

A TWENTY-PAGE BILL IN PLAIN ENGLISH TO REDUCE PREMIUMS AND HELP LAID –OFF AMERICANS

**THIS BILL IS NOT DANGEROUS TO YOUR HEALTH OR YOUR FREEDOM
CONTAINS NO MANDATE ON STATES OR INDIVIDUALS**

DEFINITION: SHORT TITLE; PURPOSE.

(a) Short Title. – This Act may be cited as the “Mandate Free Act for Reducing the Number of Uninsured Americans..

(b) Purpose. – The purpose of this Act is to make health insurance more affordable and dependable without imposing mandates on states or individuals.

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This bill is limited to twenty pages in length to ensure that it is accessible to the public and readable by Members of Congress before they vote on it.

TITLE 1 – PROMOTING FREE MARKET COMPETITION AND CONSUMER PROTECTIONS ACROSS STATE LINES

SEC. 101. INTERSTATE PURCHASING OF HEALTH INSURANCE.

IN GENERAL.—Title XXVII of the Public Health

Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

APPLICATION OF LAW:

(a) IN GENERAL.—The covered laws of the primary State, as defined in Sec. 104(3), shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, as defined in Sec. 104(4).

(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.— Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would make — make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied

on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer's financial condition, if—

(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

(ii) any such examination is conducted in accordance with the examiners' handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

(D) to comply with a lawful order issued—

(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C);

or

(ii) in a voluntary dissolution proceeding;

(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

(G) to comply with any State law regarding fraud and abuse (as defined in Section), except that if the State seeks an injunction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

(H) to comply with any State law regarding unfair claims settlement practices (as defined in Section); or

(I) to comply with the applicable requirements for independent review under Section with respect to coverage offered in the State;

(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

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

(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State.

“THIS POLICY IS ISSUED BY ____ AND IS GOVERNED BY THE LAWS AND REGULATIONS OF THE STATE OF ____, AND IT HAS

MET ALL THE LAWS OF THAT STATE AS DETERMINED BY THAT STATE'S DEPARTMENT OF INSURANCE. THIS POLICY MAY BE LESS EXPENSIVE THAN OTHERS BECAUSE IT IS NOT SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF THE STATE OF _____, INCLUDING COVERAGE OF SOME SERVICES OR BENEFITS MANDATED BY THE LAW OF THE STATE OF _____. ADDITIONALLY, THIS POLICY IS NOT SUBJECT TO ALL OF THE CONSUMER PROTECTION LAWS OR RESTRICTIONS ON RATE CHANGES OF THE STATE OF _____. AS WITH ALL INSURANCE PRODUCTS, BEFORE PURCHASING THIS POLICY, YOU SHOULD CAREFULLY REVIEW THE POLICY AND DETERMINE WHAT HEALTHCARE SERVICES THE POLICY COVERS AND WHAT BENEFITS IT PROVIDES, INCLUDING ANY EXCLUSIONS, LIMITATIONS, OR CONDITIONS FOR SUCH SERVICES OR BENEFITS.''

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

(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

- (A) move or reclassify the individual insured under the health insurance coverage from the class such individuals in at the time of issue of the contract based on the health status of the individual FINISHED: ; or health-status related factors of the individual; or
- (B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

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

- (A) from terminating or discontinuing coverage or a class of coverage.
- (B) from raising premium rates for all policy holders within a class based on claims experience;
- (C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—
 - (i) are disclosed to the consumer in the insurance contract;
 - (ii) are based on specific wellness activities that are not applicable to all individuals; and
 - (iii) are not obtainable by all individuals to whom coverage is offered;
- (D) from reinstating lapsed coverage; or
- (E) from retroactively adjusting the rates charged an

insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

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

(f) **LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.**—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

(g) **DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.**—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

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

(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

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

(B) a qualified loss reserve specialist.

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

(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in this Act.

(i) **POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.**—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State’s laws.

(j) **STATE POWERS TO ENFORCE STATE LAWS.**—

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

(2) **COURTS OF COMPETENT JURISDICTION.**— If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

(k) **STATES’ AUTHORITY TO SUE.**—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

(l) **GENERALLY APPLICABLE LAWS.**—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

SEC. 102. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.

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

Sec. 102(a) In order to protect the insured from unjust cancellations of their coverage, issuers may issue in a secondary state only if the issuer’s primary state imposes limits on nonrenewal and rescission in the individual market and provides for an independent, external third-party opportunity for review before such nonrenewal, discontinuation, or rescission shall take effect.

SEC. 103. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) **RIGHT TO EXTERNAL APPEAL.**—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the ‘Health Carrier External Review Model Act’ of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism,

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

SEC. 104. DEFINITIONS.—For purposes of this Act:

(1) **ENROLLEE.**—The term ‘enrollee’ means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(2) **HEALTH CARE PROFESSIONAL.**—The term ‘healthcare professional’ means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(3) **PRIMARY STATE.**—The term ‘primary State’ means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance coverage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

(4) **SECONDARY STATE.**—The term ‘secondary State’ means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

(5) **HEALTH INSURANCE ISSUER.**—The term ‘health insurance issuer’ means an issuer licensed in the primary State and qualified to sell individual health insurance coverage in that State.

(6) **INDIVIDUAL HEALTH INSURANCE COVERAGE.**—

The term ‘individual health insurance coverage’ means health insurance coverage offered in the individual market,

(7) **APPLICABLE STATE AUTHORITY.**—

The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

(8) **HAZARDOUS FINANCIAL CONDITION.**—The term ‘hazardous financial condition’ means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

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

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

(9) COVERED LAWS.—

(A) IN GENERAL.—The term ‘covered laws’ means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

(i) individual health insurance coverage issued by a health insurance issuer;

(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

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

(11) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term ‘unfair claims settlement practices’ means only the following practices:

(A) Knowingly misrepresenting to claimants and insured individuals relevant facts or policy provisions relating to coverage at issue.

(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

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

(E) Refusing to pay claims without conducting a reasonable investigation.

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

(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

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

(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

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

(12) FRAUD AND ABUSE.—The term ‘fraud and abuse’ means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

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

(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

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

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

(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

(vii) The financial condition of an insurer or reinsurer.

(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

(ix) The issuance of written evidence of insurance.

(x) The reinstatement of an insurance policy.

(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

SEC. 105. ENFORCEMENT.

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

(b) **SECONDARY STATE’S AUTHORITY.**—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws

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

(d) **NOTICE OF COMPLIANCE FAILURE.**—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.

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

TITLE II - INCENTIVES FOR STATES TO REDUCE MEDICAL LIABILITY COSTS

SECTION 1. SHORT TITLE; PURPOSE.

(a) **Short Title.** – This Title may be cited as Incentives for States to Reduce Medical Liability Costs

(b) **Purpose.** – The purpose of this title is to provide incentives and help defray the start-up costs incurred by states that seek to establish medical courts and impose caps on damages in order to:

- (1) improve justice for injured patients,
- (2) lower health costs by reducing “defensive medicine,” and
- (3) slow the exodus of physicians from medicine by reforming the way medical malpractice claims are handled in the legal system.

SEC. 101. EXPERT HEALTHCARE TRIBUNALS TO HEAR HEALTHCARE LAWSUITS.

Within five years from the date of enactment of this title, states that establish healthcare tribunals to adjudicate lawsuits regarding injuries allegedly caused by healthcare providers or healthcare organizations and impose damage caps will be eligible for federal block grants. Each tribunal shall be presided over by a judge who largely hears only healthcare disputes and consequently develops expertise in this area. Nothing in this title shall diminish the right to trial by jury.

In establishing such healthcare tribunals, States shall ensure that

- (a) judges meet all applicable State standards for judges;
- (b) judges agree to preside over such healthcare court voluntarily;
- (c) healthcare courts call independent expert witnesses commissioned by the tribunal. The expense of these witnesses shall be billed equally to the claimant and defendant(s). This provision shall not prevent the parties from calling their own expert witnesses as well;
- (d) an appeals process shall be made available to review decisions by State healthcare courts.

SEC. 102. COMPENSATING PATIENT INJURY.

(a) **UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.**—In any healthcare lawsuit, nothing in this title shall limit a claimant’s recovery of the full amount of the available economic damages. To be eligible for federal block grant incentives under this title, a state must adopt the following regulations:

(b) **FAIR SHARE RULE.**—To be eligible for federal block grant , States must provide that in any healthcare lawsuit, each party shall be liable for that party’s share of any damages only and not for the share of any other person.

(c) **NONECONOMIC DAMAGES.**—For each injury, regardless of the number of parties against whom the action is brought or the number of separate claims or actions, the amount of noneconomic damages is capped at \$250,000. This provision shall be in effect in order for the state to qualify for a federal block grant under this title.

(d) **PUNITIVE DAMAGES.**—In order for a State to be eligible for a block grant under this title, punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a healthcare 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. In any 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. The maximum amount of punitive damages, if awarded, in a healthcare lawsuit may be \$250,000 or as much as two times the amount of economic damages, whichever is greater.

(1) **FACTORS CONSIDERED IN DETERMINING AMOUNT OF PUNITIVE DAMAGES.**—In determining the amount of punitive

damages, if awarded, in a healthcare 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.

Sec. 103. 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 any healthcare lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference 1 of Commissioners on Uniform State Laws.

(b) **APPLICABILITY.**—This section applies only in states seeking eligibility for federal block grants under this title and only to actions which not been first set for trial or retrial before the effective date of this title.

SEC. 104. THERE IS APPROPRIATED TO CARRY OUT THIS TITLE \$12,000,000,000 FOR THE FISCAL YEARS 2011-2019 (or approximately \$1.3 billion per year).

DEFINITIONS.

In this Act:

(1) **CLAIMANT.**—The term “claimant” means any person who brings a health care lawsuit, including 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 asserted or such an action is brought, whether deceased, incompetent, or a minor.

(2) **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 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, 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 non-pecuniary losses of any kind or nature. The term “compensatory damages” includes economic damages and noneconomic damages, as such terms are defined in this Act.

(3) 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.

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

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

(6) HEALTH CARE LIABILITY CLAIM.—The term “health care liability claim” means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) healthcare 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.

(7) **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.

(8) **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.

(9) **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.

(10) **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.

(11) **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 (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.

(12) **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 non-pecuniary losses of any kind or nature.

(13) **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.

(14) **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 healthcare incurred by the plaintiff and the attorneys’ office overhead costs or charges for legal services are

not deductible disbursements or costs for such purpose. (15) 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 Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 104. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit 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. 105. 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. 106. 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 healthcare organizations from liability, loss, or damages than those provided by this title or create a cause of action.

(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 Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 302(a); or

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

SEC. 107. 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 Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

**TITLE III – INCENTIVES FOR THE ESTABLISHMENT OR
IMPROVEMENT OF STATE HIGH-RISK POOLS AND
REINSURANCE PROGRAMS**

SECTION 1. SHORT TITLE; PURPOSE.

(a) Short Title. – This Title may be cited as Incentives for States to Reduce Medical Liability Costs

(b) Purpose. – The purpose of this title is to provide incentives and help defray the start-up costs incurred by states that seek to establish medical courts and impose caps on damages in order to:

(1) to provide federal block grants to states to encourage states to create high risk pools and eliminate barriers to enrollment in existing pools.

(2) the purpose is to assist citizens and legal residents whose medical histories, chronic illnesses, or pre-existing conditions make insurance offered in the marketplace unaffordable or unavailable.

This section imposes no mandates on any state.

SEC. 101. WHAT TYPES OF STATE RISK POOLS QUALIFY?

(1) IN GENERAL.—Not later than January 1, 2012, each State may qualify for a block grant under the following conditions:

(A) STATES NOT OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that is not operating a qualified high risk pool as of the date of the enactment of this Act—

(i) the State may only meet the requirement of paragraph (1) through the operation of a qualified State reinsurance program described in subsection (b); and

(ii) the State’s operation of such a reinsurance program shall be treated, for purposes of section 2745 of the Public Health Service Act, as the operation of a qualified high risk pool described in such section.

(B) STATE OPERATING A QUALIFIED HIGH RISK POOL.—In the case of a State that is operating a current section 2745 qualified high risk pool as of the date of the enactment of this Act—

(i) as of January 1, 2011, such a pool shall not be treated as a qualified high risk pool under section 2745 of the Public Health Service Act unless the pool is a qualifying State high risk pool described in subsection (c)(1); and

(b) QUALIFIED STATE REINSURANCE PROGRAM.—

(1) IN GENERAL.—For purposes of this section, a “qualified State reinsurance program” means a program operated by a State program that provides reinsurance for health insurance coverage offered in the small group market in accordance with the model for such a program established (as of the date of the enactment of this Act).

(2) FORM OF PROGRAM.—A qualified State reinsurance program may provide reinsurance—

(A) on a prospective or retrospective basis; and

(B) on a basis that protects health insurance issuers against the annual aggregate spending of their enrollees as well as purchase protection against individual catastrophic costs.

(3) **SATISFACTION OF HIPAA REQUIREMENT.**— A qualified State reinsurance program shall be deemed, for purposes of section 2745 of the Public Health Service Act, to be a qualified high-risk pool under such section.

(c) **QUALIFYING STATE HIGH RISK POOL.**—

(1) **IN GENERAL.**—A qualifying State high-risk pool described in this subsection means a current section 2745 qualified high risk pool that meets the following requirements:

(A) The pool must provide at least two coverage options, one of which must be a high-deductible health plan coupled with a health savings account.

(B) The pool must be funded with a stable funding source.

(C) The pool must eliminate any waiting lists so that all eligible residents who are seeking coverage through the pool should be allowed to receive coverage through the pool.

(D) The pool must allow for coverage of individuals who, but for the 24-month disability waiting period under section 226(b) of the Social Security Act, would be eligible for Medicare during the period of such waiting period.

(E) The pool must limit the pool premiums to no more than 150 percent of the average premium for applicable standard risk rates in that State.

(2) **VERIFICATION OF CITIZENSHIP OR ALIEN QUALIFICATION.**—

(A) **IN GENERAL.**—Notwithstanding any other provision of law, only citizens and nationals of the United States shall be eligible to participate in a qualifying State high risk pool that receives funds under section 2745 of the Public Health Service Act or this section.

(B) **CONDITION OF PARTICIPATION.**—As a condition of a State receiving such funds, the Secretary shall require the State to certify, to the satisfaction of the Secretary, that such State requires all applicants for coverage in the qualifying State high risk pool to provide satisfactory documentation of citizenship or nationality in a manner consistent with section 1903(x) of the Social Security Act.

(C) **RECORDS.**—The Secretary shall keep sufficient records such that a determination of citizenship or nationality only has to be made once for any individual under this paragraph.

(3) **RELATION TO SECTION 2745.**—As of January 1, 2012, a pool shall not qualify as qualified high-risk pool under section 2745 of the Public Health Service Act unless the pool is a qualifying State high risk pool described in paragraph (1).

(d) **WAIVERS.**—In order to accommodate new and innovative programs, the Secretary may waive such requirements of this section for qualified State

reinsurance programs and for qualifying State high-risk pools as the Secretary deems appropriate.

(e) FUNDING.—In addition to any other amounts appropriated, there is appropriated to carry out section 2745 of the Public Health Service Act (including through a program or pool described in subsection (a)(1), \$15,000,000,000 for the period of fiscal years 2011 through 2019 (or approximately \$1.6 billion per year).

(f) DEFINITIONS.—In this section:

(1) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms in section 2791 of the Public Health Service Act.

(2) CURRENT SECTION 2745 QUALIFIED HIGH RISK POOL.—The term “current section 2745 qualified high risk pool” has the meaning given the term “qualified high risk pool” under section 2745(g) of the Public Health Service Act as in effect as of the date of the enactment of this Act.

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

(4) STANDARD RISK RATE.—The term “standard risk rate” means a rate that—

(A) is determined under the State high-risk pool by considering the premium rates charged by other health insurance issuers offering health insurance coverage to individuals in the insurance market served;

(B) is established using reasonable actuarial techniques; and

(C) reflects anticipated claims experience and expenses for the coverage involved.

(5) STATE.—The term “State” means any of the 50 States or the District of Columbia.

TITLE IV - HELPING INDUSTRIOUS AMERICANS CONTINUE COVERAGE BETWEEN JOBS

(a) Short Title: This Title may be cited as COBRA Subsidy Title

(b) Purpose: The purpose of this title is to provide temporary assistance to working Americans who are involuntarily unemployed and need help paying COBRA premiums. It is estimated that this subsidy could reduce the number of uninsured by as many as 7 million at any one time.

SEC. 101 EXTENSION OF PERIOD FOR INDIVIDUALS TO QUALIFY AS ASSISTANCE ELIGIBLE INDIVIDUALS: Subsection (a)(3)(A) of section 3001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is amended by striking December 31, 2009 and adding June, 30, 2015

SEC. 101 (b) No one who is in the United States unlawfully would be eligible for this assistance. Employers must require proof of legal residence before assisting employees in applying for this COBRA subsidy.

SEC. 102. There is appropriated under this title \$24,000,000,000 per year for each fiscal year 2011 through 2015 to fund the subsidies provided under this title.