

113TH CONGRESS
1ST SESSION

S. 1860

To reform the medical liability system, improve access to health care for rural and indigent patients, enhance access to affordable prescription drugs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 19, 2013

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

A BILL

To reform the medical liability system, improve access to health care for rural and indigent patients, enhance access to affordable prescription drugs, and for other purposes.

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Steps Toward Access and Reform Act of 2013” or the
6 “STAR Act of 2013”.

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

Sec. 101. Encouraging speedy resolution of claims.
 Sec. 102. Compensating patient injury.
 Sec. 103. Maximizing patient recovery.
 Sec. 104. Additional collateral source benefits.
 Sec. 105. Punitive damages.
 Sec. 106. Authorization of payment of future damages to claimants in health care lawsuits.
 Sec. 107. Effect on other laws.
 Sec. 108. State flexibility and protection of States' rights.
 Sec. 109. Applicability; effective date.
 Sec. 110. Sense of Congress.
 Sec. 111. Definitions.

Sec. 201. Improving access for rural and indigent patients.

Sec. 301. Providing for affordable prescription drugs.

Sec. 401. Interstate purchasing of health insurance.

3 SEC. 101. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

12 (1) upon proof of fraud;

1 (2) intentional concealment; or

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

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

15 **SEC. 102. COMPENSATING PATIENT INJURY.**

16 (a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL
17 ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any
18 health care lawsuit, nothing in this title shall limit a claim-
19 ant's recovery of the full amount of the available economic
20 damages, notwithstanding the limitation in subsection (b).

21 (b) ADDITIONAL NONECONOMIC DAMAGES.—In any
22 health care lawsuit, the amount of noneconomic damages,
23 if available, shall not exceed \$250,000, regardless of the
24 number of parties against whom the action is brought or

1 the number of separate claims or actions brought with re-
2 spect to the same injury.

3 (c) NO DISCOUNT OF AWARD FOR NONECONOMIC
4 DAMAGES.—For purposes of applying the limitation in
5 subsection (b), future noneconomic damages shall not be
6 discounted to present value. The jury shall not be in-
7 formed about the maximum award for noneconomic dam-
8 ages. An award for noneconomic damages in excess of
9 \$250,000 shall be reduced either before the entry of judg-
10 ment, or by amendment of the judgment after entry of
11 judgment, and such reduction shall be made before ac-
12 counting for any other reduction in damages required by
13 law. If separate awards are rendered for past and future
14 noneconomic damages and the combined awards exceed
15 \$250,000, the future noneconomic damages shall be re-
16 duced first.

17 (d) FAIR SHARE RULE.—In any health care lawsuit,
18 each party shall be liable for that party's several share
19 of any damages only and not for the share of any other
20 person. Each party shall be liable only for the amount of
21 damages allocated to such party in direct proportion to
22 such party's percentage of responsibility. Whenever a
23 judgment of liability is rendered as to any party, a sepa-
24 rate judgment shall be rendered against each such party
25 for the amount allocated to such party. For purposes of

1 this section, the trier of fact shall determine the propor-
 2 tion of responsibility of each party for the claimant's
 3 harm.

4 **SEC. 103. MAXIMIZING PATIENT RECOVERY.**

5 (a) COURT SUPERVISION OF SHARE OF DAMAGES
 6 ACTUALLY PAID TO CLAIMANTS.—In any health care law-
 7 suit, the court shall supervise the arrangements for pay-
 8 ment of damages to protect against conflicts of interest
 9 that may have the effect of reducing the amount of dam-
 10 ages awarded that are actually paid to claimants. In par-
 11 ticular, in any health care lawsuit in which the attorney
 12 for a party claims a financial stake in the outcome by vir-
 13 tue of a contingent fee, the court shall have the power
 14 to restrict the payment of a claimant's damage recovery
 15 to such attorney, and to redirect such damages to the
 16 claimant based upon the interests of justice and principles
 17 of equity. In no event shall the total of all contingent fees
 18 for representing all claimants in a health care lawsuit ex-
 19 ceed the following limits:

20 (1) 40 percent of the first \$50,000 recovered by
 21 the claimants.

22 (2) 33⅓ percent of the next \$50,000 recovered
 23 by the claimants.

24 (3) 25 percent of the next \$500,000 recovered
 25 by the claimants.

1 (4) 15 percent of any amount by which the re-
2 covery by the claimants is in excess of \$600,000.

3 (b) APPLICABILITY.—The limitations in this section
4 shall apply whether the recovery is by judgment, settle-
5 ment, mediation, arbitration, or any other form of alter-
6 native dispute resolution. In a health care lawsuit involv-
7 ing a minor or incompetent person, a court retains the
8 authority to authorize or approve a fee that is less than
9 the maximum permitted under this section. The require-
10 ment for court supervision in the first two sentences of
11 subsection (a) applies only in civil actions.

12 **SEC. 104. ADDITIONAL COLLATERAL SOURCE BENEFITS.**

13 In any health care lawsuit involving injury or wrong-
14 ful death, any party may introduce evidence of collateral
15 source benefits. If a party elects to introduce such evi-
16 dence, any opposing party may introduce evidence of any
17 amount paid or contributed or reasonably likely to be paid
18 or contributed in the future by or on behalf of the oppos-
19 ing party to secure the right to such collateral source bene-
20 fits. No provider of collateral source benefits shall recover
21 any amount against the claimant or receive any lien or
22 credit against the claimant's recovery or be equitably or
23 legally subrogated to the right of the claimant in a health
24 care lawsuit involving injury or wrongful death. This sec-
25 tion shall apply to any health care lawsuit that is settled

1 as well as a health care lawsuit that is resolved by a fact
2 finder. This section shall not apply to section 1862(b) (42
3 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C.
4 1396a(a)(25)) of the Social Security Act.

5 **SEC. 105. PUNITIVE DAMAGES.**

6 (a) IN GENERAL.—Punitive damages may, if other-
7 wise permitted by applicable State or Federal law, be
8 awarded against any person in a health care lawsuit only
9 if it is proven by clear and convincing evidence that such
10 person acted with malicious intent to injure the claimant,
11 or that such person deliberately failed to avoid unneces-
12 sary injury that such person knew the claimant was sub-
13 stantially certain to suffer. In any health care lawsuit
14 where no judgment for compensatory damages is rendered
15 against such person, no punitive damages may be awarded
16 with respect to the claim in such lawsuit. No demand for
17 punitive damages shall be included in a health care lawsuit
18 as initially filed. A court may allow a claimant to file an
19 amended pleading for punitive damages only upon a mo-
20 tion by the claimant and after a finding by the court, upon
21 review of supporting and opposing affidavits or after a
22 hearing, after weighing the evidence, that the claimant has
23 established by a substantial probability that the claimant
24 will prevail on the claim for punitive damages. At the re-

1 quest of any party in a health care lawsuit, the trier of
 2 fact shall consider in a separate proceeding—

3 (1) whether punitive damages are to be award-
 4 ed and the amount of such award; and

5 (2) the amount of punitive damages following a
 6 determination of punitive liability.

7 If a separate proceeding is requested, evidence relevant
 8 only to the claim for punitive damages, as determined by
 9 applicable State law, shall be inadmissible in any pro-
 10 ceeding to determine whether compensatory damages are
 11 to be awarded.

12 (b) DETERMINING AMOUNT OF PUNITIVE DAM-
 13 AGES.—

14 (1) FACTORS CONSIDERED.—In determining
 15 the amount of punitive damages, if awarded, in a
 16 health care lawsuit, the trier of fact shall consider
 17 only the following—

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

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

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

24 (D) the number of products sold or med-
 25 ical procedures rendered for compensation, as

1 the case may be, by such party, of the kind
2 causing the harm complained of by the claim-
3 ant;

4 (E) any criminal penalties imposed on such
5 party, as a result of the conduct complained of
6 by the claimant; and

7 (F) the amount of any civil fines assessed
8 against such party as a result of the conduct
9 complained of by the claimant.

10 (2) MAXIMUM AWARD.—The amount of punitive
11 damages, if awarded, in a health care lawsuit may
12 not exceed \$250,000 or two times the amount of
13 economic damages awarded, whichever is greater.
14 The jury shall not be informed of this limitation.

15 (c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT
16 COMPLY WITH FDA STANDARDS.—

17 (1) IN GENERAL.—

18 (A) No punitive damages may be awarded
19 against the manufacturer or distributor of a
20 medical product, or a supplier of any compo-
21 nent or raw material of such medical product,
22 based on a claim that such product caused the
23 claimant's harm where—

24 (i)(I) such medical product was sub-
25 ject to premarket approval, clearance, or li-

1 censure by the Food and Drug Administra-
2 tion with respect to the safety of the for-
3 mulation or performance of the aspect of
4 such medical product which caused the
5 claimant's harm or the adequacy of the
6 packaging or labeling of such medical
7 product; and

8 (II) such medical product was so ap-
9 proved, cleared, or licensed; or

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

23 (B) RULE OF CONSTRUCTION.—Subpara-
24 graph (A) may not be construed as establishing
25 the obligation of the Food and Drug Adminis-

1 tration to demonstrate affirmatively that a
2 manufacturer, distributor, or supplier referred
3 to in such subparagraph meets any of the con-
4 ditions described in such subparagraph.

5 (2) LIABILITY OF HEALTH CARE PROVIDERS.—

6 A health care provider who prescribes, or who dis-
7 penses pursuant to a prescription, a medical product
8 approved, licensed, or cleared by the Food and Drug
9 Administration shall not be named as a party to a
10 product liability lawsuit involving such product and
11 shall not be liable to a claimant in a class action
12 lawsuit against the manufacturer, distributor, or
13 seller of such product. Nothing in this paragraph
14 prevents a court from consolidating cases involving
15 health care providers and cases involving products li-
16 ability claims against the manufacturer, distributor,
17 or product seller of such medical product.

18 (3) PACKAGING.—In a health care lawsuit for

19 harm which is alleged to relate to the adequacy of
20 the packaging or labeling of a drug which is required
21 to have tamper-resistant packaging under regula-
22 tions of the Secretary of Health and Human Serv-
23 ices (including labeling regulations related to such
24 packaging), the manufacturer or product seller of
25 the drug shall not be held liable for punitive dam-

1 ages unless such packaging or labeling is found by
2 the trier of fact by clear and convincing evidence to
3 be substantially out of compliance with such regula-
4 tions.

5 (4) EXCEPTION.—Paragraph (1) shall not
6 apply in any health care lawsuit in which—

7 (A) a person, before or after premarket ap-
8 proval, clearance, or licensure of such medical
9 product, knowingly misrepresented to or with-
10 held from the Food and Drug Administration
11 information that is required to be submitted
12 under the Federal Food, Drug, and Cosmetic
13 Act (21 U.S.C. 301 et seq.) or section 351 of
14 the Public Health Service Act (42 U.S.C. 262)
15 that is material and is causally related to the
16 harm which the claimant allegedly suffered; or

17 (B) a person made an illegal payment to
18 an official of the Food and Drug Administra-
19 tion for the purpose of either securing or main-
20 taining approval, clearance, or licensure of such
21 medical product.

1 **SEC. 106. AUTHORIZATION OF PAYMENT OF FUTURE DAM-**
2 **AGES TO CLAIMANTS IN HEALTH CARE LAW-**
3 **SUITS.**

4 (a) IN GENERAL.—In any health care lawsuit, if an
5 award of future damages, without reduction to present
6 value, equaling or exceeding \$50,000 is made against a
7 party with sufficient insurance or other assets to fund a
8 periodic payment of such a judgment, the court shall, at
9 the request of any party, enter a judgment ordering that
10 the future damages be paid by periodic payments. In any
11 health care lawsuit, the court may be guided by the Uni-
12 form Periodic Payment of Judgments Act promulgated by
13 the National Conference of Commissioners on Uniform
14 State Laws.

15 (b) APPLICABILITY.—This section applies to all ac-
16 tions which have not been first set for trial or retrial be-
17 fore the effective date of this Act.

18 **SEC. 107. EFFECT ON OTHER LAWS.**

19 (a) VACCINE INJURY.—

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

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

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

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

11 (b) OTHER FEDERAL LAW.—Except as provided in
 12 this section, nothing in this title shall be deemed to affect
 13 any defense available to a defendant in a health care law-
 14 suit or action under any other provision of Federal law.

15 **SEC. 108. STATE FLEXIBILITY AND PROTECTION OF**
 16 **STATES' RIGHTS.**

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

6 (2) prohibits the introduction of evidence re-
7 garding collateral source benefits, or mandates or
8 permits subrogation or a lien on collateral source
9 benefits.

10 (b) PROTECTION OF STATES' RIGHTS AND OTHER
11 LAWS.—(1) Any issue that is not governed by any provi-
12 sion of law established by or under this title (including
13 State standards of negligence) shall be governed by other-
14 wise applicable State or Federal law.

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

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

23 (1) any State law (whether effective before, on,
24 or after the date of the enactment of this Act) that
25 specifies a particular monetary amount of compen-

1 satory or punitive damages (or the total amount of
2 damages) that may be awarded in a health care law-
3 suit, regardless of whether such monetary amount is
4 greater or lesser than is provided for under this title,
5 notwithstanding section 104(a); or

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

9 **SEC. 109. APPLICABILITY; EFFECTIVE DATE.**

10 This title shall apply to any health care lawsuit
11 brought in a Federal or State court, or subject to an alter-
12 native dispute resolution system, that is initiated on or
13 after the date of the enactment of this Act, except that
14 any health care lawsuit arising from an injury occurring
15 prior to the date of the enactment of this Act shall be
16 governed by the applicable statute of limitations provisions
17 in effect at the time the injury occurred.

18 **SEC. 110. SENSE OF CONGRESS.**

19 It is the sense of Congress that a health insurer
20 should be liable for damages for harm caused when it
21 makes a decision as to what care is medically necessary
22 and appropriate.

23 **SEC. 111. DEFINITIONS.**

24 In this title:

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

7 (2) CLAIMANT.—The term “claimant” means
 8 any person who brings a title, including a person
 9 who asserts or claims a right to legal or equitable
 10 contribution, indemnity, or subrogation, arising out
 11 of a health care liability claim or action, and any
 12 person on whose behalf such a claim is asserted or
 13 such an action is brought, whether deceased, incom-
 14 petent, or a minor.

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

23 (A) any State or Federal health, sickness,
 24 income-disability, accident, or workers’ com-
 25 pensation law;

1 (B) any health, sickness, income-disability,
 2 or accident insurance that provides health bene-
 3 fits or income-disability coverage;

4 (C) any contract or agreement of any
 5 group, organization, partnership, or corporation
 6 to provide, pay for, or reimburse the cost of
 7 medical, hospital, dental, or income-disability
 8 benefits; and

9 (D) any other publicly or privately funded
 10 program.

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

1 of any kind or nature. The term “compensatory
 2 damages” includes economic damages and non-
 3 economic damages, as such terms are defined in this
 4 section.

5 (5) CONTINGENT FEE.—The term “contingent
 6 fee” includes all compensation to any person or per-
 7 sons which is payable only if a recovery is effected
 8 on behalf of one or more claimants.

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

18 (7) HEALTH CARE LAWSUIT.—The term
 19 “health care lawsuit” means any health care liability
 20 claim concerning the provision of health care goods
 21 or services or any medical product affecting inter-
 22 state commerce, or any health care liability action
 23 concerning the provision of health care goods or
 24 services or any medical product affecting interstate
 25 commerce, brought in a State or Federal court or

1 pursuant to an alternative dispute resolution system,
2 against a health care provider, a health care organi-
3 zation, or the manufacturer, distributor, supplier,
4 marketer, promoter, or seller of a medical product,
5 regardless of the theory of liability on which the
6 claim is based, or the number of claimants, plain-
7 tiffs, defendants, or other parties, or the number of
8 claims or causes of action, in which the claimant al-
9 leges a health care liability claim. Such term does
10 not include a claim or action which is based on
11 criminal liability; which seeks civil fines or penalties
12 paid to Federal, State, or local government; or which
13 is grounded in antitrust.

14 (8) HEALTH CARE LIABILITY ACTION.—The
15 term “health care liability action” means a civil ac-
16 tion brought in a State or Federal court or pursuant
17 to an alternative dispute resolution system, against
18 a health care provider, a health care organization, or
19 the manufacturer, distributor, supplier, marketer,
20 promoter, or seller of a medical product, regardless
21 of the theory of liability on which the claim is based,
22 or the number of plaintiffs, defendants, or other par-
23 ties, or the number of causes of action, in which the
24 claimant alleges a health care liability claim.

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

15 (10) HEALTH CARE ORGANIZATION.—The term
16 “health care organization” means any person or en-
17 tity which is obligated to provide or pay for health
18 benefits under any health plan, including any person
19 or entity acting under a contract or arrangement
20 with a health care organization to provide or admin-
21 ister any health benefit.

22 (11) HEALTH CARE PROVIDER.—The term
23 “health care provider” means any person or entity
24 required by State or Federal laws or regulations to
25 be licensed, registered, or certified to provide health

1 care services, and being either so licensed, reg-
 2 istered, or certified, or exempted from such require-
 3 ment by other statute or regulation.

4 (12) HEALTH CARE GOODS OR SERVICES.—The
 5 term “health care goods or services” means any
 6 goods or services provided by a health care organiza-
 7 tion, provider, or by any individual working under
 8 the supervision of a health care provider, that relates
 9 to the diagnosis, prevention, or treatment of any
 10 human disease or impairment, or the assessment or
 11 care of the health of human beings.

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

17 (14) MEDICAL PRODUCT.—The term “medical
 18 product” means a drug, device, or biological product
 19 intended for humans, and the terms “drug”, “de-
 20 vice”, and “biological product” have the meanings
 21 given such terms in sections 201(g)(1) and 201(h)
 22 of the Federal Food, Drug, and Cosmetic Act (21
 23 U.S.C. 321(g)(1) and (h)) and section 351(a) of the
 24 Public Health Service Act (42 U.S.C. 262(a)), re-

spectively, including any component or raw material used therein, but excluding health care services.

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

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

(17) RECOVERY.—The term “recovery” means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys’ office

1 overhead costs or charges for legal services are not
2 deductible disbursements or costs for such purpose.

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

10 **TITLE II—IMPROVING ACCESS**
11 **FOR RURAL AND INDIGENT**
12 **PATIENTS**

13 **SEC. 201. IMPROVING ACCESS FOR RURAL AND INDIGENT**
14 **PATIENTS.**

15 (a) LOAN FORGIVENESS FOR PRIMARY CARE PRO-
16 VIDERS.—

17 (1) IN GENERAL.—The Secretary of Health and
18 Human Services shall carry out a program of enter-
19 ing into contracts with eligible individuals under
20 which—

21 (A) the individual agrees to serve for a pe-
22 riod of not less than 4 years as a primary care
23 provider in a medically underserved community
24 (as defined in section 799B of the Public
25 Health Service Act (42 U.S.C. 295p)); and

1 (B) in consideration of such service, the
2 Secretary agrees to pay not more than
3 \$100,000 on the principal and interest on the
4 individual's graduate educational loans.

5 (2) ELIGIBILITY.—To be eligible to enter into a
6 contract under subsection (1), an individual must—

7 (A) have a graduate degree in medicine,
8 osteopathic medicine, or another health profes-
9 sion from an accredited (as determined by the
10 Secretary of Health and Human Services) insti-
11 tution of higher education; and

12 (B) have practiced as a primary care pro-
13 vider for a period (excluding any residency or
14 fellowship training period) of not less than 3
15 years in a medically underserved community (as
16 defined in section 799B of the Public Health
17 Service Act (42 U.S.C. 295p)).

18 (3) INSTALLMENTS.—Payments under this sec-
19 tion may be made in installments of not more than
20 \$25,000 for each year of service described in para-
21 graph (1) (A).

22 (4) APPLICABILITY OF CERTAIN PROVISIONS.—
23 The provisions of subpart III of part D of title III
24 of the Public Health Service Act shall, except as in-
25 consistent with this section, apply to the program es-

1 tablished under this section in the same manner and
 2 to the same extent as such provisions apply to the
 3 National Health Service Corps Loan Repayment
 4 Program established in such subpart.

5 (b) PERMITTING STATE DESIGNATION OF CRITICAL
 6 ACCESS HOSPITALS.—Section 1820(c)(2)(B)(i)(II) of the
 7 Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) is
 8 amended by inserting “or on or after the date of enact-
 9 ment of the Steps Toward Access and Reform Act of
 10 2013” after “January 1, 2006,”.

11 (c) PATIENT FAIRNESS AND INDIGENT CARE PRO-
 12 MOTION.—

13 (1) IN GENERAL.—Section 166 of the Internal
 14 Revenue Code of 1986 (relating to bad debts) is
 15 amended by redesignating subsection (f) as sub-
 16 section (g) and by inserting after subsection (e) the
 17 following new subsection:

18 “(f) UNPAID MEDICAL CARE PROVIDED TO LOW-IN-
 19 COME INDIVIDUALS.—

20 “(1) IN GENERAL.—In the case of a taxpayer
 21 to whom this subsection applies, the deduction under
 22 subsection (a) for worthless qualified medical care
 23 debt shall not be less than 75 percent of the tax-
 24 payer’s charge for such care.

1 “(2) TAXPAYER TO WHOM SUBSECTION AP-
 2 PLIES.—This subsection shall apply to any taxpayer
 3 who is engaged in the trade or business of providing
 4 medical care other than as an employee and who
 5 used the cash receipts and disbursements method of
 6 accounting.

7 “(3) QUALIFIED MEDICAL CARE DEBT.—For
 8 purposes of this subsection, the term ‘qualified med-
 9 ical care debt’ means any debt for medical care pro-
 10 vided by the taxpayer to a low-income individual who
 11 is a citizen or legal resident of the United States.

12 “(4) DETERMINATION OF CHARGE.—The
 13 amount of the taxpayer’s charge which may be taken
 14 into account—

15 “(A) shall not exceed the amount of the
 16 charge that would be recognized for purposes of
 17 title XVIII of the Social Security Act, and

18 “(B) shall not include any amount for
 19 which the taxpayer is not entitled to reimburse-
 20 ment from the low-income individual.

21 “(5) LOW-INCOME INDIVIDUAL.—For purposes
 22 of this subsection, the term ‘low-income individual’
 23 means an individual who, at the time the medical
 24 care attributable to the debt is provided, has an an-
 25 nual household income below 135 percent of the pov-

erty line (as defined in section 673 of the Community Services Block Grant Act (42 U.S.C. 9902)) applicable to the size of the family involved, and is a citizen or legal resident of the United States.

“(6) MEDICAL CARE.—For purposes of this subsection, the term ‘medical care’ has the meaning given to such term by section 213(d).

“(7) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary or appropriate to carry out this section, including regulations providing for methods of establishing that an individual is a low-income individual for purposes of this section.”.

(2) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

TITLE III—PROVIDING FOR AFFORDABLE PRESCRIPTION DRUGS

SEC. 301. PROVIDING FOR AFFORDABLE PRESCRIPTION DRUGS.

Notwithstanding any other provision of law, the Food and Drug Administration shall not take any action to prevent an individual not in the business of importing a prescription drug (within the meaning of section 801(g) of

1 the Federal Food, Drug, and Cosmetic Act (21 U.S.C.
 2 381(g))) from importing a prescription drug from Canada
 3 that complies with the Federal Food, Drug, and Cosmetic
 4 Act.

5 **TITLE IV—EXPANDING CHOICES**
 6 **BY ALLOWING AMERICANS TO**
 7 **BUY HEALTH CARE COV-**
 8 **ERAGE ACROSS STATE LINES**

9 **SEC. 401. INTERSTATE PURCHASING OF HEALTH INSUR-**
 10 **ANCE.**

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:

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 quest 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**
5 **IS GOVERNED BY THE LAWS AND REGULA-**
6 **TIONS OF THE STATE OF _____, AND IT**
7 **HAS MET ALL THE LAWS OF THAT STATE**
8 **AS DETERMINED BY THAT STATE'S DE-**
9 **PARTMENT OF INSURANCE. THIS POLICY**
10 **MAY BE LESS EXPENSIVE THAN OTHERS**
11 **BECAUSE IT IS NOT SUBJECT TO ALL OF**
12 **THE INSURANCE LAWS AND REGULATIONS**
13 **OF THE STATE OF _____, INCLUDING**
14 **COVERAGE OF SOME SERVICES OR BENE-**
15 **FITS MANDATED BY THE LAW OF THE**
16 **STATE OF _____. ADDITIONALLY, THIS**
17 **POLICY IS NOT SUBJECT TO ALL OF THE**
18 **CONSUMER PROTECTION LAWS OR RE-**
19 **STRICTIONS ON RATE CHANGES OF THE**
20 **STATE OF _____. AS WITH ALL INSUR-**
21 **ANCE PRODUCTS, BEFORE PURCHASING**
22 **THIS POLICY, YOU SHOULD CAREFULLY**
23 **REVIEW THE POLICY AND DETERMINE**
24 **WHAT HEALTH CARE SERVICES THE POL-**
25 **ICY COVERS AND WHAT BENEFITS IT PRO-**

1 **VIDES, INCLUDING ANY EXCLUSIONS, LIM-**
 2 **ITATIONS, OR CONDITIONS FOR SUCH**
 3 **SERVICES OR BENEFITS.**

4 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS
 5 AND PREMIUM INCREASES.—

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

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

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

21 “(2) CONSTRUCTION.—Nothing in paragraph
 22 (1) shall be construed to prohibit a health insurance
 23 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 or fea-
 23 sibility study or any similar statement of the
 24 policy being offered and its coverage (which

1 shall include the name of its primary State and
2 its 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 section
5 2796(b)(1).

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

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

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

19 “(2) COURTS OF COMPETENT JURISDICTION.—

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

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

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

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

21 **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**
 22 **BEFORE ISSUER MAY SELL INTO SECONDARY**
 23 **STATES.**

24 “A health insurance issuer may not offer, sell, or
 25 issue individual health insurance coverage in a secondary

1 State if the State insurance commissioner does not use
 2 a risk-based capital formula for the determination of cap-
 3 ital and surplus requirements for all health insurance
 4 issuers.

5 **“SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCE-**
 6 **DURES.**

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

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

16 “(2) in any case in which the requirements of
 17 subparagraph (A) are not met with respect to the ei-
 18 ther of such States, the issuer provides an inde-
 19 pendent review mechanism substantially identical (as
 20 determined by the applicable State authority of such
 21 State) to that prescribed in the ‘Health Carrier Ex-
 22 ternal Review Model Act’ of the National Association
 23 of Insurance Commissioners for all individuals who
 24 purchase insurance coverage under the terms of this
 25 part, except that, under such mechanism, the review

1 is conducted by an independent medical reviewer, or
 2 a panel of such reviewers, with respect to whom the
 3 requirements of subsection (b) are met.

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

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 the
6 primary State for such coverage has sole jurisdiction to
7 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 preexisting
 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

- 1 date of the amendment made by subsection (a), on
- 2 the ongoing study conducted under paragraph (1).

