AN ACT

To improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,
3 
4 This Act may be cited as the “Protecting Access to
5 Healthcare Act”.

Be it enacted by the Senate and House of Representa-
tives of the United States of America in Congress assembled,
TITLE I—HEALTH ACT

SEC. 101. SHORT TITLE.

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

SEC. 102. FINDINGS AND PURPOSE.

It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of “defensive medicine” and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

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

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

SEC. 103. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care law-
suit shall be 3 years after the date of manifestation of
injury or 1 year after the claimant discovers, or through
the use of reasonable diligence should have discovered, the
injury, whichever occurs first. In no event shall the time
for commencement of a health care lawsuit exceed 3 years
after the date of manifestation of injury unless tolled for
any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

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

Actions by a minor shall be commenced within 3 years
from the date of the alleged manifestation of injury except
that actions by a minor under the full age of 6 years shall
be commenced within 3 years of manifestation of injury
or prior to the minor’s 8th birthday, whichever provides
a longer period. Such time limitation shall be tolled for
minors for any period during which a parent or guardian
and a health care provider or health care organization
have committed fraud or collusion in the failure to bring
an action on behalf of the injured minor.

SEC. 104. COMPENSATING PATIENT INJURY.

(a) Unlimited Amount of Damages for Actual
Economic Losses in Health Care Lawsuits.—In any
health care lawsuit, nothing in this title shall limit a claim-
ant’s recovery of the full amount of the available economic
damages, notwithstanding the limitation in subsection (b).

(b) Additional Noneconomic Damages.—In any
health care lawsuit, the amount of noneconomic damages,
if available, may be as much as $250,000, regardless of
the number of parties against whom the action is brought
or the number of separate claims or actions brought with
respect to the same injury.

(c) No Discount of Award for Noneconomic
Damages.—For purposes of applying the limitation in
subsection (b), future noneconomic damages shall not be
discounted to present value. The jury shall not be in-
formed about the maximum award for noneconomic dam-
ages. An award for noneconomic damages in excess of
$250,000 shall be reduced either before the entry of judg-
ment, or by amendment of the judgment after entry of
judgment, and such reduction shall be made before ac-
counting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) Fair Share Rule.—In any health care lawsuit, each party shall be liable for that party’s several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party’s percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant’s harm.

SEC. 105. MAXIMIZING PATIENT RECOVERY.

(a) Court Supervision of Share of Damages Actually Paid to Claimants.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney
for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant’s damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

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

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

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

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

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.
SEC. 106. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

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

(2) the amount of punitive damages following a determination of punitive liability.
If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) Determining Amount of Punitive Damages.—

(1) Factors Considered.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

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

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

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

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and
(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

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

(c) No Punitive Damages for Products That Comply With FDA Standards.—

(1) In General.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, based on a claim that such product caused the claimant’s harm where—

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

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

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

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

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

(3) PACKAGING.—In a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially out of compliance with such regulations.
(4) EXCEPTION.—Paragraph (1) shall not apply in any health care lawsuit in which—

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

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product; or

(C) the defendant caused the medical product which caused the claimant’s harm to be misbranded or adulterated (as such terms are used in chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.)).
SEC. 107. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments, in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SEC. 108. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term “alternative dispute resolution system” or “ADR” means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

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

(3) COMPENSATORY DAMAGES.—The term
“compensatory damages” means objectively
verifiable monetary losses incurred as a result of the
provision of, use of, or payment for (or failure to
provide, use, or pay for) health care services or med-
ical products, such as past and future medical ex-
penses, loss of past and future earnings, cost of ob-
taining domestic services, loss of employment, and
loss of business or employment opportunities, dam-
ages for physical and emotional pain, suffering, in-
convenience, physical impairment, mental anguish,
disfigurement, loss of enjoyment of life, loss of soci-
ety and companionship, loss of consortium (other
than loss of domestic service), hedonic damages, in-
jury to reputation, and all other nonpecuniary losses
of any kind or nature. The term “compensatory
damages” includes economic damages and non-
economic damages, as such terms are defined in this
section.
(4) **CONTINGENT FEE.**—The term “contingent fee” includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

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

(6) **HEALTH CARE LAWSUIT.**—The term “health care lawsuit” means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,
regardless of the theory of liability on which the claim is based, or the number of claimants, plain-
tiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant al-
leges a health care liability claim. Such term does not include a claim or action which is based on
criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(7) Health care liability action.—The term “health care liability action” means a civil ac-
tion brought in a State or Federal court or pursuant to an alternative dispute resolution system, against
a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer,
promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based,
or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(8) Health care liability claim.—The term “health care liability claim” means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organiza-
tion, or the manufacturer, distributor, supplier, mar-
keter, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(9) Health Care Organization.—The term “health care organization” means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(10) Health Care Provider.—The term “health care provider” means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(11) Health Care Goods or Services.—The term “health care goods or services” means any
goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(12) MALICIOUS INTENT TO INJURE.—The term “malicious intent to injure” means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(13) MEDICAL PRODUCT.—The term “medical product” means a drug, device, or biological product intended for humans, and the terms “drug”, “device”, and “biological product” have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(14) NONECONOMIC DAMAGES.—The term “noneconomic damages” means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement,
loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) **PUNITIVE DAMAGES.**—The term “punitive damages” means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(16) **RECOVERY.**—The term “recovery” means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys’ office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

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

SEC. 109. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title does not affect the application of the rule of law to such an action; and

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

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.
SEC. 110. STATE FLEXIBILITY AND PROTECTION OF STATES’ RIGHTS.

(a) Health Care Lawsuits.—The provisions governing health care lawsuits set forth in this title preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates or permits subrogation or a lien on collateral source benefits.

(b) Protection of States’ Rights and Other Laws.—(1) Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

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

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

(1) any State law (whether effective before, on,
or after the date of the enactment of this title) that
specifies a particular monetary amount of compen-
satory or punitive damages (or the total amount of
damages) that may be awarded in a health care law-
suit, regardless of whether such monetary amount is
greater or lesser than is provided for under this title,
notwithstanding section 4(a); or

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

SEC. 111. APPLICABILITY; EFFECTIVE DATE.
This title shall apply to any health care lawsuit
brought in a Federal or State court, or subject to an alter-
native dispute resolution system, that is initiated on or
after the date of the enactment of this title, except that
any health care lawsuit arising from an injury occurring
prior to the date of the enactment of this title shall be
23 governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

**TITLE II—REPEAL OF INDEPENDENT PAYMENT ADVISORY BOARD**

**SEC. 201. SHORT TITLE.**

This title may be cited as the “Medicare Decisions Accountability Act of 2012”.

**SEC. 202. REPEAL OF THE INDEPENDENT PAYMENT ADVISORY BOARD.**

Effective as of the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148), sections 3403 and 10320 of such Act (including the amendments made by such sections, but excluding subsection (d) of section 1899A of the Social Security Act, as added and amended by such sections) are repealed, and any provision of law amended by such sections is hereby restored as if such sections had not been enacted into law.

**TITLE III—HEALTH CARE SAFETY NET ENHANCEMENT**

**SEC. 301. SHORT TITLE.**

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

HR 5 PCS
SEC. 302. PROTECTION FOR EMERGENCY AND RELATED SERVICES FURNISHED PURSUANT TO EMTALA.

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

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

and

(2) by adding at the end the following:

“(6)(A) For purposes of this section—

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

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

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

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

“(III) notwithstanding paragraph (3), this paragraph shall apply only with respect to causes of action arising from acts or omissions that occur on or after January 1, 2012;
“(IV) paragraph (5) shall not apply to a physician or physician group described in subparagraph (B)(ii);

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

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

“(VII) subsection (m) shall not apply to entities described in subparagraph (B).
“(B) An entity described in this subparagraph is—

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

“(ii) a physician or physician group that is employed by, is under contract with, or is an on-call provider of such hospital or emergency department, to furnish items and services to individuals under such section.

“(C) For purposes of this paragraph, the term ‘on-call provider’ means a physician or physician group that—

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

“(ii) is not employed by or under contract with such hospital or emergency department, but agrees to be ready and available to provide services pursuant to section 1867 of the Social Security Act or post-stabilization services to individuals being treated in the hospital or emergency department with or without compensation from the hospital or emergency department.
“(D) For purposes of this paragraph, the term ‘post stabilization services’ means, with respect to an individual who has been treated by an entity described in subparagraph (B) for purposes of complying with section 1867 of the Social Security Act, services that are—

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

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

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

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

SEC. 303. CONSTITUTIONAL AUTHORITY.

The constitutional authority upon which this title rests is the power of the Congress to provide for the general welfare, to regulate commerce, and to make all laws which shall be necessary and proper for carrying into execution Federal powers, as enumerated in section 8 of article I of the Constitution of the United States.

TITLE IV—RESTORING THE APPLICATION OF ANTITRUST LAWS TO HEALTH SECTOR INSURERS

SEC. 401. SHORT TITLE.

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

SEC. 402. APPLICATION OF THE ANTITRUST LAWS TO THE BUSINESS OF HEALTH INSURANCE.

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

“(c) Nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance. For purposes of the preceding sentence, the term ‘antitrust laws’ has the meaning given it in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition. For the purposes of this subsection, the term ‘business of health insurance’ shall—

“(1) mean ‘health insurance coverage’ offered by a ‘health insurance issuer’ as those terms are defined in section 9001 of the Patient Protection and Affordable Care Act, which incorporates by reference and utilizes the definitions included in section 9832 of the Internal Revenue Code (26 U.S.C. 9832); and

“(2) not include—

“(A) life insurance and annuities;

“(B) property or casualty insurance, including but not limited to, automobile, medical malpractice or workers’ compensation insurance; or
“(C) any insurance or benefits defined as ‘excepted benefits’ under section 9832(c) of the Internal Revenue Code (26 U.S.C. 9832(c)), whether offered separately or in combination with products described in subparagraph (A).”.

(b) RELATED PROVISION.—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, section 3(c) of the McCarran-Ferguson Act shall apply with respect to the business of health insurance without regard to whether such business is carried on for profit, notwithstanding the definition of “Corporation” contained in section 4 of the Federal Trade Commission Act.

(c) LIMITATION ON CLASS ACTIONS.—

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

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

(A) by the United States or any State; or
(B) by a named claimant for an injury only to itself.

TITLE V—PROTECTIONS FOR GOOD SAMARITAN HEALTH PROFESSIONALS

SEC. 501. SHORT TITLE.

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

SEC. 502. LIMITATION ON LIABILITY FOR VOLUNTEER HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by inserting after section 224 the following:

“SEC. 224A. LIMITATION ON LIABILITY FOR VOLUNTEER HEALTH CARE PROFESSIONALS.

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

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

“(2) the act or omission occurs—

“(A) during the period of the disaster, as determined under the laws listed in subsection (e)(1);
“(B) in the health care professional’s capacity as such a volunteer; and

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

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

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

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

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

“(d) PREEMPTION.—

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

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

“(e) DEFINITIONS.—In this section:

“(1) The term ‘disaster’ means—

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

“(B) an emergency or major disaster de-
clared by the President under the Robert T.
Stafford Disaster Relief and Emergency Assist-
ance Act; or

“(C) a public health emergency determined
by the Secretary under section 319 of this Act.

“(2) The term ‘harm’ includes physical, non-
physical, economic, and noneconomic losses.

“(3) The term ‘health care professional’ means
an individual who is licensed, certified, or authorized
in one or more States to practice a health care pro-
fession.

“(4) The term ‘State’ includes each of the sev-
eral States, the District of Columbia, the Common-
wealth of Puerto Rico, the Virgin Islands, Guam,
American Samoa, the Northern Mariana Islands,
and any other territory or possession of the United States.

“(5)(A) The term ‘volunteer’ means a health care professional who, with respect to the health care services rendered, does not receive—

“(i) compensation; or

“(ii) any other thing of value in lieu of compensation, in excess of $500 per year.

“(B) For purposes of subparagraph (A), the term ‘compensation’—

“(i) includes payment under any insurance policy or health plan, or under any Federal or State health benefits program; and

“(ii) excludes—

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

“(II) receipt of paid leave; and

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

(b) **Effective Date.**—
(1) IN GENERAL.—This title and the amend-
ment made by subsection (a) shall take effect 90
days after the date of the enactment of this title.

(2) APPLICATION.—This title applies to any
claim for harm caused by an act or omission of a
health care professional where the claim is filed on
or after the effective date of this title, but only if the
harm that is the subject of the claim or the conduct
that caused such harm occurred on or after such ef-
fective date.

Passed the House of Representatives March 22,
2012.

Attest: KAREN L. HAAS,
Clerk.
AN ACT

To improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

MARCH 26, 2012

Read the second time and placed on the calendar.