair and adequate com-
7 pensation, including reasonable noneconomic dam-
8 ages;

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

14 (5) provide an increased sharing of information
15 in the health care system which will reduce unin-
16 tended injury and improve patient care.

17 **SEC. 123. DEFINITIONS.**

18 In this subtitle:

19 (1) ALTERNATIVE DISPUTE RESOLUTION SYS-
20 TEM; ADR.—The term “alternative dispute resolution
21 system” or “ADR” means a system that provides
22 for the resolution of health care lawsuits in a man-
23 ner other than through a civil action brought in a
24 State or Federal court.

1 (2) CLAIMANT.—The term “claimant” means
2 any person who brings a health care lawsuit, includ-
3 ing a person who asserts or claims a right to legal
4 or equitable contribution, indemnity or subrogation,
5 arising out of a health care liability claim or action,
6 and any person on whose behalf such a claim is as-
7 serted or such an action is brought, whether de-
8 ceased, incompetent, or a minor.

9 (3) COLLATERAL SOURCE BENEFITS.—The
10 term “collateral source benefits” means any amount
11 paid or reasonably likely to be paid in the future to
12 or on behalf of the claimant, or any service, product
13 or other benefit provided or reasonably likely to be
14 provided in the future to or on behalf of the claim-
15 ant, as a result of the injury or wrongful death, pur-
16 suant to—

17 (A) any State or Federal health, sickness,
18 income-disability, accident, or workers’ com-
19 pensation law;

20 (B) any health, sickness, income-disability,
21 or accident insurance that provides health bene-
22 fits or income-disability coverage;

23 (C) any contract or agreement of any
24 group, organization, partnership, or corporation
25 to provide, pay for, or reimburse the cost of

1 medical, hospital, dental, or income disability
2 benefits; and

3 (D) any other publicly or privately funded
4 program.

5 (4) COMPENSATORY DAMAGES.—The term
6 “compensatory damages” means objectively
7 verifiable monetary losses incurred as a result of the
8 provision of, use of, or payment for (or failure to
9 provide, use, or pay for) health care services or med-
10 ical products, such as past and future medical ex-
11 penses, loss of past and future earnings, cost of ob-
12 taining domestic services, loss of employment, and
13 loss of business or employment opportunities, dam-
14 ages for physical and emotional pain, suffering, in-
15 convenience, physical impairment, mental anguish,
16 disfigurement, loss of enjoyment of life, loss of soci-
17 ety and companionship, loss of consortium (other
18 than loss of domestic service), hedonic damages, in-
19 jury to reputation, and all other nonpecuniary losses
20 of any kind or nature. Such term includes economic
21 damages and noneconomic damages, as such terms
22 are defined in this section.

23 (5) CONTINGENT FEE.—The term “contingent
24 fee” includes all compensation to any person or per-

1 sons which is payable only if a recovery is effected
2 on behalf of one or more claimants.

3 (6) ECONOMIC DAMAGES.—The term “economic
4 damages” means objectively verifiable monetary
5 losses incurred as a result of the provision of, use
6 of, or payment for (or failure to provide, use, or pay
7 for) health care services or medical products, such as
8 past and future medical expenses, loss of past and
9 future earnings, cost of obtaining domestic services,
10 loss of employment, and loss of business or employ-
11 ment opportunities.

12 (7) HEALTH CARE GOODS OR SERVICES.—The
13 term “health care goods or services” means any
14 goods or services provided by a health care institu-
15 tion, provider, or by any individual working under
16 the supervision of a health care provider, that relates
17 to the diagnosis, prevention, care, or treatment of
18 any human disease or impairment, or the assessment
19 of the health of human beings.

20 (8) HEALTH CARE INSTITUTION.—The term
21 “health care institution” means any entity licensed
22 under Federal or State law to provide health care
23 services (including but not limited to ambulatory
24 surgical centers, assisted living facilities, emergency
25 medical services providers, hospices, hospitals and

1 hospital systems, nursing homes, or other entities li-
2 censed to provide such services).

3 (9) HEALTH CARE LAWSUIT.—The term
4 “health care lawsuit” means any health care liability
5 claim concerning the provision of health care goods
6 or services affecting interstate commerce, or any
7 health care liability action concerning the provision
8 of (or the failure to provide) health care goods or
9 services affecting interstate commerce, brought in a
10 State or Federal court or pursuant to an alternative
11 dispute resolution system, against a health care pro-
12 vider or a health care institution regardless of the
13 theory of liability on which the claim is based, or the
14 number of claimants, plaintiffs, defendants, or other
15 parties, or the number of claims or causes of action,
16 in which the claimant alleges a health care liability
17 claim.

18 (10) HEALTH CARE LIABILITY ACTION.—The
19 term “health care liability action” means a civil ac-
20 tion brought in a State or Federal Court or pursu-
21 ant to an alternative dispute resolution system,
22 against a health care provider or a health care insti-
23 tution regardless of the theory of liability on which
24 the claim is based, or the number of plaintiffs, de-
25 fendants, or other parties, or the number of causes

1 of action, in which the claimant alleges a health care
2 liability claim.

3 (11) HEALTH CARE LIABILITY CLAIM.—The
4 term “health care liability claim” means a demand
5 by any person, whether or not pursuant to ADR,
6 against a health care provider or health care institu-
7 tion, including third-party claims, cross-claims,
8 counter-claims, or contribution claims, which are
9 based upon the provision of, use of, or payment for
10 (or the failure to provide, use, or pay for) health
11 care services, regardless of the theory of liability on
12 which the claim is based, or the number of plaintiffs,
13 defendants, or other parties, or the number of
14 causes of action.

15 (12) HEALTH CARE PROVIDER.—

16 (A) IN GENERAL.—The term “health care
17 provider” means any person (including but not
18 limited to a physician (as defined by section
19 1861(r) of the Social Security Act (42 U.S.C.
20 1395x(r)), registered nurse, dentist, podiatrist,
21 pharmacist, chiropractor, or optometrist) re-
22 quired by State or Federal law to be licensed,
23 registered, or certified to provide health care
24 services, and being either so licensed, reg-

1 istered, or certified, or exempted from such re-
2 quirement by other statute or regulation.

3 (B) TREATMENT OF CERTAIN PROFES-
4 SIONAL ASSOCIATIONS.—For purposes of this
5 subtitle, a professional association that is orga-
6 nized under State law by an individual physi-
7 cian or group of physicians, a partnership or
8 limited liability partnership formed by a group
9 of physicians, a nonprofit health corporation
10 certified under State law, or a company formed
11 by a group of physicians under State law shall
12 be treated as a health care provider under sub-
13 paragraph (A).

14 (13) MALICIOUS INTENT TO INJURE.—The
15 term “malicious intent to injure” means inten-
16 tionally causing or attempting to cause physical in-
17 jury other than providing health care goods or serv-
18 ices.

19 (14) NONECONOMIC DAMAGES.—The term
20 “noneconomic damages” means damages for phys-
21 ical and emotional pain, suffering, inconvenience,
22 physical impairment, mental anguish, disfigurement,
23 loss of enjoyment of life, loss of society and compan-
24 ionship, loss of consortium (other than loss of do-
25 mestic service), hedonic damages, injury to reputa-

1 tion, and all other nonpecuniary losses of any kind
2 or nature.

3 (15) PUNITIVE DAMAGES.—The term “punitive
4 damages” means damages awarded, for the purpose
5 of punishment or deterrence, and not solely for com-
6 pensatory purposes, against a health care provider
7 or health care institution. Punitive damages are nei-
8 ther economic nor noneconomic damages.

9 (16) RECOVERY.—The term “recovery” means
10 the net sum recovered after deducting any disburse-
11 ments or costs incurred in connection with prosecu-
12 tion or settlement of the claim, including all costs
13 paid or advanced by any person. Costs of health care
14 incurred by the plaintiff and the attorneys’ office
15 overhead costs or charges for legal services are not
16 deductible disbursements or costs for such purpose.

17 (17) STATE.—The term “State” means each of
18 the several States, the District of Columbia, the
19 Commonwealth of Puerto Rico, the Virgin Islands,
20 Guam, American Samoa, the Northern Mariana Is-
21 lands, the Trust Territory of the Pacific Islands, and
22 any other territory or possession of the United
23 States, or any political subdivision thereof.

1 **SEC. 124. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.**

2 (a) **IN GENERAL.**—Except as otherwise provided for
3 in this section, the time for the commencement of a health
4 care lawsuit shall be 3 years after the date of manifesta-
5 tion of injury or 1 year after the claimant discovers, or
6 through the use of reasonable diligence should have discov-
7 ered, the injury, whichever occurs first.

8 (b) **GENERAL EXCEPTION.**—The time for the com-
9 mencement of a health care lawsuit shall not exceed 3
10 years after the date of manifestation of injury unless the
11 tolling of time was delayed as a result of—

12 (1) fraud;

13 (2) intentional concealment; or

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

17 (c) **MINORS.**—An action by a minor shall be com-
18 menced within 3 years from the date of the alleged mani-
19 festation of injury except that if such minor is under the
20 full age of 6 years, such action shall be commenced within
21 3 years of the manifestation of injury, or prior to the
22 eighth birthday of the minor, whichever provides a longer
23 period. Such time limitation shall be tolled for minors for
24 any period during which a parent or guardian and a health
25 care provider or health care institution have committed

1 fraud or collusion in the failure to bring an action on be-
2 half of the injured minor.

3 (d) **RULE 11 SANCTIONS.**—Whenever a Federal or
4 State court determines (whether by motion of the parties
5 or whether on the motion of the court) that there has been
6 a violation of rule 11 of the Federal Rules of Civil Proce-
7 dure (or a similar violation of applicable State court rules)
8 in a health care liability action to which this subtitle ap-
9 plies, the court shall impose upon the attorneys, law firms,
10 or pro se litigants that have violated rule 11 or are respon-
11 sible for the violation, an appropriate sanction, which shall
12 include an order to pay the other party or parties for the
13 reasonable expenses incurred as a direct result of the filing
14 of the pleading, motion, or other paper that is the subject
15 of the violation, including a reasonable attorneys’ fee.
16 Such sanction shall be sufficient to deter repetition of such
17 conduct or comparable conduct by others similarly situ-
18 ated, and to compensate the party or parties injured by
19 such conduct.

20 **SEC. 125. COMPENSATING PATIENT INJURY.**

21 (a) **UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL**
22 **ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.**—In any
23 health care lawsuit, nothing in this subtitle shall limit the
24 recovery by a claimant of the full amount of the available

1 economic damages, notwithstanding the limitation con-
2 tained in subsection (b).

3 (b) ADDITIONAL NONECONOMIC DAMAGES.—

4 (1) HEALTH CARE PROVIDERS.—In any health
5 care lawsuit where final judgment is rendered
6 against a health care provider, the amount of non-
7 economic damages recovered from the provider, if
8 otherwise available under applicable Federal or State
9 law, may be as much as \$250,000, regardless of the
10 number of parties other than a health care institu-
11 tion against whom the action is brought or the num-
12 ber of separate claims or actions brought with re-
13 spect to the same occurrence.

14 (2) HEALTH CARE INSTITUTIONS.—

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

1 (B) MULTIPLE INSTITUTIONS.—In any
2 health care lawsuit where final judgment is ren-
3 dered against more than one health care insti-
4 tution, the amount of noneconomic damages re-
5 covered from each institution, if otherwise avail-
6 able under applicable Federal or State law, may
7 be as much as \$250,000, regardless of the
8 number of parties against whom the action is
9 brought or the number of separate claims or ac-
10 tions brought with respect to the same occur-
11 rence, except that the total amount recovered
12 from all such institutions in such lawsuit shall
13 not exceed \$500,000.

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

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

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

21 (3) an award for noneconomic damages in ex-
22 cess of the limitations provided for in subsection (b)
23 shall be reduced either before the entry of judgment,
24 or by amendment of the judgment after entry of
25 judgment, and such reduction shall be made before

1 accounting for any other reduction in damages re-
2 quired by law; and

3 (4) if separate awards are rendered for past
4 and future noneconomic damages and the combined
5 awards exceed the limitations described in subsection
6 (b), the future noneconomic damages shall be re-
7 duced first.

8 (d) FAIR SHARE RULE.—In any health care lawsuit,
9 each party shall be liable for that party's several share
10 of any damages only and not for the share of any other
11 person. Each party shall be liable only for the amount of
12 damages allocated to such party in direct proportion to
13 such party's percentage of responsibility. A separate judg-
14 ment shall be rendered against each such party for the
15 amount allocated to such party. For purposes of this sec-
16 tion, the trier of fact shall determine the proportion of
17 responsibility of each party for the claimant's harm.

18 **SEC. 126. MAXIMIZING PATIENT RECOVERY.**

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

21 (1) IN GENERAL.—In any health care lawsuit,
22 the court shall supervise the arrangements for pay-
23 ment of damages to protect against conflicts of in-
24 terest that may have the effect of reducing the

1 amount of damages awarded that are actually paid
2 to claimants.

3 (2) CONTINGENCY FEES.—

4 (A) IN GENERAL.—In any health care law-
5 suit in which the attorney for a party claims a
6 financial stake in the outcome by virtue of a
7 contingent fee, the court shall have the power
8 to restrict the payment of a claimant's damage
9 recovery to such attorney, and to redirect such
10 damages to the claimant based upon the inter-
11 ests of justice and principles of equity.

12 (B) LIMITATION.—The total of all contin-
13 gent fees for representing all claimants in a
14 health care lawsuit shall not exceed the fol-
15 lowing limits:

16 (i) 40 percent of the first \$50,000 re-
17 covered by the claimant(s).

18 (ii) $33\frac{1}{3}$ percent of the next \$50,000
19 recovered by the claimant(s).

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

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

25 (b) APPLICABILITY.—

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

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

9 (c) EXPERT WITNESSES.—

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

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

16 (i) is appropriately credentialed or li-
17 censed in 1 or more States to deliver
18 health care services; and

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

22 (B) can demonstrate by competent evi-
23 dence that, as a result of training, education,
24 knowledge, and experience in the evaluation, di-
25 agnosis, and treatment of the disease or injury

1 which is the subject matter of the lawsuit
2 against the defendant, the individual was sub-
3 stantially familiar with applicable standards of
4 care and practice as they relate to the act or
5 omission which is the subject of the lawsuit on
6 the date of the incident.

7 (2) PHYSICIAN REVIEW.—In a health care law-
8 suit, if the claim of the plaintiff involved treatment
9 that is recommended or provided by a physician
10 (allopathic or osteopathic), an individual shall not be
11 qualified to be an expert witness under this sub-
12 section with respect to issues of negligence con-
13 cerning such treatment unless such individual is a
14 physician.

15 (3) SPECIALTIES AND SUBSPECIALTIES.—With
16 respect to a lawsuit described in paragraph (1), a
17 court shall not permit an expert in one medical spe-
18 cialty or subspecialty to testify against a defendant
19 in another medical specialty or subspecialty unless,
20 in addition to a showing of substantial familiarity in
21 accordance with paragraph (1)(B), there is a show-
22 ing that the standards of care and practice in the
23 two specialty or subspecialty fields are similar.

24 (4) LIMITATION.—The limitations in this sub-
25 section shall not apply to expert witnesses testifying

1 as to the degree or permanency of medical or phys-
2 ical impairment.

3 **SEC. 127. ADDITIONAL HEALTH BENEFITS.**

4 (a) IN GENERAL.—The amount of any damages re-
5 ceived by a claimant in any health care lawsuit shall be
6 reduced by the court by the amount of any collateral
7 source benefits to which the claimant is entitled, less any
8 insurance premiums or other payments made by the claim-
9 ant (or by the spouse, parent, child, or legal guardian of
10 the claimant) to obtain or secure such benefits.

11 (b) PRESERVATION OF CURRENT LAW.—Where a
12 payor of collateral source benefits has a right of recovery
13 by reimbursement or subrogation and such right is per-
14 mitted under Federal or State law, subsection (a) shall
15 not apply.

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

19 **SEC. 128. PUNITIVE DAMAGES.**

20 (a) PUNITIVE DAMAGES PERMITTED.—

21 (1) IN GENERAL.—Punitive damages may, if
22 otherwise available under applicable State or Federal
23 law, be awarded against any person in a health care
24 lawsuit only if it is proven by clear and convincing
25 evidence that such person acted with malicious in-

1 tent to injure the claimant, or that such person de-
2 liberately failed to avoid unnecessary injury that
3 such person knew the claimant was substantially
4 certain to suffer.

5 (2) FILING OF LAWSUIT.—No demand for puni-
6 tive damages shall be included in a health care law-
7 suit as initially filed. A court may allow a claimant
8 to file an amended pleading for punitive damages
9 only upon a motion by the claimant and after a find-
10 ing by the court, upon review of supporting and op-
11 posing affidavits or after a hearing, after weighing
12 the evidence, that the claimant has established by a
13 substantial probability that the claimant will prevail
14 on the claim for punitive damages.

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

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

20 (B) the amount of punitive damages fol-
21 lowing a determination of punitive liability.

22 If a separate proceeding is requested, evidence rel-
23 evant only to the claim for punitive damages, as de-
24 termined by applicable State law, shall be inadmis-

1 sible in any proceeding to determine whether com-
2 pensatory damages are to be awarded.

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

9 (b) DETERMINING AMOUNT OF PUNITIVE DAM-
10 AGES.—

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

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

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

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

20 (D) the number of products sold or med-
21 ical procedures rendered for compensation, as
22 the case may be, by such party, of the kind
23 causing the harm complained of by the claim-
24 ant;

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

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

7 (2) MAXIMUM AWARD.—The amount of punitive
8 damages awarded in a health care lawsuit may not
9 exceed an amount equal to two times the amount of
10 economic damages awarded in the lawsuit or
11 \$250,000, whichever is greater. The jury shall not
12 be informed of the limitation under the preceding
13 sentence.

14 (c) LIABILITY OF HEALTH CARE PROVIDERS.—

15 (1) IN GENERAL.—A health care provider who
16 prescribes, or who dispenses pursuant to a prescrip-
17 tion, a drug, biological product, or medical device
18 approved by the Food and Drug Administration, for
19 an approved indication of the drug, biological prod-
20 uct, or medical device, shall not be named as a party
21 to a product liability lawsuit invoking such drug, bi-
22 ological product, or medical device and shall not be
23 liable to a claimant in a class action lawsuit against
24 the manufacturer, distributor, or product seller of
25 such drug, biological product, or medical device.

1 (2) **MEDICAL PRODUCT.**—The term “medical
2 product” means a drug or device intended for hu-
3 mans. The terms “drug” and “device” have the
4 meanings given such terms in sections 201(g)(1) and
5 201(h) of the Federal Food, Drug and Cosmetic Act
6 (21 U.S.C. 321), respectively, including any compo-
7 nent or raw material used therein, but excluding
8 health care services.

9 **SEC. 129. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**
10 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**
11 **SUITS.**

12 (a) **IN GENERAL.**—In any health care lawsuit, if an
13 award of future damages, without reduction to present
14 value, equaling or exceeding \$50,000 is made against a
15 party with sufficient insurance or other assets to fund a
16 periodic payment of such a judgment, the court shall, at
17 the request of any party, enter a judgment ordering that
18 the future damages be paid by periodic payments in ac-
19 cordance with the Uniform Periodic Payment of Judg-
20 ments Act promulgated by the National Conference of
21 Commissioners on Uniform State Laws.

22 (b) **APPLICABILITY.**—This section applies to all ac-
23 tions which have not been first set for trial or retrial be-
24 fore the effective date of this subtitle.

1 **SEC. 130. EFFECT ON OTHER LAWS.**

2 (a) GENERAL VACCINE INJURY.—

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

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

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

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

19 (b) SMALLPOX VACCINE INJURY.—

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

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

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

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

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

16 **SEC. 131. STATE FLEXIBILITY AND PROTECTION OF**
17 **STATES' RIGHTS.**

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

1 (1) provides for a greater amount of damages
2 or contingent fees, a longer period in which a health
3 care lawsuit may be commenced, or a reduced appli-
4 cability or scope of periodic payment of future dam-
5 ages, than provided in this subtitle; or

6 (2) prohibits the introduction of evidence re-
7 garding collateral source benefits.

8 (b) PREEMPTION OF CERTAIN STATE LAWS.—No
9 provision of this subtitle shall be construed to preempt any
10 State law (whether effective before, on, or after the date
11 of the enactment of this subtitle) that specifies a par-
12 ticular monetary amount of compensatory or punitive
13 damages (or the total amount of damages) that may be
14 awarded in a health care lawsuit, regardless of whether
15 such monetary amount is greater or lesser than is provided
16 for under this subtitle, notwithstanding section 125(a).

17 (c) PROTECTION OF STATES' RIGHTS AND OTHER
18 LAWS.—

19 (1) IN GENERAL.—Any issue that is not gov-
20 erned by a provision of law established by or under
21 this subtitle (including the State standards of neg-
22 ligence) shall be governed by otherwise applicable
23 Federal or State law.

24 (2) RULE OF CONSTRUCTION.—Nothing in this
25 subtitle shall be construed to—

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

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

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

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

17 **SEC. 132. APPLICABILITY; EFFECTIVE DATE.**

18 This subtitle shall apply to any health care lawsuit
19 brought in a Federal or State court, or subject to an alter-
20 native dispute resolution system, that is initiated on or
21 after the date of the enactment of this subtitle, except that
22 any health care lawsuit arising from an injury occurring
23 prior to the date of enactment of this subtitle shall be gov-
24 erned by the applicable statute of limitations provisions
25 in effect at the time the injury occurred.

1 **TITLE II—ENHANCEMENT OF IN-**
2 **SURANCE MARKETS FOR ALL**
3 **AMERICANS**

4 **Subtitle A—Elimination of Barriers**

5 **SEC. 201. SHORT TITLE.**

6 This title may be cited as “Health Care Choice Act
7 of 2009”.

8 **SEC. 202. SPECIFICATION OF CONSTITUTIONAL AUTHORITY**
9 **FOR ENACTMENT OF LAW.**

10 This title is enacted pursuant to the power granted
11 Congress under article I, section 8, clause 3, of the United
12 States Constitution.

13 **SEC. 203. FINDINGS.**

14 Congress finds the following:

15 (1) The application of numerous and significant
16 variations in State law impacts the ability of insur-
17 ers to offer, and individuals to obtain, affordable in-
18 dividual health insurance coverage, thereby impeding
19 commerce in individual health insurance coverage.

20 (2) Individual health insurance coverage is in-
21 creasingly offered through the Internet, other elec-
22 tronic means, and by mail, all of which are inher-
23 ently part of interstate commerce.

24 (3) In response to these issues, it is appropriate
25 to encourage increased efficiency in the offering of

1 individual health insurance coverage through a col-
 2 laborative approach by the States in regulating this
 3 coverage.

4 (4) The establishment of risk-retention groups
 5 has provided a successful model for the sale of insur-
 6 ance across State lines, as the acts establishing
 7 those groups allow insurance to be sold in multiple
 8 States but regulated by a single State.

9 **SEC. 204. COOPERATIVE GOVERNING OF INDIVIDUAL**
 10 **HEALTH INSURANCE COVERAGE.**

11 (a) IN GENERAL.—Title XXVII of the Public Health
 12 Service Act (42 U.S.C. 300gg et seq.) is amended by add-
 13 ing at the end the following new part:

14 **“PART D—COOPERATIVE GOVERNING OF**
 15 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

16 **“SEC. 2795. DEFINITIONS.**

17 “In this part:

18 “(1) PRIMARY STATE.—The term ‘primary
 19 State’ means, with respect to individual health insur-
 20 ance coverage offered by a health insurance issuer,
 21 the State designated by the issuer as the State
 22 whose covered laws shall govern the health insurance
 23 issuer in the sale of such coverage under this part.
 24 An issuer, with respect to a particular policy, may
 25 only designate one such State as its primary State

1 with respect to all such coverage it offers. Such an
2 issuer may not change the designated primary State
3 with respect to individual health insurance coverage
4 once the policy is issued, except that such a change
5 may be made upon renewal of the policy. With re-
6 spect to such designated State, the issuer is deemed
7 to be doing business in that State.

8 “(2) SECONDARY STATE.—The term ‘secondary
9 State’ means, with respect to individual health insur-
10 ance coverage offered by a health insurance issuer,
11 any State that is not the primary State. In the case
12 of a health insurance issuer that is selling a policy
13 in, or to a resident of, a secondary State, the issuer
14 is deemed to be doing business in that secondary
15 State.

16 “(3) HEALTH INSURANCE ISSUER.—The term
17 ‘health insurance issuer’ has the meaning given such
18 term in section 2791(b)(2), except that such an
19 issuer must be licensed in the primary State and be
20 qualified to sell individual health insurance coverage
21 in that State.

22 “(4) INDIVIDUAL HEALTH INSURANCE COV-
23 ERAGE.—The term ‘individual health insurance cov-
24 erage’ means health insurance coverage offered in

1 the individual market, as defined in section
2 2791(e)(1).

3 “(5) APPLICABLE STATE AUTHORITY.—The
4 term ‘applicable State authority’ means, with respect
5 to a health insurance issuer in a State, the State in-
6 surance commissioner or official or officials des-
7 ignated by the State to enforce the requirements of
8 this title for the State with respect to the issuer.

9 “(6) HAZARDOUS FINANCIAL CONDITION.—The
10 term ‘hazardous financial condition’ means that,
11 based on its present or reasonably anticipated finan-
12 cial condition, a health insurance issuer is unlikely
13 to be able—

14 “(A) to meet obligations to policyholders
15 with respect to known claims and reasonably
16 anticipated claims; or

17 “(B) to pay other obligations in the normal
18 course of business.

19 “(7) COVERED LAWS.—

20 “(A) IN GENERAL.—The term ‘covered
21 laws’ means the laws, rules, regulations, agree-
22 ments, and orders governing the insurance busi-
23 ness pertaining to—

24 “(i) individual health insurance cov-
25 erage issued by a health insurance issuer;

1 “(ii) the offer, sale, rating (including
2 medical underwriting), renewal, and
3 issuance of individual health insurance cov-
4 erage to an individual;

5 “(iii) the provision to an individual in
6 relation to individual health insurance cov-
7 erage of health care and insurance related
8 services;

9 “(iv) the provision to an individual in
10 relation to individual health insurance cov-
11 erage of management, operations, and in-
12 vestment activities of a health insurance
13 issuer; and

14 “(v) the provision to an individual in
15 relation to individual health insurance cov-
16 erage of loss control and claims adminis-
17 tration for a health insurance issuer with
18 respect to liability for which the issuer pro-
19 vides insurance.

20 “(B) EXCEPTION.—Such term does not in-
21 clude any law, rule, regulation, agreement, or
22 order governing the use of care or cost manage-
23 ment techniques, including any requirement re-
24 lated to provider contracting, network access or

1 adequacy, health care data collection, or quality
2 assurance.

3 “(8) STATE.—The term ‘State’ means the 50
4 States and includes the District of Columbia, Puerto
5 Rico, the Virgin Islands, Guam, American Samoa,
6 and the Northern Mariana Islands.

7 “(9) UNFAIR CLAIMS SETTLEMENT PRAC-
8 TICES.—The term ‘unfair claims settlement prac-
9 tices’ means only the following practices:

10 “(A) Knowingly misrepresenting to claim-
11 ants and insured individuals relevant facts or
12 policy provisions relating to coverage at issue.

13 “(B) Failing to acknowledge with reason-
14 able promptness pertinent communications with
15 respect to claims arising under policies.

16 “(C) Failing to adopt and implement rea-
17 sonable standards for the prompt investigation
18 and settlement of claims arising under policies.

19 “(D) Failing to effectuate prompt, fair,
20 and equitable settlement of claims submitted in
21 which liability has become reasonably clear.

22 “(E) Refusing to pay claims without con-
23 ducting a reasonable investigation.

24 “(F) Failing to affirm or deny coverage of
25 claims within a reasonable period of time after

1 having completed an investigation related to
2 those claims.

3 “(G) A pattern or practice of compelling
4 insured individuals or their beneficiaries to in-
5 stitute suits to recover amounts due under its
6 policies by offering substantially less than the
7 amounts ultimately recovered in suits brought
8 by them.

9 “(H) A pattern or practice of attempting
10 to settle or settling claims for less than the
11 amount that a reasonable person would believe
12 the insured individual or his or her beneficiary
13 was entitled by reference to written or printed
14 advertising material accompanying or made
15 part of an application.

16 “(I) Attempting to settle or settling claims
17 on the basis of an application that was materi-
18 ally altered without notice to, or knowledge or
19 consent of, the insured.

20 “(J) Failing to provide forms necessary to
21 present claims within 15 calendar days of a re-
22 quests with reasonable explanations regarding
23 their use.

1 “(K) Attempting to cancel a policy in less
2 time than that prescribed in the policy or by the
3 law of the primary State.

4 “(10) FRAUD AND ABUSE.—The term ‘fraud
5 and abuse’ means an act or omission committed by
6 a person who, knowingly and with intent to defraud,
7 commits, or conceals any material information con-
8 cerning, one or more of the following:

9 “(A) Presenting, causing to be presented
10 or preparing with knowledge or belief that it
11 will be presented to or by an insurer, a rein-
12 surer, broker or its agent, false information as
13 part of, in support of or concerning a fact ma-
14 terial to one or more of the following:

15 “(i) An application for the issuance or
16 renewal of an insurance policy or reinsur-
17 ance contract.

18 “(ii) The rating of an insurance policy
19 or reinsurance contract.

20 “(iii) A claim for payment or benefit
21 pursuant to an insurance policy or reinsur-
22 ance contract.

23 “(iv) Premiums paid on an insurance
24 policy or reinsurance contract.

1 “(v) Payments made in accordance
2 with the terms of an insurance policy or
3 reinsurance contract.

4 “(vi) A document filed with the com-
5 missioner or the chief insurance regulatory
6 official of another jurisdiction.

7 “(vii) The financial condition of an in-
8 surer or reinsurer.

9 “(viii) The formation, acquisition,
10 merger, reconsolidation, dissolution or
11 withdrawal from one or more lines of in-
12 surance or reinsurance in all or part of a
13 State by an insurer or reinsurer.

14 “(ix) The issuance of written evidence
15 of insurance.

16 “(x) The reinstatement of an insur-
17 ance policy.

18 “(B) Solicitation or acceptance of new or
19 renewal insurance risks on behalf of an insurer
20 reinsurer or other person engaged in the busi-
21 ness of insurance by a person who knows or
22 should know that the insurer or other person
23 responsible for the risk is insolvent at the time
24 of the transaction.

1 “(C) Transaction of the business of insur-
2 ance in violation of laws requiring a license, cer-
3 tificate of authority, or other legal authority for
4 the transaction of the business of insurance.

5 “(D) Attempt to commit, aiding or abet-
6 ting in the commission of, or conspiracy to com-
7 mit the acts or omissions specified in this para-
8 graph.

9 **“SEC. 2796. APPLICATION OF LAW.**

10 “(a) IN GENERAL.—The covered laws of the primary
11 State shall apply to individual health insurance coverage
12 offered by a health insurance issuer in the primary State
13 and in any secondary State, but only if the coverage and
14 issuer comply with the conditions of this section with re-
15 spect to the offering of coverage in any secondary State.

16 “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-
17 ONDARY STATE.—Except as provided in this section, a
18 health insurance issuer with respect to its offer, sale, rat-
19 ing (including medical underwriting), renewal, and
20 issuance of individual health insurance coverage in any
21 secondary State is exempt from any covered laws of the
22 secondary State (and any rules, regulations, agreements,
23 or orders sought or issued by such State under or related
24 to such covered laws) to the extent that such laws would—

1 “(1) make unlawful, or regulate, directly or in-
2 directly, the operation of the health insurance issuer
3 operating in the secondary State, except that any
4 secondary State may require such an issuer—

5 “(A) to pay, on a nondiscriminatory basis,
6 applicable premium and other taxes (including
7 high risk pool assessments) which are levied on
8 insurers and surplus lines insurers, brokers, or
9 policyholders under the laws of the State;

10 “(B) to register with and designate the
11 State insurance commissioner as its agent solely
12 for the purpose of receiving service of legal doc-
13 uments or process;

14 “(C) to submit to an examination of its fi-
15 nancial condition by the State insurance com-
16 missioner in any State in which the issuer is
17 doing business to determine the issuer’s finan-
18 cial condition, if—

19 “(i) the State insurance commissioner
20 of the primary State has not done an ex-
21 amination within the period recommended
22 by the National Association of Insurance
23 Commissioners; and

24 “(ii) any such examination is con-
25 ducted in accordance with the examiners’

1 handbook of the National Association of
2 Insurance Commissioners and is coordi-
3 nated to avoid unjustified duplication and
4 unjustified repetition;

5 “(D) to comply with a lawful order
6 issued—

7 “(i) in a delinquency proceeding com-
8 menced by the State insurance commis-
9 sioner if there has been a finding of finan-
10 cial impairment under subparagraph (C);

11 or

12 “(ii) in a voluntary dissolution pro-
13 ceeding;

14 “(E) to comply with an injunction issued
15 by a court of competent jurisdiction, upon a pe-
16 tition by the State insurance commissioner al-
17 leging that the issuer is in hazardous financial
18 condition;

19 “(F) to participate, on a nondiscriminatory
20 basis, in any insurance insolvency guaranty as-
21 sociation or similar association to which a
22 health insurance issuer in the State is required
23 to belong;

24 “(G) to comply with any State law regard-
25 ing fraud and abuse (as defined in section

1 2795(10)), except that if the State seeks an in-
2 junction regarding the conduct described in this
3 subparagraph, such injunction must be obtained
4 from a court of competent jurisdiction;

5 “(H) to comply with any State law regard-
6 ing unfair claims settlement practices (as de-
7 fined in section 2795(9)); or

8 “(I) to comply with the applicable require-
9 ments for independent review under section
10 2798 with respect to coverage offered in the
11 State;

12 “(2) require any individual health insurance
13 coverage issued by the issuer to be countersigned by
14 an insurance agent or broker residing in that Sec-
15 ondary State; or

16 “(3) otherwise discriminate against the issuer
17 issuing insurance in both the primary State and in
18 any secondary State.

19 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A
20 health insurance issuer shall provide the following notice,
21 in 12-point bold type, in any insurance coverage offered
22 in a secondary State under this part by such a health in-
23 surance issuer and at renewal of the policy, with the 5
24 blank spaces therein being appropriately filled with the
25 name of the health insurance issuer, the name of primary

1 State, the name of the secondary State, the name of the
 2 secondary State, and the name of the secondary State, re-
 3 spectively, for the coverage concerned:

4 “‘This policy is issued by _____ and is governed
 5 by the laws and regulations of the State of _____,
 6 and it has met all the laws of that State as determined
 7 by that State’s Department of Insurance. This policy may
 8 be less expensive than others because it is not subject to
 9 all of the insurance laws and regulations of the State of
 10 _____, including coverage of some services or bene-
 11 fits mandated by the law of the State of _____. Ad-
 12 ditionally, this policy is not subject to all of the consumer
 13 protection laws or restrictions on rate changes of the State
 14 of _____. As with all insurance products, before pur-
 15 chasing this policy, you should carefully review the policy
 16 and determine what health care services the policy covers
 17 and what benefits it provides, including any exclusions,
 18 limitations, or conditions for such services or benefits.’

19 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
 20 AND PREMIUM INCREASES.—

21 “(1) IN GENERAL.—For purposes of this sec-
 22 tion, a health insurance issuer that provides indi-
 23 vidual health insurance coverage to an individual
 24 under this part in a primary or secondary State may
 25 not upon renewal—

1 “(A) move or reclassify the individual in-
2 sured under the health insurance coverage from
3 the class such individual is in at the time of
4 issue of the contract based on the health-status
5 related factors of the individual; or

6 “(B) increase the premiums assessed the
7 individual for such coverage based on a health
8 status-related factor or change of a health sta-
9 tus-related factor or the past or prospective
10 claim experience of the insured individual.

11 “(2) CONSTRUCTION.—Nothing in paragraph
12 (1) shall be construed to prohibit a health insurance
13 issuer—

14 “(A) from terminating or discontinuing
15 coverage or a class of coverage in accordance
16 with subsections (b) and (c) of section 2742;

17 “(B) from raising premium rates for all
18 policy holders within a class based on claims ex-
19 perience;

20 “(C) from changing premiums or offering
21 discounted premiums to individuals who engage
22 in wellness activities at intervals prescribed by
23 the issuer, if such premium changes or incen-
24 tives—

1 “(i) are disclosed to the consumer in
2 the insurance contract;

3 “(ii) are based on specific wellness ac-
4 tivities that are not applicable to all indi-
5 viduals; and

6 “(iii) are not obtainable by all individ-
7 uals to whom coverage is offered;

8 “(D) from reinstating lapsed coverage; or

9 “(E) from retroactively adjusting the rates
10 charged an insured individual if the initial rates
11 were set based on material misrepresentation by
12 the individual at the time of issue.

13 “(e) PRIOR OFFERING OF POLICY IN PRIMARY
14 STATE.—A health insurance issuer may not offer for sale
15 individual health insurance coverage in a secondary State
16 unless that coverage is currently offered for sale in the
17 primary State.

18 “(f) LICENSING OF AGENTS OR BROKERS FOR
19 HEALTH INSURANCE ISSUERS.—Any State may require
20 that a person acting, or offering to act, as an agent or
21 broker for a health insurance issuer with respect to the
22 offering of individual health insurance coverage obtain a
23 license from that State, with commissions or other com-
24 pensation subject to the provisions of the laws of that
25 State, except that a State may not impose any qualifica-

1 tion or requirement which discriminates against a non-
 2 resident agent or broker.

3 “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-
 4 SURANCE COMMISSIONER.—Each health insurance issuer
 5 issuing individual health insurance coverage in both pri-
 6 mary and secondary States shall submit—

7 “(1) to the insurance commissioner of each
 8 State in which it intends to offer such coverage, be-
 9 fore it may offer individual health insurance cov-
 10 erage in such State—

11 “(A) a copy of the plan of operation or fea-
 12 sibility study or any similar statement of the
 13 policy being offered and its coverage (which
 14 shall include the name of its primary State and
 15 its principal place of business);

16 “(B) written notice of any change in its
 17 designation of its primary State; and

18 “(C) written notice from the issuer of the
 19 issuer’s compliance with all the laws of the pri-
 20 mary State; and

21 “(2) to the insurance commissioner of each sec-
 22 ondary State in which it offers individual health in-
 23 surance coverage, a copy of the issuer’s quarterly fi-
 24 nancial statement submitted to the primary State,
 25 which statement shall be certified by an independent

1 public accountant and contain a statement of opin-
2 ion on loss and loss adjustment expense reserves
3 made by—

4 “(A) a member of the American Academy
5 of Actuaries; or

6 “(B) a qualified loss reserve specialist.

7 “(h) POWER OF COURTS TO ENJOIN CONDUCT.—
8 Nothing in this section shall be construed to affect the
9 authority of any Federal or State court to enjoin—

10 “(1) the solicitation or sale of individual health
11 insurance coverage by a health insurance issuer to
12 any person or group who is not eligible for such in-
13 surance; or

14 “(2) the solicitation or sale of individual health
15 insurance coverage that violates the requirements of
16 the law of a secondary State which are described in
17 subparagraphs (A) through (H) of section
18 2796(b)(1).

19 “(i) POWER OF SECONDARY STATES TO TAKE AD-
20 MINISTRATIVE ACTION.—Nothing in this section shall be
21 construed to affect the authority of any State to enjoin
22 conduct in violation of that State’s laws described in sec-
23 tion 2796(b)(1).

24 “(j) STATE POWERS TO ENFORCE STATE LAWS.—

1 “(1) IN GENERAL.—Subject to the provisions of
2 subsection (b)(1)(G) (relating to injunctions) and
3 paragraph (2), nothing in this section shall be con-
4 strued to affect the authority of any State to make
5 use of any of its powers to enforce the laws of such
6 State with respect to which a health insurance issuer
7 is not exempt under subsection (b).

8 “(2) COURTS OF COMPETENT JURISDICTION.—
9 If a State seeks an injunction regarding the conduct
10 described in paragraphs (1) and (2) of subsection
11 (h), such injunction must be obtained from a Fed-
12 eral or State court of competent jurisdiction.

13 “(k) STATES’ AUTHORITY TO SUE.—Nothing in this
14 section shall affect the authority of any State to bring ac-
15 tion in any Federal or State court.

16 “(l) GENERALLY APPLICABLE LAWS.—Nothing in
17 this section shall be construed to affect the applicability
18 of State laws generally applicable to persons or corpora-
19 tions.

20 “(m) GUARANTEED AVAILABILITY OF COVERAGE TO
21 HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a
22 health insurance issuer is offering coverage in a primary
23 State that does not accommodate residents of secondary
24 States or does not provide a working mechanism for resi-
25 dents of a secondary State, and the issuer is offering cov-

1 erage under this part in such secondary State which has
 2 not adopted a qualified high risk pool as its acceptable
 3 alternative mechanism (as defined in section 2744(c)(2)),
 4 the issuer shall, with respect to any individual health in-
 5 surance coverage offered in a secondary State under this
 6 part, comply with the guaranteed availability requirements
 7 for eligible individuals in section 2741.

8 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
 9 **BEFORE ISSUER MAY SELL INTO SECONDARY**
 10 **STATES.**

11 “A health insurance issuer may not offer, sell, or
 12 issue individual health insurance coverage in a secondary
 13 State if the State insurance commissioner does not use
 14 a risk-based capital formula for the determination of cap-
 15 ital and surplus requirements for all health insurance
 16 issuers.

17 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**
 18 **DURES.**

19 “(a) **RIGHT TO EXTERNAL APPEAL.**—A health insur-
 20 ance issuer may not offer, sell, or issue individual health
 21 insurance coverage in a secondary State under the provi-
 22 sions of this title unless—

23 “(1) both the secondary State and the primary
 24 State have legislation or regulations in place estab-
 25 lishing an independent review process for individuals

1 who are covered by individual health insurance cov-
2 erage, or

3 “(2) in any case in which the requirements of
4 subparagraph (A) are not met with respect to the ei-
5 ther of such States, the issuer provides an inde-
6 pendent review mechanism substantially identical (as
7 determined by the applicable State authority of such
8 State) to that prescribed in the ‘Health Carrier Ex-
9 ternal Review Model Act’ of the National Association
10 of Insurance Commissioners for all individuals who
11 purchase insurance coverage under the terms of this
12 part, except that, under such mechanism, the review
13 is conducted by an independent medical reviewer, or
14 a panel of such reviewers, with respect to whom the
15 requirements of subsection (b) are met.

16 “(b) QUALIFICATIONS OF INDEPENDENT MEDICAL
17 REVIEWERS.—In the case of any independent review
18 mechanism referred to in subsection (a)(2)—

19 “(1) IN GENERAL.—In referring a denial of a
20 claim to an independent medical reviewer, or to any
21 panel of such reviewers, to conduct independent
22 medical review, the issuer shall ensure that—

23 “(A) each independent medical reviewer
24 meets the qualifications described in paragraphs
25 (2) and (3);

1 “(B) with respect to each review, each re-
2 viewer meets the requirements of paragraph (4)
3 and the reviewer, or at least 1 reviewer on the
4 panel, meets the requirements described in
5 paragraph (5); and

6 “(C) compensation provided by the issuer
7 to each reviewer is consistent with paragraph
8 (6).

9 “(2) LICENSURE AND EXPERTISE.—Each inde-
10 pendent medical reviewer shall be a physician
11 (allopathic or osteopathic) or health care profes-
12 sional who—

13 “(A) is appropriately credentialed or li-
14 censed in 1 or more States to deliver health
15 care services; and

16 “(B) typically treats the condition, makes
17 the diagnosis, or provides the type of treatment
18 under review.

19 “(3) INDEPENDENCE.—

20 “(A) IN GENERAL.—Subject to subpara-
21 graph (B), each independent medical reviewer
22 in a case shall—

23 “(i) not be a related party (as defined
24 in paragraph (7));

1 “(ii) not have a material familial, fi-
2 nancial, or professional relationship with
3 such a party; and

4 “(iii) not otherwise have a conflict of
5 interest with such a party (as determined
6 under regulations).

7 “(B) EXCEPTION.—Nothing in subpara-
8 graph (A) shall be construed to—

9 “(i) prohibit an individual, solely on
10 the basis of affiliation with the issuer,
11 from serving as an independent medical re-
12 viewer if—

13 “(I) a non-affiliated individual is
14 not reasonably available;

15 “(II) the affiliated individual is
16 not involved in the provision of items
17 or services in the case under review;

18 “(III) the fact of such an affili-
19 ation is disclosed to the issuer and the
20 enrollee (or authorized representative)
21 and neither party objects; and

22 “(IV) the affiliated individual is
23 not an employee of the issuer and
24 does not provide services exclusively or
25 primarily to or on behalf of the issuer;

1 “(ii) prohibit an individual who has
2 staff privileges at the institution where the
3 treatment involved takes place from serv-
4 ing as an independent medical reviewer
5 merely on the basis of such affiliation if
6 the affiliation is disclosed to the issuer and
7 the enrollee (or authorized representative),
8 and neither party objects; or

9 “(iii) prohibit receipt of compensation
10 by an independent medical reviewer from
11 an entity if the compensation is provided
12 consistent with paragraph (6).

13 “(4) PRACTICING HEALTH CARE PROFESSIONAL
14 IN SAME FIELD.—

15 “(A) IN GENERAL.—In a case involving
16 treatment, or the provision of items or serv-
17 ices—

18 “(i) by a physician, a reviewer shall be
19 a practicing physician (allopathic or osteo-
20 pathic) of the same or similar specialty, as
21 a physician who, acting within the appro-
22 priate scope of practice within the State in
23 which the service is provided or rendered,
24 typically treats the condition, makes the

1 diagnosis, or provides the type of treat-
2 ment under review; or

3 “(ii) by a non-physician health care
4 professional, the reviewer, or at least 1
5 member of the review panel, shall be a
6 practicing non-physician health care pro-
7 fessional of the same or similar specialty
8 as the non-physician health care profes-
9 sional who, acting within the appropriate
10 scope of practice within the State in which
11 the service is provided or rendered, typi-
12 cally treats the condition, makes the diag-
13 nosis, or provides the type of treatment
14 under review.

15 “(B) PRACTICING DEFINED.—For pur-
16 poses of this paragraph, the term ‘practicing’
17 means, with respect to an individual who is a
18 physician or other health care professional, that
19 the individual provides health care services to
20 individual patients on average at least 2 days
21 per week.

22 “(5) PEDIATRIC EXPERTISE.—In the case of an
23 external review relating to a child, a reviewer shall
24 have expertise under paragraph (2) in pediatrics.

1 “(6) LIMITATIONS ON REVIEWER COMPENSA-
2 TION.—Compensation provided by the issuer to an
3 independent medical reviewer in connection with a
4 review under this section shall—

5 “(A) not exceed a reasonable level; and

6 “(B) not be contingent on the decision ren-
7 dered by the reviewer.

8 “(7) RELATED PARTY DEFINED.—For purposes
9 of this section, the term ‘related party’ means, with
10 respect to a denial of a claim under a coverage relat-
11 ing to an enrollee, any of the following:

12 “(A) The issuer involved, or any fiduciary,
13 officer, director, or employee of the issuer.

14 “(B) The enrollee (or authorized represent-
15 ative).

16 “(C) The health care professional that pro-
17 vides the items or services involved in the de-
18 nial.

19 “(D) The institution at which the items or
20 services (or treatment) involved in the denial
21 are provided.

22 “(E) The manufacturer of any drug or
23 other item that is included in the items or serv-
24 ices involved in the denial.

1 “(F) Any other party determined under
2 any regulations to have a substantial interest in
3 the denial involved.

4 “(8) DEFINITIONS.—For purposes of this sub-
5 section:

6 “(A) ENROLLEE.—The term ‘enrollee’
7 means, with respect to health insurance cov-
8 erage offered by a health insurance issuer, an
9 individual enrolled with the issuer to receive
10 such coverage.

11 “(B) HEALTH CARE PROFESSIONAL.—The
12 term ‘health care professional’ means an indi-
13 vidual who is licensed, accredited, or certified
14 under State law to provide specified health care
15 services and who is operating within the scope
16 of such licensure, accreditation, or certification.

17 **“SEC. 2799. ENFORCEMENT.**

18 “(a) IN GENERAL.—Subject to subsection (b), with
19 respect to specific individual health insurance coverage the
20 primary State for such coverage has sole jurisdiction to
21 enforce the primary State’s covered laws in the primary
22 State and any secondary State.

23 “(b) SECONDARY STATE’S AUTHORITY.—Nothing in
24 subsection (a) shall be construed to affect the authority

1 of a secondary State to enforce its laws as set forth in
2 the exception specified in section 2796(b)(1).

3 “(c) COURT INTERPRETATION.—In reviewing action
4 initiated by the applicable secondary State authority, the
5 court of competent jurisdiction shall apply the covered
6 laws of the primary State.

7 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case
8 of individual health insurance coverage offered in a sec-
9 ondary State that fails to comply with the covered laws
10 of the primary State, the applicable State authority of the
11 secondary State may notify the applicable State authority
12 of the primary State.”.

13 (b) EFFECTIVE DATE.—The amendment made by
14 subsection (a) shall apply to individual health insurance
15 coverage offered, issued, or sold after the date that is one
16 year after the date of the enactment of this Act.

17 (c) GAO ONGOING STUDY AND REPORTS.—

18 (1) STUDY.—The Comptroller General of the
19 United States shall conduct an ongoing study con-
20 cerning the effect of the amendment made by sub-
21 section (a) on—

22 (A) the number of uninsured and under-in-
23 sured;

1 (B) the availability and cost of health in-
2 surance policies for individuals with pre-existing
3 medical conditions;

4 (C) the availability and cost of health in-
5 surance policies generally;

6 (D) the elimination or reduction of dif-
7 ferent types of benefits under health insurance
8 policies offered in different States; and

9 (E) cases of fraud or abuse relating to
10 health insurance coverage offered under such
11 amendment and the resolution of such cases.

12 (2) ANNUAL REPORTS.—The Comptroller Gen-
13 eral shall submit to Congress an annual report, after
14 the end of each of the 5 years following the effective
15 date of the amendment made by subsection (a), on
16 the ongoing study conducted under paragraph (1).

17 **SEC. 205. SEVERABILITY.**

18 If any provision of the Act or the application of such
19 provision to any person or circumstance is held to be un-
20 constitutional, the remainder of this Act and the applica-
21 tion of the provisions of such to any other person or cir-
22 cumstance shall not be affected.

1 **Subtitle B—Pre-existing Condition**

2 **SEC. 211. BLOCK GRANTS TO STATES.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services (referred to in this section as the “Sec-
5 retary”) shall award block grants to States to provide for
6 the development of innovative models that ensure afford-
7 able health insurance coverage for Americans with pre-ex-
8 isting health conditions.

9 (b) APPLICATION.—To be eligible to receive a grant
10 under this section a State shall submit to the Secretary
11 an application, at such time, in such manner, and con-
12 taining such information as the Secretary may require.

13 (c) USE OF FUNDS.—A State shall use amounts re-
14 ceived under a grant under this section to develop innova-
15 tive programs that ensure the provision of affordable
16 health insurance coverage for eligible individuals with pre-
17 existing health conditions. Such models may include the
18 development and funding of State high-risk pools and the
19 enhancement of funding for existing State high risk pools.

20 (d) ELIGIBILITY.—To be eligible to participate in a
21 program developed under subsection (c), an individual
22 shall—

23 (1) be a resident of the State involved;

24 (2) provide assurances to the Secretary that ac-
25 tivities carried out under the grant will not result in

1 an increase in health insurance premiums for resi-
 2 dents of the State; and

3 (3) comply with any other requirements estab-
 4 lished by the State.

5 (e) AMOUNT OF GRANT.—The amount of a grant to
 6 a State under this section shall be determined by the Sec-
 7 retary.

8 (f) AUTHORIZATION OF APPROPRIATIONS.—There is
 9 authorized to be appropriated to carry out this section,
 10 \$5,000,000,000 for each of the fiscal years 2010 through
 11 2014.

12 (g) DEFINITION.—In this section, the term “pre-ex-
 13 isting condition” means a medical or other condition in
 14 an individual that exists prior to the date on which such
 15 individuals attempts to enroll in health insurance cov-
 16 erage, whether or not any medical advice, diagnosis, care,
 17 or treatment was recommended or received before such
 18 date.

19 **TITLE III—EMPOWERING THE**
 20 **HEALTH CARE CONSUMER**

21 **SEC. 301. ENHANCING THE PATIENT-PROVIDER RELATION-**
 22 **SHIP.**

23 (a) PROVISION OF INFORMATION.—The Secretary of
 24 Health and Human Services shall promulgate regulations
 25 under which a health care provider (including a hospital)

1 that receives reimbursement under title XVIII or XIX of
2 the Social Security Act (42 U.S.C. 1395 and 1396 et seq.)
3 shall be required to provide each patient of such provider
4 (or hospital), upon the request of such patient, price infor-
5 mation with respect to the items or services provided (or
6 that will be provided) to such patient.

7 (b) REQUIREMENT.—The pricing information re-
8 quired under subsection (a) shall be broken down into the
9 following categories:

10 (1) The usual and customary price charged for
11 the item or service involved.

12 (2) The amount that would be provided as re-
13 imbursement under the Medicare and Medicaid Pro-
14 grams under titles XVIII and XIX of the Social Se-
15 curity Act (42 U.S.C. 1395 and 1396 et seq.) for
16 the items or services involved.

17 (3) The average amount that would be paid by
18 an insured individual with respect to such item or
19 service.

20 **SEC. 302. HEALTH INSURANCE POLICY INFORMATION.**

21 (a) IN GENERAL.—A group health plan, or health in-
22 surance issuer in connection with group or individual
23 health insurance coverage, shall provide an enrollee, upon
24 the request of the enrollee, with information concerning

1 their allowable payment for items or services under the
2 plan or coverage involved.

3 (b) FEE.—A plan or issuer may assess an enrollee
4 a reasonable fee to cover the costs incurred by the plan
5 or issuer in providing the enrollee with the information
6 requested under subsection (a).

7 (c) DEFINITIONS.—The definitions contained in sec-
8 tion 2791 of the Public Health Service Act (42 U.S.C.
9 300gg–91) shall apply for purposes of this section.

10 **TITLE IV—FUNDING**

11 **SEC. 401. FUNDING PROVISIONS.**

12 (a) TERMINATION OF TARP PROGRAM.—Notwith-
13 standing any provision of the Emergency Economic Sta-
14 bilization Act of 2008 (12 U.S.C. 5201 et seq.) or any
15 other provision of law, the Secretary of Treasury may not,
16 on and after the date of enactment of this Act, make any
17 payment or obligation under the Emergency Economic
18 Stabilization Act of 2008 (12 U.S.C. 5201 et seq.). Any
19 funds made available under such Act that have not been
20 obligated shall be rescinded and made available to carry
21 out this Act.

22 (b) COLLECTING FUNDS.—Notwithstanding any
23 other provision of the Emergency Economic Stabilization
24 Act of 2008 (12 U.S.C. 5201 et seq.) or any other provi-
25 sion of law, the Secretary of Treasury shall collect all reve-

1 nues relating to, and proceeds from the sale of, obligations
2 purchased and made under the Emergency Economic Sta-
3 bilization Act of 2008 (12 U.S.C. 5201 et seq.) by not
4 later than September 30, 2014, at a rate of not less than
5 20 percent per year of the total obligations purchased and
6 made under such Act.

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