CLINICAL INTEGRITY & PATIENT SAFETY

Proposed Addition to S.3829 — Corporate Crimes Against Healthcare Act

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S.3829 targets executives. This amendment targets the mechanism. Together they close the Wrongful Denial Echo Chamber.

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§ 1 PROHIBITION OF PRIOR KNOWLEDGE OMISSION

(a) Continuity of Clinical Baselines.

When a Medicare Advantage organization or ERISA plan has previously approved a specific functional classification, medical baseline, or K-Level for a beneficiary, that classification shall be deemed an Established Medical Fact for a period of not less than 12 months.

(b) Prohibition on Retroactive Denial.

A plan may not subsequently deny coverage for a related service by claiming the beneficiary does not meet the criteria of the Established Medical Fact, unless the plan provides new, objective clinical evidence proving a material regression in the beneficiary's condition.

> *Example: If UHC acknowledges a beneficiary's K3 functional mobility status in March, it may not deny a permanent prosthetic in September by claiming the same mobility threshold is unmet — unless it can produce new clinical evidence of decline.*

VIOLATION: Denial issued against an Established Medical Fact without documented evidence of regression shall be deemed void ab initio and subject to the Buffer Fund penalty under § 3.

§ 2 THE CLINICAL INTEGRITY RULE — The Act 146 Standard

(a) Specialty Matching Requirement.

Any adverse benefit determination based on medical necessity must be reviewed and certified by a physician holding current, valid Board Certification in the same or a directly relevant specialty as the treating physician.

> *A pediatrician may not review an adult bariatric claim. A general practitioner may not review a specialized prosthetic claim. A non-vascular physician may not review a vascular surgical necessity determination.*

(b) Mandatory Data Review.

The reviewing physician must certify, under penalty of perjury, that they have reviewed all objective clinical data submitted — including physical therapy and occupational therapy evaluations, imaging, and standardized assessment scores. Failure to review submitted evidence renders the denial void.

VIOLATION: Denial issued by a physician outside the required specialty, or without certified review of submitted clinical data, shall be void and trigger mandatory board reporting under § 5.

(c) The Record Rule — Mandatory Peer-to-Peer Documentation.

Every peer-to-peer review shall be recorded in full. The reviewing physician shall state their name, license number, and board certification on the record at the outset. The complete recording and transcript shall be furnished to the patient and the treating physician within 5 business days, and shall be admissible in any proceeding under this Amendment — including Denial on Trial review, § 5 board referral, and § 8 prosecution.

An unrecorded or unproduced peer-to-peer review shall create a presumption in favor of the treating physician's determination. The party that controls the record and fails to preserve it shall not benefit from its absence.

> *Only 16% of physicians participating in peer-to-peer reviews report that the health plan's 'peer' often or always has appropriate qualifications (2025 AMA Prior Authorization Physician Survey). The peer-to-peer is where the mismatch reveals itself live — the Record Rule makes it prove itself.*

The recorded peer-to-peer is bodycam footage for medicine. A medical license, like a badge, is authority held in public trust — and when that authority is abused against the people it exists to protect, the recording turns abuse into evidence, and evidence into

removal under § 5.

§ 3 THE PATIENT SAFETY BUFFER FUND

(a) Presumption of Coverage.

Upon submission of a medical necessity override by the treating physician, coverage shall be provisionally granted through the Patient Safety Buffer Fund while the determination is under review. Patients shall not be denied care during the appeals process.

(b) Funding Mechanism.

The Buffer Fund shall be capitalized and sustained by the 500% clawback penalties generated under S.3829 (Corporate Crimes Against Healthcare Act) when IRE overturns are issued. The insurer funds the safety net their denials necessitate.

IF DENIAL IS UPHELD	IF DENIAL IS OVERTURNED
The treating provider shall repay the Buffer Fund in full.	The insurer shall reimburse the Buffer Fund at 300% of the claim rate.

(c) Trust Status.

All Buffer Fund assets shall be held in trust for the benefit of wrongfully denied patients as provided in § 7. The Fund is not general revenue and may not be diverted to any other purpose.

§ 4 THE ADMINISTRATIVE CURE MANDATE

(a) Prohibition on Pretextual Administrative Denials.

A plan may not issue a final denial for administrative reasons without first providing the provider a 48-Hour Cure Period to correct the identified clerical or procedural deficiency.

(b) Misclassification Penalty.

If a plan classifies a denial as administrative to circumvent the Clinical Integrity review process when the submitted record contained sufficient clinical data to warrant medical review, the plan shall be subject to a civil monetary penalty of $10,000 per violation.

This provision closes the loophole by which insurers reject claims on paperwork pretexts to avoid the specialty-matching and data-review requirements of § 2.

§ 5 PHYSICIAN ACCOUNTABILITY — The Malpractice Trigger

(a) Reportable Conduct.

Any physician acting as a medical director or reviewer who issues a denial that is subsequently overturned by an IRE — due to a demonstrable failure to adhere to established clinical standards (including Medicare LCDs and FDA labeling) or failure to review submitted evidence — shall be deemed to have engaged in Unprofessional Conduct.

(b) Mandatory Board Reporting.

The Independent Review Entity shall be statutorily required, upon issuing an overturn under this section, to report the name and license number of the reviewing physician to their respective State Medical Board for investigation into malpractice and negligence.

(c) Pierce the Corporate Veil.

Reviewing physicians shall not be shielded from personal liability for patient harm caused by denials issued in contradiction to established medical consensus, regardless of their employment relationship with the plan.

A prosecutor who hides exculpatory evidence faces disbarment. A corporate reviewer who ignores qualifying clinical data faces nothing — until now.

§ 6 DYNAMIC MULTIPLIER SCALING — Triennial Adjustment

(a) Automatic Review.
The 300% reimbursement multiplier and 500% clawback penalty shall be subject to automatic triennial review by the Department of Recovery. Multipliers shall adjust downward as national wrongful denial rates fall.

(b) Scaling Schedule.

National wrongful denial rate	Multiplier status
Above 20%	300% / 500% multipliers remain in full force
5% – 20%	Multipliers reduce by 50%
Below 5%	Multipliers floor at 100% reimbursement plus flat administrative fines — the fund no longer needs rocket fuel; it needs maintenance

(c) Transparency.
The Department of Recovery shall publish the national wrongful denial rate and all scaling determinations. When the multipliers scale down, it is not a sign of weakness — it is the actuarial signature of a system that no longer needs to punish its way to solvency.

§ 7 THE PATIENT RESTITUTION TRUST — The Path to Justice

Under current law, a patient who wins their appeal receives only the care they were owed from the start. The wrongful denial itself — the delay, the harm, the extraction of months of unpaid advocacy — carries no remedy short of years of litigation. This section creates the remedy.

(a) Trust Establishment and Fiduciary Duty.
The Patient Safety Buffer Fund shall be held and administered as a trust. Patients subjected to wrongful denial are its named beneficiary class. The Department of Recovery shall serve as trustee, bound by the fiduciary duties of loyalty, prudence, and full annual public accounting. Any beneficiary shall have standing to bring an action against the trustee for maladministration.

(b) Automatic Restitution.
Upon an IRE overturn, the affected patient shall receive from the Trust a restitution payment equal to 100% of the claim value, disbursed within 30 days of the overturn. No further action by the patient shall be required: the independent third-party appeal has already served as the adjudication. The overturn is the verdict; the check follows automatically.

(c) Out-of-Pocket Make-Whole.
The Trust shall reimburse documented losses proximately caused by the wrongful denial, including out-of-pocket payments for care, travel, interest and financing costs, and documented credit harm.

(d) Disability, Dismemberment, and Death Benefit.
Where a wrongful denial constitutes a clear and unmistakable error of negligence leading to severe harm — Disability, Dismemberment, or Death — the Trust shall pay a defined benefit of not less than $1,000,000 to the beneficiary or their survivors, per a schedule published by the Department of Recovery.

(e) Appeal Representation.
The Trust shall fund qualified patient advocacy and representation in proceedings under the Denial on Trial framework — court-appointed counsel for healthcare. The patient stands as the accused in a proceeding where the insurer operates as both the judge and the prosecution, and its peer-to-peer review sits as the jury. The Gideon principle applies: no patient shall stand alone in that room — and the offender, not the patient, bears the cost of the defense.

(f) Non-Waiver and Cumulative Remedies.

Acceptance of any Trust benefit shall not waive, release, or offset any civil claim. All Trust payments are cumulative with civil recovery, and no provision of ERISA shall bar or preempt a beneficiary's claims under this section.

(g) Funding — Assessed Against the Offender.
Every payment under this section shall be assessed against the offending insurer as a liability separate from, and in addition to, the § 3(b) reimbursement and the S.3829 clawback penalties. The path to justice is paid for by the party that made it necessary.

§ 8 OBSTRUCTION OF MEDICAL CARE — A Separate Offense

(a) The Offense.
Whoever corruptly influences, obstructs, or impedes a coverage appeal proceeding — or attempts to do so — commits Obstruction of Medical Care. The law already recognizes this logic: obstruction of justice is prosecuted separately from the underlying offense, because corrupting the mechanism designed to deliver accountability is itself a harm to the public. The appeal is the only process the patient has. Corrupting it is a separate harm, and a separate crime.

(b) Enumerated Acts.
Obstruction includes, without limitation: (1) concealment of a reviewing physician's conflict of interest or employment relationship; (2) issuance of denials by algorithmic or automated means without qualified clinical review; (3) Prior Knowledge Omission as defined in § 1; (4) suppression of, or failure to consider, submitted clinical evidence; (5) manipulation of appeal timelines to induce abandonment of care; and (6) failure to record, preserve, or produce a peer-to-peer review as required by § 2(c).

(c) Separate Prosecution.
An offense under this section shall be charged and prosecuted independently of the disposition of the underlying denial. Reversal of the denial shall neither cure nor mitigate the obstruction, just as acquittal on an underlying charge does not cure obstruction of its investigation. The integrity of the proceeding is a protected thing in its own right.

(d) Penalties.
Violations shall be subject to criminal referral to the Department of Justice, civil monetary penalties per count against the plan, and personal exposure for officers and reviewing physicians who direct or knowingly permit the obstructing conduct.

HOW THIS AMENDMENT COMPLETES S.3829

- S.3829 punishes the corporation. This amendment strips the license from the physician who pulled the trigger.
- S.3829 generates penalty revenue. The Buffer Fund deploys it to protect the next patient in line.
- S.3829 collects the penalty. The Restitution Trust delivers justice to the patient who earned it — automatically, without a second war.
- S.3829 calls for investigation. The mandatory board reporting pipeline makes every IRE overturn a self-executing referral.
- S.3829 is the sword. This amendment is the shield. The Buffer Fund is the refuge. The Trust is the restitution. The Department of Recovery is the courthouse.