

111TH CONGRESS  
1ST SESSION

# S. 1459

To amend the Public Health Service Act to provide for cooperative governing of individual health insurance coverage offered in interstate commerce.

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IN THE SENATE OF THE UNITED STATES

JULY 16, 2009

Mr. DEMINT (for himself and Mr. VITTER) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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## A BILL

To amend the Public Health Service Act to provide for cooperative governing of individual health insurance coverage offered in interstate commerce.

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 Choice  
5 Act of 2009”.

1 **SEC. 2. SPECIFICATION OF CONSTITUTIONAL AUTHORITY**  
2 **FOR ENACTMENT OF LAW.**

3 This Act is enacted pursuant to the power granted  
4 Congress under article I, section 8, clause 3, of the United  
5 States Constitution.

6 **SEC. 3. FINDINGS.**

7 Congress finds the following:

8 (1) The application of numerous and significant  
9 variations in State law impacts the ability of insur-  
10 ers to offer, and individuals to obtain, affordable in-  
11 dividual health insurance coverage, thereby impeding  
12 commerce in individual health insurance coverage.

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

17 (3) In response to these issues, it is appropriate  
18 to encourage increased efficiency in the offering of  
19 individual health insurance coverage through a col-  
20 laborative approach by the States in regulating this  
21 coverage.

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

1 **SEC. 4. COOPERATIVE GOVERNING OF INDIVIDUAL**  
 2 **HEALTH INSURANCE COVERAGE.**

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

6 **“PART D—COOPERATIVE GOVERNING OF**  
 7 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

8 **“SEC. 2795. DEFINITIONS.**

9 “In this part:

10 “(1) PRIMARY STATE.—The term ‘primary  
 11 State’ means, with respect to individual health insur-  
 12 ance coverage offered by a health insurance issuer,  
 13 the State designated by the issuer as the State  
 14 whose covered laws shall govern the health insurance  
 15 issuer in the sale of such coverage under this part.  
 16 An issuer, with respect to a particular policy, may  
 17 only designate one such State as its primary State  
 18 with respect to all such coverage it offers. Such an  
 19 issuer may not change the designated primary State  
 20 with respect to individual health insurance coverage  
 21 once the policy is issued, except that such a change  
 22 may be made upon renewal of the policy. With re-  
 23 spect to such designated State, the issuer is deemed  
 24 to be doing business in that State.

25 “(2) SECONDARY STATE.—The term ‘secondary  
 26 State’ means, with respect to individual health insur-

1       ance coverage offered by a health insurance issuer,  
2       any State that is not the primary State. In the case  
3       of a health insurance issuer that is selling a policy  
4       in, or to a resident of, a secondary State, the issuer  
5       is deemed to be doing business in that secondary  
6       State.

7               “(3) HEALTH INSURANCE ISSUER.—The term  
8       ‘health insurance issuer’ has the meaning given such  
9       term in section 2791(b)(2), except that such an  
10       issuer must be licensed in the primary State and be  
11       qualified to sell individual health insurance coverage  
12       in that State.

13               “(4) INDIVIDUAL HEALTH INSURANCE COV-  
14       ERAGE.—The term ‘individual health insurance cov-  
15       erage’ means health insurance coverage offered in  
16       the individual market, as defined in section  
17       2791(e)(1).

18               “(5) APPLICABLE STATE AUTHORITY.—The  
19       term ‘applicable State authority’ means, with respect  
20       to a health insurance issuer in a State, the State in-  
21       surance commissioner or official or officials des-  
22       ignated by the State to enforce the requirements of  
23       this title for the State with respect to the issuer.

24               “(6) HAZARDOUS FINANCIAL CONDITION.—The  
25       term ‘hazardous financial condition’ means that,

1 based on its present or reasonably anticipated finan-  
2 cial condition, a health insurance issuer is unlikely  
3 to be able—

4 “(A) to meet obligations to policyholders  
5 with respect to known claims and reasonably  
6 anticipated claims; or

7 “(B) to pay other obligations in the normal  
8 course of business.

9 “(7) COVERED LAWS.—

10 “(A) IN GENERAL.—The term ‘covered  
11 laws’ means the laws, rules, regulations, agree-  
12 ments, and orders governing the insurance busi-  
13 ness pertaining to—

14 “(i) individual health insurance cov-  
15 erage issued by a health insurance issuer;

16 “(ii) the offer, sale, rating (including  
17 medical underwriting), renewal, and  
18 issuance of individual health insurance cov-  
19 erage to an individual;

20 “(iii) the provision to an individual in  
21 relation to individual health insurance cov-  
22 erage of health care and insurance related  
23 services;

24 “(iv) the provision to an individual in  
25 relation to individual health insurance cov-

1 erage of management, operations, and in-  
2 vestment activities of a health insurance  
3 issuer; and

4 “(v) the provision to an individual in  
5 relation to individual health insurance cov-  
6 erage of loss control and claims adminis-  
7 tration for a health insurance issuer with  
8 respect to liability for which the issuer pro-  
9 vides insurance.

10 “(B) EXCEPTION.—Such term does not in-  
11 clude any law, rule, regulation, agreement, or  
12 order governing the use of care or cost manage-  
13 ment techniques, including any requirement re-  
14 lated to provider contracting, network access or  
15 adequacy, health care data collection, or quality  
16 assurance.

17 “(8) STATE.—The term ‘State’ means the 50  
18 States and includes the District of Columbia, the  
19 Commonwealth of Puerto Rico, the Virgin Islands,  
20 Guam, American Samoa, and the Commonwealth of  
21 the Northern Mariana Islands.

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

1           “(A) Knowingly misrepresenting to claim-  
2           ants and insured individuals relevant facts or  
3           policy provisions relating to coverage at issue.

4           “(B) Failing to acknowledge with reason-  
5           able promptness pertinent communications with  
6           respect to claims arising under policies.

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

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

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

15          “(F) Failing to affirm or deny coverage of  
16          claims within a reasonable period of time after  
17          having completed an investigation related to  
18          those claims.

19          “(G) A pattern or practice of compelling  
20          insured individuals or their beneficiaries to in-  
21          stitute suits to recover amounts due under its  
22          policies by offering substantially less than the  
23          amounts ultimately recovered in suits brought  
24          by them.

1           “(H) A pattern or practice of attempting  
2           to settle or settling claims for less than the  
3           amount that a reasonable person would believe  
4           the insured individual or the individual’s bene-  
5           ficiary was entitled by reference to written or  
6           printed advertising material accompanying or  
7           made part of an application.

8           “(I) Attempting to settle or settling claims  
9           on the basis of an application that was materi-  
10          ally altered without notice to, or knowledge or  
11          consent of, the insured.

12          “(J) Failing to provide forms necessary to  
13          present claims within 15 calendar days of a re-  
14          quests with reasonable explanations regarding  
15          their use.

16          “(K) Attempting to cancel a policy in less  
17          time than that prescribed in the policy or by the  
18          law of the primary State.

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

24                 “(A) Presenting, causing to be presented,  
25                 or preparing with knowledge or belief that it



1 will be presented to or by an insurer, a rein-  
2 surer, broker, or its agent, false information as  
3 part of, in support of, or concerning a fact ma-  
4 terial to one or more of the following:

5 “(i) An application for the issuance or  
6 renewal of an insurance policy or reinsur-  
7 ance contract.

8 “(ii) The rating of an insurance policy  
9 or reinsurance contract.

10 “(iii) A claim for payment or benefit  
11 pursuant to an insurance policy or reinsur-  
12 ance contract.

13 “(iv) Premiums paid on an insurance  
14 policy or reinsurance contract.

15 “(v) Payments made in accordance  
16 with the terms of an insurance policy or  
17 reinsurance contract.

18 “(vi) A document filed with the com-  
19 missioner or the chief insurance regulatory  
20 official of another jurisdiction.

21 “(vii) The financial condition of an in-  
22 surer or reinsurer.

23 “(viii) The formation, acquisition,  
24 merger, reconsolidation, dissolution, or  
25 withdrawal from one or more lines of in-

1 insurance or reinsurance in all or part of a  
2 State by an insurer or reinsurer.

3 “(ix) The issuance of written evidence  
4 of insurance.

5 “(x) The reinstatement of an insur-  
6 ance policy.

7 “(B) Solicitation or acceptance of new or  
8 renewal insurance risks on behalf of an insurer,  
9 reinsurer, or other person engaged in the busi-  
10 ness of insurance by a person who knows or  
11 should know that the insurer or other person  
12 responsible for the risk is insolvent at the time  
13 of the transaction.

14 “(C) Transaction of the business of insur-  
15 ance in violation of laws requiring a license, cer-  
16 tificate of authority, or other legal authority for  
17 the transaction of the business of insurance.

18 “(D) Attempt to commit, aiding or abet-  
19 ting in the commission of, or conspiracy to com-  
20 mit the acts or omissions specified in this para-  
21 graph.

22 **“SEC. 2796. APPLICATION OF LAW.**

23 “(a) IN GENERAL.—The covered laws of the primary  
24 State shall apply to individual health insurance coverage  
25 offered by a health insurance issuer in the primary State

1 and in any secondary State, but only if the coverage and  
 2 issuer comply with the conditions of this section with re-  
 3 spect to the offering of coverage in any secondary State.

4       “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-  
 5 ONDARY STATE.—Except as provided in this section, a  
 6 health insurance issuer with respect to its offer, sale, rat-  
 7 ing (including medical underwriting), renewal, and  
 8 issuance of individual health insurance coverage in any  
 9 secondary State is exempt from any covered laws of the  
 10 secondary State (and any rules, regulations, agreements,  
 11 or orders sought or issued by such State under or related  
 12 to such covered laws) to the extent that such laws would—

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

17                       “(A) to pay, on a nondiscriminatory basis,  
 18 applicable premium and other taxes (including  
 19 high risk pool assessments) which are levied on  
 20 insurers and surplus lines insurers, brokers, or  
 21 policyholders under the laws of the State;

22                       “(B) to register with and designate the  
 23 State insurance commissioner as its agent solely  
 24 for the purpose of receiving service of legal doc-  
 25 uments or process;

1           “(C) to submit to an examination of its fi-  
2           nancial condition by the State insurance com-  
3           missioner in any State in which the issuer is  
4           doing business to determine the issuer’s finan-  
5           cial condition, if—

6                   “(i) the State insurance commissioner  
7                   of the primary State has not done an ex-  
8                   amination within the period recommended  
9                   by the National Association of Insurance  
10                  Commissioners; and

11                   “(ii) any such examination is con-  
12                   ducted in accordance with the examiners’  
13                   handbook of the National Association of  
14                   Insurance Commissioners and is coordi-  
15                   nated to avoid unjustified duplication and  
16                   unjustified repetition;

17           “(D) to comply with a lawful order  
18           issued—

19                   “(i) in a delinquency proceeding com-  
20                   menced by the State insurance commis-  
21                   sioner if there has been a finding of finan-  
22                   cial impairment under subparagraph (C);  
23                   or

24                   “(ii) in a voluntary dissolution pro-  
25                   ceeding;

1           “(E) to comply with an injunction issued  
2 by a court of competent jurisdiction, upon a pe-  
3 tition by the State insurance commissioner al-  
4 leging that the issuer is in hazardous financial  
5 condition;

6           “(F) to participate, on a nondiscriminatory  
7 basis, in any insurance insolvency guaranty as-  
8 sociation or similar association to which a  
9 health insurance issuer in the State is required  
10 to belong;

11           “(G) to comply with any State law regard-  
12 ing fraud and abuse (as defined in section  
13 2795(10)), except that if the State seeks an in-  
14 junction regarding the conduct described in this  
15 subparagraph, such injunction must be obtained  
16 from a court of competent jurisdiction;

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

20           “(I) to comply with the applicable require-  
21 ments for independent review under section  
22 2798 with respect to coverage offered in the  
23 State;

24           “(2) require any individual health insurance  
25 coverage issued by the issuer to be countersigned by

1 an insurance agent or broker residing in that sec-  
2 ondary State; or

3 “(3) otherwise discriminate against the issuer  
4 issuing insurance in both the primary State and in  
5 any secondary State.

6 “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A  
7 health insurance issuer shall provide the following notice,  
8 in 12-point bold type, in any insurance coverage offered  
9 in a secondary State under this part by such a health in-  
10 surance issuer and at renewal of the policy, with the 5  
11 blank spaces therein being appropriately filled with the  
12 name of the health insurance issuer, the name of primary  
13 State, the name of the secondary State, the name of the  
14 secondary State, and the name of the secondary State, re-  
15 spectively, for the coverage concerned:

16 This policy is issued by \_\_\_\_\_, and is governed by  
17 the laws and regulations of the State of \_\_\_\_\_, and  
18 it has met all the laws of that State as determined by  
19 that State’s Department of Insurance. This policy may be  
20 less expensive than others because it is not subject to all  
21 of the insurance laws and regulations of the State of  
22 \_\_\_\_\_, including coverage of some services or bene-  
23 fits mandated by the law of the State of \_\_\_\_\_. Ad-  
24 ditionally, this policy is not subject to all of the consumer  
25 protection laws or restrictions on rate changes of the State

1 of \_\_\_\_\_. As with all insurance products, before pur-  
 2 chasing this policy, you should carefully review the policy  
 3 and determine what health care services the policy covers  
 4 and what benefits it provides, including any exclusions,  
 5 limitations, or conditions for such services or benefits.”.

6 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
 7 AND PREMIUM INCREASES.—

8 “(1) IN GENERAL.—For purposes of this sec-  
 9 tion, a health insurance issuer that provides indi-  
 10 vidual health insurance coverage to an individual  
 11 under this part in a primary or secondary State may  
 12 not upon renewal—

13 “(A) move or reclassify the individual in-  
 14 sured under the health insurance coverage from  
 15 the class such individual is in at the time of  
 16 issue of the contract based on the health-status  
 17 related factors of the individual; or

18 “(B) increase the premiums assessed the  
 19 individual for such coverage based on a health  
 20 status-related factor or change of a health sta-  
 21 tus-related factor or the past or prospective  
 22 claim experience of the insured individual.

23 “(2) CONSTRUCTION.—Nothing in paragraph  
 24 (1) shall be construed to prohibit a health insurance  
 25 issuer—

1           “(A) from terminating or discontinuing  
2 coverage or a class of coverage in accordance  
3 with subsections (b) and (c) of section 2742;

4           “(B) from raising premium rates for all  
5 policy holders within a class based on claims ex-  
6 perience;

7           “(C) from changing premiums or offering  
8 discounted premiums to individuals who engage  
9 in wellness activities at intervals prescribed by  
10 the issuer, if such premium changes or incen-  
11 tives—

12                   “(i) are disclosed to the consumer in  
13 the insurance contract;

14                   “(ii) are based on specific wellness ac-  
15 tivities that are not applicable to all indi-  
16 viduals; and

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

19           “(D) from reinstating lapsed coverage; or

20           “(E) from retroactively adjusting the rates  
21 charged an insured individual if the initial rates  
22 were set based on material misrepresentation by  
23 the individual at the time of issue.

24           “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
25 STATE.—A health insurance issuer may not offer for sale



1 individual health insurance coverage in a secondary State  
2 unless that coverage is currently offered for sale in the  
3 primary State.

4       “(f) LICENSING OF AGENTS OR BROKERS FOR  
5 HEALTH INSURANCE ISSUERS.—Any State may require  
6 that a person acting, or offering to act, as an agent or  
7 broker for a health insurance issuer with respect to the  
8 offering of individual health insurance coverage obtain a  
9 license from that State, with commissions or other com-  
10 pensation subject to the provisions of the laws of that  
11 State, except that a State may not impose any qualifica-  
12 tion or requirement which discriminates against a non-  
13 resident agent or broker.

14       “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
15 SURANCE COMMISSIONER.—Each health insurance issuer  
16 issuing individual health insurance coverage in both pri-  
17 mary and secondary States shall submit—

18               “(1) to the insurance commissioner of each  
19 State in which it intends to offer such coverage, be-  
20 fore it may offer individual health insurance cov-  
21 erage in such State—

22                       “(A) a copy of the plan of operation, feasi-  
23 bility study, or any similar statement of the pol-  
24 icy being offered and its coverage (which shall

1 include the name of its primary State and its  
2 principal place of business);

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

5 “(C) written notice from the issuer of the  
6 issuer’s compliance with all the laws of the pri-  
7 mary State; and

8 “(2) to the insurance commissioner of each sec-  
9 ondary State in which it offers individual health in-  
10 surance coverage, a copy of the issuer’s quarterly fi-  
11 nancial statement submitted to the primary State,  
12 which statement shall be certified by an independent  
13 public accountant and contain a statement of opin-  
14 ion on loss and loss adjustment expense reserves  
15 made by—

16 “(A) a member of the American Academy  
17 of Actuaries; or

18 “(B) a qualified loss reserve specialist.

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

22 “(1) the solicitation or sale of individual health  
23 insurance coverage by a health insurance issuer to  
24 any person or group who is not eligible for such in-  
25 surance; or

1           “(2) the solicitation or sale of individual health  
2 insurance coverage that violates the requirements of  
3 the law of a secondary State which are described in  
4 subparagraphs (A) through (H) of subsection (b)(1).

5           “(i) POWER OF SECONDARY STATES TO TAKE AD-  
6 MINISTRATIVE ACTION.—Nothing in this section shall be  
7 construed to affect the authority of any State to enjoin  
8 conduct in violation of that State’s laws described in sub-  
9 section (b)(1).

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

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

18           “(2) COURTS OF COMPETENT JURISDICTION.—

19 If a State seeks an injunction regarding the conduct  
20 described in paragraphs (1) and (2) of subsection  
21 (h), such injunction must be obtained from a Fed-  
22 eral or State court of competent jurisdiction.

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

1       “(l) **GENERALLY APPLICABLE LAWS.**—Nothing in  
 2 this section shall be construed to affect the applicability  
 3 of State laws generally applicable to persons or corpora-  
 4 tions.

5       “(m) **GUARANTEED AVAILABILITY OF COVERAGE TO**  
 6 **HIPPA ELIGIBLE INDIVIDUALS.**—To the extent that a  
 7 health insurance issuer is offering coverage in a primary  
 8 State that does not accommodate residents of secondary  
 9 States or does not provide a working mechanism for resi-  
 10 dents of a secondary State, and the issuer is offering cov-  
 11 erage under this part in such secondary State which has  
 12 not adopted a qualified high risk pool as its acceptable  
 13 alternative mechanism (as defined in section 2744(c)(2)),  
 14 the issuer shall, with respect to any individual health in-  
 15 surance coverage offered in a secondary State under this  
 16 part, comply with the guaranteed availability requirements  
 17 for eligible individuals in section 2741.

18 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
 19 **BEFORE ISSUER MAY SELL INTO SECONDARY**  
 20 **STATES.**

21       “A health insurance issuer may not offer, sell, or  
 22 issue individual health insurance coverage in a secondary  
 23 State if the State insurance commissioner does not use  
 24 a risk-based capital formula for the determination of cap-

1 ital and surplus requirements for all health insurance  
2 issuers.

3 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**  
4 **DURES.**

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

9 “(1) both the secondary State and the primary  
10 State have legislation or regulations in place estab-  
11 lishing an independent review process for individuals  
12 who are covered by individual health insurance cov-  
13 erage, or

14 “(2) in any case in which the requirements of  
15 paragraph (1) are not met with respect to either of  
16 such States, the issuer provides an independent re-  
17 view mechanism substantially identical (as deter-  
18 mined by the applicable State authority of such  
19 State) to that prescribed in the ‘Health Carrier Ex-  
20 ternal Review Model Act’ of the National Association  
21 of Insurance Commissioners for all individuals who  
22 purchase insurance coverage under the terms of this  
23 part, except that, under such mechanism, the review  
24 is conducted by an independent medical reviewer, or

1 a panel of such reviewers, with respect to whom the  
2 requirements of subsection (b) are met.

3 “(b) QUALIFICATIONS OF INDEPENDENT MEDICAL  
4 REVIEWERS.—In the case of any independent review  
5 mechanism referred to in subsection (a)(2), the following  
6 provisions shall apply:

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

11 “(A) each independent medical reviewer  
12 meets the qualifications described in paragraphs  
13 (2) and (3);

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

19 “(C) compensation provided by the issuer  
20 to each reviewer is consistent with paragraph  
21 (6).

22 “(2) LICENSURE AND EXPERTISE.—Each inde-  
23 pendent medical reviewer shall be a physician  
24 (allopathic or osteopathic) or health care profes-  
25 sional who—

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

4           “(B) typically treats the condition, makes  
5 the diagnosis, or provides the type of treatment  
6 under review.

7           “(3) INDEPENDENCE.—

8           “(A) IN GENERAL.—Subject to subpara-  
9 graph (B), each independent medical reviewer  
10 in a case shall—

11           “(i) not be a related party (as defined  
12 in paragraph (7));

13           “(ii) not have a material familial, fi-  
14 nancial, or professional relationship with  
15 such a party; and

16           “(iii) not otherwise have a conflict of  
17 interest with such a party (as determined  
18 under regulations).

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

21           “(i) prohibit an individual, solely on  
22 the basis of affiliation with the issuer,  
23 from serving as an independent medical re-  
24 viewer if—

1                   “(I) a non-affiliated individual is  
2 not reasonably available;

3                   “(II) the affiliated individual is  
4 not involved in the provision of items  
5 or services in the case under review;

6                   “(III) the fact of such an affili-  
7 ation is disclosed to the issuer and the  
8 enrollee (or authorized representative)  
9 and neither party objects; and

10                  “(IV) the affiliated individual is  
11 not an employee of the issuer and  
12 does not provide services exclusively or  
13 primarily to or on behalf of the issuer;

14                  “(ii) prohibit an individual who has  
15 staff privileges at the institution where the  
16 treatment involved takes place from serv-  
17 ing as an independent medical reviewer  
18 merely on the basis of such affiliation if  
19 the affiliation is disclosed to the issuer and  
20 the enrollee (or authorized representative)  
21 and neither party objects; or

22                  “(iii) prohibit receipt of compensation  
23 by an independent medical reviewer from  
24 an entity if the compensation is provided  
25 consistent with paragraph (6).



1           “(4) PRACTICING HEALTH CARE PROFESSIONAL  
2           IN SAME FIELD.—

3           “(A) IN GENERAL.—In a case involving  
4           treatment, or the provision of items or serv-  
5           ices—

6                   “(i) by a physician, a reviewer shall be  
7                   a practicing physician (allopathic or osteo-  
8                   pathic) of the same or similar specialty, as  
9                   a physician who, acting within the appro-  
10                  priate scope of practice within the State in  
11                  which the service is provided or rendered,  
12                  typically treats the condition, makes the  
13                  diagnosis, or provides the type of treat-  
14                  ment under review; or

15                   “(ii) by a non-physician health care  
16                  professional, the reviewer, or at least 1  
17                  member of the review panel, shall be a  
18                  practicing non-physician health care pro-  
19                  fessional of the same or similar specialty  
20                  as the non-physician health care profes-  
21                  sional who, acting within the appropriate  
22                  scope of practice within the State in which  
23                  the service is provided or rendered, typi-  
24                  cally treats the condition, makes the diag-

1           nosis, or provides the type of treatment  
2           under review.

3           “(B) PRACTICING DEFINED.—For pur-  
4           poses of this paragraph, the term ‘practicing’  
5           means, with respect to an individual who is a  
6           physician or other health care professional, that  
7           the individual provides health care services to  
8           individual patients on average at least 2 days  
9           per week.

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

13          “(6) LIMITATIONS ON REVIEWER COMPENSA-  
14          TION.—Compensation provided by the issuer to an  
15          independent medical reviewer in connection with a  
16          review under this section shall—

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

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

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

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

1           “(B) The enrollee (or authorized represent-  
2           ative).

3           “(C) The health care professional that pro-  
4           vides the items or services involved in the de-  
5           nial.

6           “(D) The institution at which the items or  
7           services (or treatment) involved in the denial  
8           are provided.

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

12          “(F) Any other party determined under  
13          any regulations to have a substantial interest in  
14          the denial involved.

15          “(8) DEFINITIONS.—For purposes of this sub-  
16          section:

17                 “(A) ENROLLEE.—The term ‘enrollee’  
18                 means, with respect to health insurance cov-  
19                 erage offered by a health insurance issuer, an  
20                 individual enrolled with the issuer to receive  
21                 such coverage.

22                 “(B) HEALTH CARE PROFESSIONAL.—The  
23                 term ‘health care professional’ means an indi-  
24                 vidual who is licensed, accredited, or certified  
25                 under State law to provide specified health care

1 services and who is operating within the scope  
2 of such licensure, accreditation, or certification.

3 **“SEC. 2799. ENFORCEMENT.**

4 “(a) IN GENERAL.—Subject to subsection (b), with  
5 respect to specific individual health insurance coverage,  
6 the primary State for such coverage has sole jurisdiction  
7 to enforce the primary State’s covered laws in the primary  
8 State and any secondary State.

9 “(b) SECONDARY STATE’S AUTHORITY.—Nothing in  
10 subsection (a) shall be construed to affect the authority  
11 of a secondary State to enforce its laws as set forth in  
12 the exception specified in section 2796(b)(1).

13 “(c) COURT INTERPRETATION.—In reviewing action  
14 initiated by the applicable secondary State authority, the  
15 court of competent jurisdiction shall apply the covered  
16 laws of the primary State.

17 “(d) NOTICE OF COMPLIANCE FAILURE.—In the case  
18 of individual health insurance coverage offered in a sec-  
19 ondary State that fails to comply with the covered laws  
20 of the primary State, the applicable State authority of the  
21 secondary State may notify the applicable State authority  
22 of the primary State.”.

23 (b) EFFECTIVE DATE.—The amendment made by  
24 subsection (a) shall apply to individual health insurance

1 coverage offered, issued, or sold after the date that is one  
2 year after the date of the enactment of this Act.

3 (c) GAO ONGOING STUDY AND REPORTS.—

4 (1) STUDY.—The Comptroller General of the  
5 United States shall conduct an ongoing study con-  
6 cerning the effect of the amendment made by sub-  
7 section (a) on—

8 (A) the number of uninsured and under-in-  
9 sured;

10 (B) the availability and cost of health in-  
11 surance policies for individuals with pre-existing  
12 medical conditions;

13 (C) the availability and cost of health in-  
14 surance policies generally;

15 (D) the elimination or reduction of dif-  
16 ferent types of benefits under health insurance  
17 policies offered in different States; and

18 (E) cases of fraud or abuse relating to  
19 health insurance coverage offered under such  
20 amendment and the resolution of such cases.

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

1 **SEC. 5. SEVERABILITY.**

2       If any provision of the Act or the application of such  
3 provision to any person or circumstance is held to be un-  
4 constitutional, the remainder of this Act and the applica-  
5 tion of the provisions of such to any other person or cir-  
6 cumstance shall not be affected.

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