

103<sup>D</sup> CONGRESS  
2<sup>D</sup> SESSION

# H.R. 3918

To guarantee individuals and families continued choice and control over their doctors, hospitals, and health care services, to secure access to quality health care for all, to ensure that health coverage is portable and renewable, to control medical cost inflation through market incentives and tax reform, to reform medical malpractice litigation, and for other purposes.

---

## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 28, 1994

Mr. SANTORUM (for himself, Mr. ARMEY, and Mr. DUNCAN) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, Education and Labor, the Judiciary, and Rules

---

## A BILL

To guarantee individuals and families continued choice and control over their doctors, hospitals, and health care services, to secure access to quality health care for all, to ensure that health coverage is portable and renewable, to control medical cost inflation through market incentives and tax reform, to reform medical malpractice litigation, 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,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS; DEFINI-**  
2 **TIONS.**

3 (a) SHORT TITLE.—This Act may be cited as the  
4 “Comprehensive Family Health Access and Savings Act”.

5 (b) TABLE OF CONTENTS.—The table of contents for  
6 this Act is as follows:

Sec. 1. Short title; definitions; table of contents.

TITLE I—PORTABLE AND PERMANENT PRIVATE HEALTH  
INSURANCE

Subtitle A—Portability

Sec. 101. Amendments to COBRA.

Sec. 102. Penalty-free withdrawals from qualified retirement plans for COBRA  
coverage.

Subtitle B—Permanence

Sec. 111. General renewability requirements.

Sec. 112. Individual health insurance plans.

Sec. 113. Group health plans.

Sec. 114. Failure of health plans to meet portability and permanence require-  
ments.

TITLE II—EXPANSION OF HEALTH CARE CHOICES

Subtitle A—Employer-Provided Health Insurance

Sec. 201. Tax treatment of employer-provided health insurance.

Subtitle B—Medical Savings Accounts

Sec. 211. Individuals allowed deduction from gross income for cost of cata-  
strophic health insurance plan.

Sec. 212. Medical savings accounts.

TITLE III—EQUAL TAX TREATMENT FOR HEALTH INSURANCE  
OF SELF-EMPLOYED AND UNINSURED

Sec. 301. Equal exclusion from gross income of health insurance coverage costs.

TITLE IV—SMALL BUSINESS HEALTH INSURANCE POOLS

Sec. 401. Prohibition of restrictions on groups purchasing health insurance.

Sec. 402. Prohibition of State benefit mandates for group health plans.

Sec. 403. Prohibition of restrictions on managed care.

TITLE V—ASSISTANCE TO INDIVIDUALS WITH PREEXISTING  
CONDITIONS IN PURCHASING HEALTH INSURANCE

Sec. 501. Preexisting condition insurance pool allotment program.

TITLE VI—ENCOURAGE RESPONSIBLE BEHAVIOR BY THE  
FINANCIALLY CAPABLE

- Sec. 601. One year window to purchase health insurance coverage.
- Sec. 602. Prohibition of restrictions relating to the use of collection procedures.

TITLE VII—ASSISTANCE TO LOW-INCOME WORKERS TO  
PURCHASE HEALTH INSURANCE

- Sec. 701. Refundable catastrophic health insurance plan credit.

TITLE VIII—REWARD PREVENTIVE MEDICINE AND HEALTHY  
LIFESTYLES

- Sec. 801. Reward preventive medicine and healthy lifestyles.

TITLE IX—REFORM MEDICAID AND EXPAND CHOICES UNDER  
MEDICARE

Subtitle A—Medicaid

- Sec. 901. Cap on Federal payments made for medical assistance under the  
medicaid program.
- Sec. 902. Waivers for furnishing medical assistance under the medicaid pro-  
gram.

Subtitle B—Medicare

- Sec. 951. Individual election for type of coverage.
- Sec. 952. Health care coverage under a private health care arrangement.

TITLE X—ENHANCED EFFICIENCY THROUGH PAPERWORK  
REDUCTION

- Sec. 1001. Federal paperwork reduction and efficiency requirements.
- Sec. 1002. State paperwork reduction and efficiency requirements.
- Sec. 1003. Standardized Forms Commission.

TITLE XI—MEANINGFUL MEDICAL LIABILITY REFORM

- Sec. 1101. Applicability and preemption.
- Sec. 1102. Statute of limitations.
- Sec. 1103. Scope of liability.
- Sec. 1104. Discovery; failure to make or cooperate in discovery.
- Sec. 1105. Limitation on noneconomic damages.
- Sec. 1106. Treatment of payments for future economic losses.
- Sec. 1107. Treatment of costs and attorney's fees.
- Sec. 1108. Contribution and indemnification.
- Sec. 1109. Collateral sources.
- Sec. 1110. Damages relating to medical product liability claims.
- Sec. 1111. Class actions.
- Sec. 1112. Definitions.
- Sec. 1113. Severability.
- Sec. 1114. Effective date.

TITLE XII—ANTITRUST REFORMS

- Sec. 1201. Establishment of limited exemption program for health care joint  
ventures.

- Sec. 1202. Issuance of health care certificates of public advantage.  
 Sec. 1203. Interagency Advisory Committee on Competition, Antitrust Policy,  
 and Health Care.  
 Sec. 1204. Definitions.

TITLE XIII—EXPENDITURE TARGETS FOR THE MEDICAID AND  
 MEDICARE PROGRAMS

- Sec. 1301. Determination of expenditures under the medicaid and medicare  
 programs.  
 Sec. 1302. Delay of health insurance benefits due to excess expenditures.

1 (c) DEFINITIONS.—For purposes of this Act:

2 (1) EMPLOYER.—The term “employer” shall  
 3 have the meaning applicable under section 3(5) of  
 4 the Employee Retirement Income Security Act of  
 5 1974.

6 (2) GROUP HEALTH PLAN.—The term “group  
 7 health plan” has the meaning given such term by  
 8 section 5000(b)(1) of the Internal Revenue Code of  
 9 1986, but does not include any type of coverage ex-  
 10 cluded from the definition of a health insurance plan  
 11 under paragraph (2).

12 (3) HEALTH INSURANCE PLAN.—

13 (A) IN GENERAL.—Except as provided in  
 14 subparagraph (B), the term “health insurance  
 15 plan” means any hospital or medical service  
 16 policy or certificate, hospital or medical service  
 17 plan contract, or health maintenance organiza-  
 18 tion group contract offered by an insurer.

19 (B) EXCEPTION.—Such term does not in-  
 20 clude any of the following—

- 1 (i) coverage only for accident, dental,  
2 vision, disability income, or long-term care  
3 insurance, or any combination thereof,  
4 (ii) medicare supplemental health in-  
5 surance,  
6 (iii) coverage issued as a supplement  
7 to liability insurance,  
8 (iv) worker's compensation or similar  
9 insurance, or  
10 (v) automobile medical-payment insur-  
11 ance,  
12 or any combination thereof.

13 (4) HEALTH MAINTENANCE ORGANIZATION.—  
14 The term “health maintenance organization” in-  
15 cludes a health insurance plan that offers to provide  
16 health services on a prepaid, at-risk basis primarily  
17 through a defined set of providers.

18 (5) INSURER.—The term “insurer” means a li-  
19 censed insurance company, a prepaid hospital or  
20 medical service plan, or a health maintenance orga-  
21 nization offering such a plan to an employer, and in-  
22 cludes a similar organization regulated under State  
23 law for solvency.

24 (6) SECRETARY.—The term “Secretary” means  
25 the Secretary of Health and Human Services.

1           (7) STATE.—The term “State” means each of  
2           the several States of the United States, the District  
3           of Columbia, the Commonwealth of Puerto Rico, the  
4           United States Virgin Islands, Guam, American  
5           Samoa, and the Commonwealth of the Northern  
6           Mariana Islands.

7           **TITLE I—PORTABLE AND PER-**  
8           **MANENT PRIVATE HEALTH**  
9           **INSURANCE**

10           **Subtitle A—Portability**

11           **SEC. 101. AMENDMENTS TO COBRA.**

12           (a) LOWER COST COVERAGE OPTIONS.—Subpara-  
13           graph (A) of section 4980B(f)(2) of the Internal Revenue  
14           Code of 1986 (relating to continuation coverage require-  
15           ments of group health plans) is amended to read as  
16           follows:

17                   “(A) TYPE OF BENEFIT COVERAGE.—The  
18                   coverage must consist of coverage which, as of  
19                   the time the coverage is being provided—

20                           “(i) is identical to the coverage pro-  
21                           vided under the plan to similarly situated  
22                           beneficiaries under the plan with respect to  
23                           whom a qualifying event has not occurred,

1           “(ii) is so identical, except such cov-  
2           erage is offered with an annual \$1,000 de-  
3           ductible, and

4           “(iii) is so identical, except such cov-  
5           erage is offered with an annual \$3,000 de-  
6           ductible.

7           If coverage under the plan is modified for any  
8           group of similarly situated beneficiaries, the  
9           coverage shall also be modified in the same  
10          manner for all individuals who are qualified  
11          beneficiaries under the plan pursuant to this  
12          subsection in connection with such group.”

13          (b) TERMINATION OF COBRA COVERAGE AFTER  
14          ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90  
15          DAYS.—Clause (iv) of section 4980B(f)(2)(B) of the In-  
16          ternal Revenue Code of 1986 (relating to period of cov-  
17          erage) is amended—

18                 (1) by striking “or” at the end of subclause (I),

19                 (2) by redesignating subclause (II) as subclause  
20          (III), and

21                 (3) by inserting after subclause (I) the follow-  
22          ing new subclause:

23                         “(II) eligible for such employer-  
24                         based coverage for more than 90 days,  
25                         or”.

1 (c) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to qualifying events occurring after  
3 the date of the enactment of this Act.

4 **SEC. 102. PENALTY-FREE WITHDRAWALS FROM QUALIFIED**  
5 **RETIREMENT PLANS FOR COBRA COVERAGE.**

6 (a) IN GENERAL.—Subparagraph (A) of section  
7 72(t)(2) of the Internal Revenue Code of 1986 (relating  
8 to additional tax not to apply to certain distributions) is  
9 amended—

10 (1) by striking “or” at the end of clauses (iv)  
11 and (v),

12 (2) by striking the period at the end of clause  
13 (vi) and inserting “, or”, and

14 (3) by adding at the end the following new  
15 clause:

16 “(vii) made to an employee who is a  
17 qualified beneficiary during the period of  
18 continuation coverage under section  
19 4980B(f).”

20 (b) EFFECTIVE DATE.—The amendments made by  
21 subsection (a) shall apply to distributions made after the  
22 date of the enactment of this Act.

23 **Subtitle B—Permanence**

24 **SEC. 111. GENERAL RENEWABILITY REQUIREMENTS.**

25 (a) INSURERS.—

1           (1) IN GENERAL.—An insurer may not cancel  
2           an individual health insurance plan or group health  
3           plan or deny renewal of coverage under such a plan  
4           other than—

5                   (A) for nonpayment of premiums,

6                   (B) for fraud or other misrepresentation  
7           by the insured,

8                   (C) for noncompliance with plan provi-  
9           sions, or

10                  (D) because the insurer is ceasing to pro-  
11           vide any health insurance plan in a State, or,  
12           in the case of a health maintenance organiza-  
13           tion, in a geographic area.

14           (2) LIMITATION ON MARKET REENTRY.—If an  
15           insurer terminates the offering of health insurance  
16           plans or group health plans in an area, the insurer  
17           may not offer such a plan in the area until 5 years  
18           after the date of the termination.

19           (b) EMPLOYERS.—An employer may not cancel a  
20           self-insured group health plan or deny renewal of coverage  
21           under such a plan other than—

22                   (1) for nonpayment of premiums,

23                   (2) for fraud or other misrepresentation by the  
24           insured,

25                   (3) for noncompliance with plan provisions, or

1           (4) because the plan is ceasing to provide any  
2 coverage in a geographic area.

3           (c) EFFECTIVE DATE.—The provisions of this section  
4 shall apply to any plan on or after the date of the enact-  
5 ment of this Act.

6 **SEC. 112. INDIVIDUAL HEALTH INSURANCE PLANS.**

7           (a) EXISTING PLANS.—With respect to any individ-  
8 ual health insurance plan in effect on the date of the en-  
9 actment of this Act, the insurer shall offer the insured  
10 the option to purchase a new individual health insurance  
11 described in subsection (b).

12           (b) NEW PLANS.—With respect to any individual  
13 health insurance plan, the effective date of which with re-  
14 spect to the insured occurs after the date of the enactment  
15 of this Act, the insurer may not increase the premium for  
16 such a plan based on the health of the insured.

17 **SEC. 113. GROUP HEALTH PLANS.**

18           (a) EXISTING PLANS.—With respect to any group  
19 health plan (other than a self-insured group health plan)  
20 in effect on the date of the enactment of this Act, the  
21 insurer shall offer—

22               (1) any insured of such plan the option to pur-  
23 chase upon leaving the group a new individual health  
24 insurance plan, the premium of which shall be rated  
25 based on actuarial data, may be based on any pre-

1 existing condition of the insured, and may be in-  
2 creased based on the health of such insured, and

3 (2) the employer or group sponsor of such plan  
4 the option to purchase a new group health plan de-  
5 scribed in subsection (b).

6 (b) NEW PLANS.—With respect to any group health  
7 plan (other than a self-insured group health plan), the ef-  
8 fective date of which with respect to the employer or group  
9 sponsor occurs after the date of the enactment of this Act,  
10 the insurer—

11 (1) may not increase the premium for such a  
12 plan based on the health of the group’s insured, and

13 (2) shall offer any insured of such plan the op-  
14 tion to purchase upon leaving the group a new indi-  
15 vidual health insurance plan, the premium of which  
16 shall be rated based on actuarial data, may not be  
17 based on any preexisting condition of the insured,  
18 and may not be increased based on the health of  
19 such insured.

20 (c) SELF-INSURED GROUP HEALTH PLANS.—With  
21 respect to a self-insured group health plan—

22 (1) in effect on the date of the enactment of  
23 this Act—

1 (A) subsection (a)(1) shall apply through 1  
2 or more insurers contracted with by such plan,  
3 and

4 (B) subsection (a)(2) shall not apply, and  
5 (2) the effective date of which with respect to  
6 the employer or group sponsor occurs after the date  
7 of the enactment of this Act, subsection (b) shall  
8 apply through 1 or more insurers contracted with by  
9 such plan.

10 **SEC. 114. FAILURE OF HEALTH PLANS TO MEET PORT-**  
11 **ABILITY AND PERMANENCE REQUIREMENTS.**

12 (a) DEDUCTION FOR INDIVIDUAL HEALTH INSUR-  
13 ANCE PLANS.—Paragraph (1) of section 213(d) of the In-  
14 ternal Revenue Code of 1986 (defining medical care) is  
15 amended—

16 (1) by striking “or” at the end of subparagraph  
17 (B), and

18 (2) by striking subparagraph (C) and inserting  
19 the following new subparagraphs:

20 “(C) for insurance—

21 “(i) meeting the requirements of sec-  
22 tion 112 of the Comprehensive Family  
23 Health Access and Savings Act, and

24 “(ii) covering medical care referred to  
25 in subparagraphs (A) and (B), or

1           “(D) as premiums under part B of title  
2           XVIII of the Social Security Act, relating to  
3           supplementary medical insurance for the aged.

4           (b) TAX EXCLUSIONS FOR EMPLOYER-PROVIDED  
5 HEALTH INSURANCE.—Section 106 of the Internal Reve-  
6 nue Code of 1986 (relating to contributions by employer  
7 to accident and health plans) is amended by striking “an  
8 accident or health plan” and inserting “an accident or  
9 health plan meeting the requirements of section 113 of  
10 the Comprehensive Family Health Access and Savings  
11 Act”.

12           (c) BUSINESS EXPENSE DEDUCTION FOR HEALTH  
13 INSURANCE.—Section 162 of the Internal Revenue Code  
14 of 1986 (relating to trade or business expenses) is amend-  
15 ed by redesignating subsection (o) as subsection (p) and  
16 by inserting after subsection (n) the following new sub-  
17 section:

18           “(o) GROUP HEALTH PLANS.—The expenses paid or  
19 incurred by an employer for a group health plan shall not  
20 be allowed as a deduction under this section unless such  
21 plan meets the requirements of section 113 of the Com-  
22 prehensive Family Health Access and Savings Act.”

23           (d) PAYROLL TAX EXCLUSION FOR EMPLOYER-PRO-  
24 VIDED HEALTH INSURANCE.—Section 209(a)(2) of the  
25 Social Security Act (42 U.S.C. 409(a)(2)) is amended by

1 inserting “or group health insurance” after “group-term  
2 life insurance”.

3 (e) EFFECTIVE DATE.—The amendments made by  
4 this section shall take effect on the date of the enactment  
5 of this Act.

6 **TITLE II—EXPANSION OF**  
7 **HEALTH CARE CHOICES**  
8 **Subtitle A—Employer-Provided**  
9 **Health Insurance**

10 **SEC. 201. TAX TREATMENT OF EMPLOYER-PROVIDED**  
11 **HEALTH INSURANCE.**

12 (a) TAX EXCLUSIONS FOR EMPLOYER-PROVIDED  
13 HEALTH INSURANCE.—Section 106 of the Internal Reve-  
14 nue Code of 1986 (relating to contributions by employer  
15 to accident and health plans), as amended by section  
16 115(b), is amended by striking “an accident or health plan  
17 meeting the requirements of section 113 of the Com-  
18 prehensive Family Health Access and Savings Act” and  
19 inserting “a qualified health insurance package (as de-  
20 fined in section 162(o)(2)), which meets the requirements  
21 of section 113 of the Comprehensive Family Health Access  
22 and Savings Act, to the extent the employer contribution  
23 does not exceed the actual cost of such coverage”.

24 (b) BUSINESS EXPENSE DEDUCTION FOR HEALTH  
25 INSURANCE.—Subsection (o) of section 162 of the Inter-

1 nal Revenue Code of 1986 (relating to trade or business  
2 expenses), as added by section 115(c), is amended to read  
3 as follows:

4 “(o) GROUP HEALTH PLANS.—

5 “(1) IN GENERAL.—The expenses paid or in-  
6 curred by an employer for a group health plan shall  
7 not be allowed as a deduction under this section un-  
8 less—

9 “(A) such plan meets the requirements of  
10 section 113 of the Comprehensive Family  
11 Health Access and Savings Act,

12 “(B) such plan is offered through a quali-  
13 fied health insurance package, and

14 “(C) such employer’s contribution per em-  
15 ployee—

16 “(i) for coverage described in subpara-  
17 graph (B) or (C) of paragraph (2) is not  
18 less than such contribution for coverage  
19 described in paragraph (2)(A) (determined  
20 either on an average cost or actual cost  
21 basis as elected by the employer), and

22 “(ii) for coverage described in para-  
23 graph (2)(C) does not exceed such con-  
24 tribution for coverage described in sub-

1 paragraph (A) or (B) of paragraph (2),  
2 whichever is higher (as so determined).

3 “(2) QUALIFIED HEALTH INSURANCE PACK-  
4 AGE.—For purposes of paragraph (1), the term  
5 ‘qualified health insurance package’ means an an-  
6 nual option provided to each employee of the em-  
7 ployer during a 2-month election period to select 1  
8 of the following health insurance coverages for the  
9 following calendar year:

10 “(A) The health insurance coverage pro-  
11 vided by the employer on the date of the enact-  
12 ment of the Comprehensive Family Health Ac-  
13 cess and Savings Act.

14 “(B) Coverage in a health maintenance or-  
15 ganization, managed care arrangement, or pre-  
16 ferred provider organization.

17 “(C) Medical savings account under section  
18 220.”

19 (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply with respect to any taxable year  
21 beginning after the date of the enactment of this Act.

1           **Subtitle B—Medical Savings**  
2                           **Accounts**

3   **SEC. 211. INDIVIDUALS ALLOWED DEDUCTION FROM**  
4                           **GROSS INCOME FOR COST OF CATASTROPHIC**  
5                           **HEALTH INSURANCE PLAN.**

6           (a) IN GENERAL.—Subsection (a) of section 62 of the  
7 Internal Revenue Code of 1986 (defining adjusted gross  
8 income) is amended—

9                   (1) by striking the flush sentence immediately  
10 following paragraph (14), and

11                   (2) by inserting after paragraph (15) the fol-  
12 lowing:

13                   “(16) MEDICAL EXPENSES ATTRIBUTABLE TO  
14 CATASTROPHIC HEALTH INSURANCE PLAN COV-  
15 ERAGE.—

16                   “(A) IN GENERAL.—The deduction allowed  
17 by section 213 to the extent attributable to cov-  
18 erage under a catastrophic health insurance  
19 plan (as defined in section 220(c)(2)).

20                   “(B) EXCEPTION.—Subparagraph (A)  
21 shall not apply to coverage of an individual who  
22 has coverage described in section 220(c)(1)(B).

23 Nothing in this section shall permit the same item to be  
24 deducted more than once.”

1 (b) COORDINATION WITH DEDUCTION FOR OTHER  
2 MEDICAL EXPENSES.—Subsection (a) of section 213 of  
3 the Internal Revenue Code of 1986 (relating to medical,  
4 dental, etc., expenses) is amended to read as follows:

5 “(a) ALLOWANCE OF DEDUCTION.—There shall be  
6 allowed as a deduction the expenses paid during the tax-  
7 able year, not compensated by insurance or otherwise, for  
8 medical care of the taxpayer, his spouse, or a dependent  
9 (as defined in section 152) in an amount equal to the sum  
10 of—

11 “(1) the portion of such expenses attributable  
12 to coverage under a catastrophic health insurance  
13 plan (as defined in section 220(c)(2)), and

14 “(2) the excess of such expenses (other than ex-  
15 penses described in paragraph (1)) over 7.5 percent  
16 of the adjusted gross income of the taxpayer.”

17 (c) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to taxable years beginning after  
19 the date of the enactment of this Act.

20 **SEC. 212. MEDICAL SAVINGS ACCOUNTS.**

21 (a) IN GENERAL.—Part VII of subchapter B of chap-  
22 ter 1 of the Internal Revenue Code of 1986 (relating to  
23 additional itemized deductions for individuals) is amended  
24 by redesignating section 220 as section 221 and by insert-  
25 ing after section 219 the following new section:

1 **“SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

2 “(a) DEDUCTION ALLOWED.—In the case of an eligi-  
3 ble individual, there shall be allowed as a deduction the  
4 amounts paid in cash during the taxable year by or on  
5 behalf of such individual to a medical savings account for  
6 the benefit of such individual and (if any) such individual’s  
7 spouse and dependents if such spouse and dependents are  
8 eligible individuals.

9 “(b) LIMITATIONS.—

10 “(1) ONLY 1 ACCOUNT PER FAMILY.—Except as  
11 provided in regulations prescribed by this Secretary,  
12 no deduction shall be allowed under subsection (a)  
13 for amounts paid to any medical savings account for  
14 the benefit of an individual, such individual’s spouse,  
15 or any dependent of such individual or spouse if  
16 such individual, spouse, or dependent is a beneficiary  
17 of any other medical savings account.

18 “(2) DOLLAR LIMITATION.—The amount allow-  
19 able as a deduction under subsection (a) for the tax-  
20 able year shall not exceed \$3,000, or such higher  
21 amounts as may be specified in subparagraph  
22 (c)(2)(C).

23 “(c) DEFINITIONS.—For purposes of this section:

24 “(1) ELIGIBLE INDIVIDUAL.—

25 “(A) IN GENERAL.—The term ‘eligible in-  
26 dividual’ means any individual who is covered

1 under a catastrophic health insurance plan  
2 throughout the calendar year in which or with  
3 which the taxable year ends.

4 “(B) LIMITATIONS.—Such term does not  
5 include an individual who is 65 years of age or  
6 older, unless the individual is covered under a  
7 catastrophic health insurance plan that is a pri-  
8 mary plan (within the meaning of section  
9 1862(b)(2)(A) of the Social Security Act).

10 “(2) CATASTROPHIC HEALTH INSURANCE  
11 PLAN.—

12 “(A) IN GENERAL.—The term ‘cata-  
13 strophic health insurance plan’ means a health  
14 plan covering specified expenses incurred by an  
15 individual for medical care (as defined in sub-  
16 paragraph (B)) for such individual and the  
17 spouse and dependents (as defined in section  
18 152) of such individual only to the extent such  
19 expenses covered by the plan for any calendar  
20 year exceed \$3,000 or such higher amounts as  
21 may be specified by the plan.

22 “(B) MEDICAL CARE.—The term ‘medical  
23 care’ means—

24 “(i) medical care as defined in section  
25 213(d) (without regard to non-emergency

1 transportation under paragraph (1)(B) and  
2 amounts described in paragraph (2)), and

3 “(ii) services and care not less than  
4 such services and care identified (but not  
5 in the manner prescribed) in paragraphs  
6 (1), (2), (3), (4)(A), (4)(B), (5), (17), and  
7 (21) of section 1905(a).

8 “(C) COST-OF-LIVING ADJUSTMENT.—In  
9 the case of any calendar year after 1995, the  
10 dollar amount in subparagraph (A) and para-  
11 graph (b)(2) shall be increased by an amount  
12 equal to—

13 “(i) such dollar amount, multiplied by

14 “(ii) the cost-of-living adjustment de-  
15 termined under section 1(f)(3) for such  
16 calendar year.

17 If any increase under the preceding sentence is  
18 not a multiple of \$50, such increase shall be  
19 rounded to the nearest multiple of \$50.

20 “(d) MEDICAL SAVINGS ACCOUNT.—For purposes of  
21 this section:

22 “(1) MEDICAL SAVINGS ACCOUNT DEFINED.—

23 “(A) IN GENERAL.—The term ‘medical  
24 savings account’ means a trust created or orga-  
25 nized in the United States exclusively for the

1 purpose of paying the medical expenses of the  
2 beneficiaries of such trust, but only if the writ-  
3 ten governing instrument creating the trust  
4 meets the following requirements:

5 “(i) Except in the case of a rollover  
6 contribution described in subsection (e)(5),  
7 no contribution will be accepted unless it is  
8 in cash, and contributions will not be ac-  
9 cepted in excess of the amount allowed as  
10 a deduction under this section for the tax-  
11 able year.

12 “(ii) The trustee is a bank (as defined  
13 in section 408(n)) or another person who  
14 demonstrates to the satisfaction of the Sec-  
15 retary that the manner in which such per-  
16 son will administer the trust will be con-  
17 sistent with the requirements of this  
18 section.

19 “(iii) No part of the trust assets will  
20 be invested in life insurance contracts.

21 “(iv) The assets of the trust will not  
22 be commingled with other property except  
23 in a common trust fund or common invest-  
24 ment fund.

1           “(v) The interest of an individual in  
2           the balance in his account is nonforfeit-  
3           able.

4           “(vi) Under regulations prescribed by  
5           the Secretary, rules similar to the rules of  
6           section 401(a)(9) shall apply to the dis-  
7           tribution of the entire interest of bene-  
8           ficiaries of such trust.

9           “(B) TREATMENT OF COMPARABLE AC-  
10          COUNTS HELD BY INSURANCE COMPANIES.—  
11          For purposes of this section, an account held by  
12          an insurance company in the United States  
13          shall be treated as a medical savings account  
14          (and such company shall be treated as a bank)  
15          if—

16               “(i) such account is part of a health  
17               insurance plan that includes a catastrophic  
18               health insurance plan (as defined in sub-  
19               section (c)(2)),

20               “(ii) such account is exclusively for  
21               the purpose of paying the medical expenses  
22               of the beneficiaries of such account who  
23               are covered under such catastrophic health  
24               insurance plan, and

1           “(iii) the written instrument govern-  
2           ing the account meets the requirements of  
3           clauses (i), (v), and (vi) of subparagraph  
4           (A).

5           “(2) MEDICAL EXPENSES.—

6           “(A) IN GENERAL.—The term ‘medical ex-  
7           penses’ means, with respect to an individual,  
8           amounts paid or incurred by such individual for  
9           medical care for such individual, the spouse of  
10          such individual, and any dependent (as defined  
11          in section 152) of such individual, but only to  
12          the extent such amounts—

13               “(i) are not compensated for by insur-  
14               ance or otherwise, and

15               “(ii) are counted towards a deductible  
16               under the terms of such individual’s cata-  
17               strophic health insurance plan.

18           “(B) HEALTH PLAN COVERAGE MAY NOT  
19           BE PURCHASED FROM ACCOUNT.—Such term  
20           shall not include any amount paid for coverage  
21           under a health plan.

22           “(3) TIME WHEN CONTRIBUTIONS DEEMED  
23           MADE.—A contribution shall be deemed to be made  
24           on the last day of the preceding taxable year if the  
25           contribution is made on account of such taxable year

1 and is made not later than the time prescribed by  
2 law for filing the return for such taxable year (not  
3 including extensions thereof).

4 “(e) TAX TREATMENT OF DISTRIBUTIONS.—

5 “(1) IN GENERAL.—Except as provided in para-  
6 graphs (2), (3), and (5), any amount paid or distrib-  
7 uted out of a medical savings account shall be in-  
8 cluded in the gross income of the individual for  
9 whose benefit such account was established.

10 “(2) EXCEPTION FOR MEDICAL AND LONG  
11 TERM CARE EXPENSES.—

12 “(A) IN GENERAL.—Paragraph (1) shall  
13 not apply if such amount paid or distributed is  
14 used exclusively to pay—

15 “(i) the medical expenses of such indi-  
16 vidual, or

17 “(ii) except as provided in subpara-  
18 graph (B), the expenses for long term care  
19 services of the type identified in section  
20 1931(e)(3) of the Social Security Act for  
21 the individual.

22 “(B) NONQUALIFIED PAYMENTS OR DIS-  
23 TRIBUTIONS FOR LONG TERM EXPENSES.—

24 Paragraph (1) shall apply to any portion of a  
25 payment or distribution for expenses for long

1 term care services equal to the amount by  
2 which, after such payment or distribution—

3 “(i) the amount of the deductible  
4 under the catastrophic health insurance  
5 plan covering the individual, exceeds

6 “(ii) the aggregate balance of all med-  
7 ical savings accounts established for the  
8 benefit of the individual.

9 For purposes of this paragraph, any payment or dis-  
10 tribution for medical expenses shall be considered to  
11 have been made before any other payment or dis-  
12 tribution.

13 “(3) EXCESS CONTRIBUTIONS RETURNED BE-  
14 FORE DUE DATE OF RETURN.—Paragraph (1) shall  
15 not apply to the distribution of any contribution paid  
16 during a taxable year to a medical savings account  
17 to the extent that such contribution exceeds the  
18 amount allowable as a deduction under subsection  
19 (a) if—

20 “(A) such distribution is received by the  
21 individual on or before the last day prescribed  
22 by law (including extensions of time) for filing  
23 such individual’s return for such taxable year,  
24 and

1           “(B) such distribution is accompanied by  
2           the amount of net income attributable to such  
3           excess contribution.

4           Any net income described in subparagraph (B) shall  
5           be included in the gross income of the individual for  
6           the taxable year in which it is received.

7           “(4) PENALTY FOR DISTRIBUTIONS NOT USED  
8           FOR MEDICAL EXPENSES WHICH LEAVE AN AMOUNT  
9           LESS THAN THE CATASTROPHIC DEDUCTIBLE IN  
10          THE ACCOUNT.—

11           “(A) IN GENERAL.—The tax imposed by  
12           this chapter for any taxable year in which there  
13           is a payment or distribution from a medical  
14           savings account which is includible in gross in-  
15           come under paragraph (1) shall be increased by  
16           10 percent with respect to the penalty portion  
17           of such payment or distribution.

18           “(B) PENALTY PORTION.—For purposes of  
19           subparagraph (A), the penalty portion of any  
20           payment or distribution is equal to the amount  
21           by which, after such payment or distribution—

22           “(i) the amount of the deductible  
23           under the catastrophic health insurance  
24           plan covering the individual, exceeds

1                   “(ii) the aggregate balance of all med-  
2                   ical savings accounts established for the  
3                   benefit of the individual.

4                   For purposes of this paragraph, any payment or dis-  
5                   tribution for medical expenses shall be considered to  
6                   have been made before any other payment or dis-  
7                   tribution.

8                   “(5) ROLLOVERS.—Paragraph (1) shall not  
9                   apply to any amount paid or distributed out of a  
10                  medical savings account to the individual for whose  
11                  benefit the account is maintained if the entire  
12                  amount received (including money and any other  
13                  property) is paid into another medical savings ac-  
14                  count for the benefit of such individual not later  
15                  than the 60th day after the day on which he received  
16                  the payment or distribution.

17                  “(f) TAX TREATMENT OF ACCOUNTS.—

18                  “(1) EXEMPTION FROM TAX.—Any medical sav-  
19                  ings account is exempt from taxation under this sub-  
20                  title unless such account has ceased to be a medical  
21                  savings account by reason of paragraph (2) or (3).  
22                  Notwithstanding the preceding sentence, any such  
23                  account shall be subject to the taxes imposed by sec-  
24                  tion 511 (relating to imposition of tax on unrelated  
25                  business income of charitable, etc. organizations).

1           “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-  
2           GAGES IN PROHIBITED TRANSACTION.—

3           “(A) IN GENERAL.—If, during any taxable  
4           year of the individual for whose benefit the  
5           medical savings account was established, such  
6           individual engages in any transaction prohibited  
7           by section 4975 with respect to the account, the  
8           account ceases to be a medical savings account  
9           as of the first day of that taxable year.

10          “(B) ACCOUNT TREATED AS DISTRIBUTING  
11          ALL ITS ASSETS.—In any case in which any ac-  
12          count ceases to be a medical savings account by  
13          reason of subparagraph (A) on the first day of  
14          any taxable year, paragraph (1) of subsection  
15          (e) shall be applied as if there were a distribu-  
16          tion on such first day in an amount equal to  
17          the fair market value (on such first day) of all  
18          assets in the account (on such first day) and no  
19          portion of such distribution were used to pay  
20          medical expenses.

21          “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-  
22          ITY.—If, during any taxable year, the individual for  
23          whose benefit a medical savings account was estab-  
24          lished uses the account or any portion thereof as se-  
25          curity for a loan, the portion so used is treated as

1 distributed to that individual and not used to pay  
2 medical expenses.

3 “(g) CUSTODIAL ACCOUNTS.—For purposes of this  
4 section, a custodial account shall be treated as a trust if—

5 “(1) the assets of such account are held by a  
6 bank (as defined in section 408(n)) or another per-  
7 son who demonstrates to the satisfaction of the Sec-  
8 retary that the manner in which he will administer  
9 the account will be consistent with the requirements  
10 of this section, and

11 “(2) the custodial account would, except for the  
12 fact that it is not a trust, constitute a medical sav-  
13 ings account described in subsection (d).

14 For purposes of this title, in the case of a custodial ac-  
15 count treated as a trust by reason of the preceding sen-  
16 tence, the custodian of such account shall be treated as  
17 the trustee thereof.

18 “(h) REPORTS.—The trustee of a medical savings ac-  
19 count shall make such reports regarding such account to  
20 the Secretary and to the individual for whose benefit the  
21 account is maintained with respect to contributions, dis-  
22 tributions, and such other matters as the Secretary may  
23 require under regulations. The reports required by this  
24 subsection shall be filed at such time and in such manner

1 and furnished to such individuals at such time and in such  
2 manner as may be required by those regulations.”

3 (b) DEDUCTION ALLOWED WHETHER OR NOT INDI-  
4 VIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a)  
5 of section 62 of the Internal Revenue Code of 1986 (defin-  
6 ing adjusted gross income), as amended by section 211,  
7 is amended by inserting after paragraph (16) the following  
8 new paragraph:

9 “(17) MEDICAL SAVINGS ACCOUNTS.—The de-  
10 duction allowed by section 220.”

11 (c) DISTRIBUTIONS FROM MEDICAL SAVINGS AC-  
12 COUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUC-  
13 TION.—Section 213 of the Internal Revenue Code of 1986  
14 (relating to medical, dental, etc., expenses) is amended by  
15 adding at the end the following new subsection:

16 “(g) COORDINATION WITH MEDICAL SAVINGS AC-  
17 COUNTS.—The amount otherwise taken into account  
18 under subsection (a) as expenses paid for medical care  
19 shall be reduced by the amount (if any) of the distribu-  
20 tions from any medical savings account of the taxpayer  
21 during the taxable year which is not includible in gross  
22 income by reason of being used for medical care.”

23 (d) EXCLUSION OF EMPLOYER CONTRIBUTIONS TO  
24 MEDICAL SAVINGS ACCOUNTS FROM EMPLOYMENT  
25 TAXES.—

1 (1) SOCIAL SECURITY TAXES.—

2 (A) Subsection (a) of section 3121 of the  
3 Internal Revenue Code of 1986 (defining  
4 wages) is amended by striking “or” at the end  
5 of paragraph (20), by striking the period at the  
6 end of paragraph (21) and inserting “; or”, and  
7 by inserting after paragraph (21) the following  
8 new paragraph:

9 “(22) remuneration paid to or on behalf of an  
10 employee if (and to the extent that) at the time of  
11 payment of such remuneration it is reasonable to be-  
12 lieve that a corresponding deduction is allowable  
13 under section 220.”

14 (B) Subsection (a) of section 209 of the  
15 Social Security Act is amended by striking “or”  
16 at the end of paragraph (17), by striking the  
17 period at the end of paragraph (18) and insert-  
18 ing “; or”, and by inserting after paragraph  
19 (18) the following new paragraph:

20 “(19) remuneration paid to or on behalf of an  
21 employee if (and to the extent that) at the time of  
22 payment of such remuneration it is reasonable to be-  
23 lieve that a corresponding deduction is allowable  
24 under section 220 of the Internal Revenue Code of  
25 1986.”

1           (2) RAILROAD RETIREMENT TAX.—Subsection  
2           (e) of section 3231 of such Code (defining com-  
3           pensation) is amended by adding at the end the fol-  
4           lowing new paragraph:

5           “(10) EMPLOYER CONTRIBUTIONS TO MEDICAL  
6           SAVINGS ACCOUNTS.—The term ‘compensation’ shall  
7           not include any payment made to or on behalf of an  
8           employee if (and to the extent that) at the time of  
9           payment of such remuneration it is reasonable to be-  
10          lieve that a corresponding deduction is allowable  
11          under section 220.”

12          (3) UNEMPLOYMENT TAX.—Subsection (b) of  
13          section 3306 of such Code (defining wages) is  
14          amended by striking “or” at the end of paragraph  
15          (15), by striking the period at the end of paragraph  
16          (16) and inserting “; or”, and by inserting after  
17          paragraph (16) the following new paragraph:

18          “(17) remuneration paid to or on behalf of an  
19          employee if (and to the extent that) at the time of  
20          payment of such remuneration it is reasonable to be-  
21          lieve that a corresponding deduction is allowable  
22          under section 220.”

23          (4) WITHHOLDING TAX.—Subsection (a) of sec-  
24          tion 3401 of such Code (defining wages) is amended  
25          by striking “or” at the end of paragraph (19), by

1 striking the period at the end of paragraph (20) and  
2 inserting “; or”, and by inserting after paragraph  
3 (20) the following new paragraph:

4 “(21) remuneration paid to or on behalf of an  
5 employee if (and to the extent that) at the time of  
6 payment of such remuneration it is reasonable to be-  
7 lieve that a corresponding deduction is allowable  
8 under section 220.”

9 (e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973  
10 of the Internal Revenue Code of 1986 (relating to tax on  
11 excess contributions to individual retirement accounts, cer-  
12 tain section 403(b) contracts, and certain individual re-  
13 tirement annuities) is amended—

14 (1) by inserting “**MEDICAL SAVINGS AC-**  
15 **COUNTS,**” after “**ACCOUNTS,**” in the heading of  
16 such section,

17 (2) by redesignating paragraph (2) of sub-  
18 section (a) as paragraph (3) and by inserting after  
19 paragraph (1) the following:

20 “(2) a medical savings account (within the  
21 meaning of section 220(d)),”,

22 (3) by striking “or” at the end of paragraph  
23 (1) of subsection (a), and

24 (4) by adding at the end the following new sub-  
25 section:

1       “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS  
2 ACCOUNTS.—For purposes of this section, in the case of  
3 a medical savings account (within the meaning of section  
4 220(d)), the term ‘excess contributions’ means the amount  
5 by which the amount contributed for the taxable year to  
6 the account exceeds the amount excludable from gross in-  
7 come under section 220 for such taxable year. For pur-  
8 poses of this subsection, any contribution which is distrib-  
9 uted out of the medical savings account in a distribution  
10 to which section 220(e)(3) applies shall be treated as an  
11 amount not contributed.”

12       (f) TAX ON PROHIBITED TRANSACTIONS.—Section  
13 4975 of the Internal Revenue Code of 1986 (relating to  
14 prohibited transactions) is amended—

15             (1) by adding at the end of subsection (c) the  
16 following new paragraph:

17             “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-  
18 COUNTS.—An individual for whose benefit a medical  
19 savings account (within the meaning of section  
20 220(d)) is established shall be exempt from the tax  
21 imposed by this section with respect to any trans-  
22 action concerning such account (which would other-  
23 wise be taxable under this section) if, with respect  
24 to such transaction, the account ceases to be a medi-

1 cal savings account by reason of the application of  
2 section 220(f)(2)(A) to such account.”, and

3 (2) by inserting “or a medical savings account  
4 described in section 220(d)” in subsection (e)(1)  
5 after “described in section 408(a)”.

6 (g) FAILURE TO PROVIDE REPORTS ON MEDICAL  
7 SAVINGS ACCOUNTS.—Section 6693 of the Internal Reve-  
8 nue Code of 1986 (relating to failure to provide reports  
9 on individual retirement account or annuities) is amend-  
10 ed—

11 (1) by inserting “**OR ON MEDICAL SAVINGS**  
12 **ACCOUNTS**” after “**ANNUITIES**” in the heading of  
13 such section, and

14 (2) by adding at the end of subsection (a) the  
15 following: “The person required by section 220(h) to  
16 file a report regarding a medical savings account at  
17 the time and in the manner required by such section  
18 shall pay a penalty of \$50 for each failure unless it  
19 is shown that such failure is due to reasonable  
20 cause.”

21 (h) CLERICAL AMENDMENTS.—

22 (1) The table of sections for part VII of sub-  
23 chapter B of chapter 1 of the Internal Revenue Code  
24 of 1986 is amended by striking the last item and in-  
25 serting the following:

“Sec. 220. Medical savings accounts.

“Sec. 221. Cross reference.”

1           (2) The table of sections for chapter 43 of such  
2 Code is amended by striking the item relating to sec-  
3 tion 4973 and inserting the following:

“Sec. 4973. Tax on excess contributions to individual retirement  
accounts, medical savings accounts, certain 403(b)  
contracts, and certain individual retirement annu-  
ities.”

4           (3) The table of sections for subchapter B of  
5 chapter 68 of such Code is amended by inserting “or  
6 on medical savings accounts” after “annuities” in  
7 the item relating to section 6693.

8           (i) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to taxable years beginning after  
10 the date of the enactment of this Act.

11 **TITLE III—EQUAL TAX TREAT-**  
12 **MENT FOR HEALTH INSUR-**  
13 **ANCE OF SELF-EMPLOYED**  
14 **AND UNINSURED.**

15 **SEC. 301. EQUAL EXCLUSION FROM GROSS INCOME OF**  
16 **HEALTH INSURANCE COVERAGE COSTS.**

17           (a) IN GENERAL.—Part III of subchapter B of chap-  
18 ter 1 of the Internal Revenue Code of 1986 (relating to  
19 items specifically excluded from gross income) is amended  
20 by inserting after section 106 the following new section:

1 **“SEC. 106A. CERTAIN HEALTH INSURANCE COVERAGE**  
2 **COSTS.**

3 “(a) IN GENERAL.—Gross income does not include  
4 the applicable percentage of so much of—

5 “(1) the amounts paid by the taxpayer for cov-  
6 erage under a health insurance plan (as defined in  
7 section 1(3) of the Comprehensive Family Health  
8 Access and Savings Act), plus

9 “(2) the contributions made by such taxpayer  
10 to a medical savings account under section 220,  
11 during the taxable year as do not exceed the national per  
12 employee average of employer-provided contributions ex-  
13 cluded under section 106 for the preceding taxable year.

14 “(b) EXCLUSION NOT ALLOWED TO INDIVIDUALS  
15 ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

16 “(1) IN GENERAL.—Subsection (a) shall not  
17 apply to any individual—

18 “(A) who is eligible to participate in any  
19 subsidized health plan maintained by an em-  
20 ployer of such individual or the spouse of such  
21 individual, or

22 “(B) who is (or whose spouse is) a member  
23 of a subsidized class of employees of an em-  
24 ployer.

25 “(2) SUBSIDIZED CLASS.—For purposes of  
26 paragraph (1), an individual is a member of a sub-

1       sidized class of employees of an employer if, at any  
2       time during the 3 calendar years ending with or  
3       within the taxable year, any member of such class  
4       was eligible to participate in any subsidized health  
5       plan maintained by such employer.

6           “(3) SPECIAL RULES.—

7           “(A) CONTROLLED GROUPS.—All persons  
8       treated as a single employer under subsection  
9       (a) or (b) of section 52 or subsection (m) or (o)  
10      of section 414 shall be treated as a single em-  
11      ployer for purposes of paragraph (2).

12          “(B) CLASSES.—Classes of employees shall  
13      be determined under regulations prescribed by  
14      the Secretary based on such factors as the Sec-  
15      retary determines appropriate to carry out the  
16      purposes of this subsection.

17          “(c) APPLICABLE PERCENTAGE.—

18          “(1) IN GENERAL.—For purposes of subsection  
19      (a), the term ‘applicable percentage’ means—

20           “(A) 33 percent for any taxable year be-  
21      ginning in 1996 or, if later, the alternate year,

22           “(B) 46 percent for any taxable year be-  
23      ginning in 1997 or, if later, the alternate year,

24           “(C) 60 percent for any taxable year be-  
25      ginning in 1998 or, if later, the alternate year,

1           “(D) 73 percent for any taxable year be-  
2           ginning in 1999 or, if later, the alternate year,

3           “(E) 86 percent for any taxable year be-  
4           ginning in 2000 or, if later, the alternate year,  
5           and

6           “(F) 100 percent for taxable years begin-  
7           ning with 2001 or, if later, the alternate year.

8           “(2) ALTERNATE YEAR.—For purposes of para-  
9           graph (1), the term ‘alternate year’ means any tax-  
10          able year other than the taxable year described the  
11          applicable subparagraph of paragraph (1) as deter-  
12          mined under section 1302 of the Comprehensive  
13          Family Health Access and Savings Act.

14          “(d) COORDINATION WITH DEDUCTIONS.—No  
15          amount excluded from the gross income of the taxpayer  
16          for any taxable year under this section shall be taken into  
17          account for purposes of determining the allowable deduc-  
18          tion for such year under sections 162(l), 213, and 220.

19          “(e) COORDINATION WITH HEALTH CARE EXPENSES  
20          CREDIT.—The amount otherwise taken into account  
21          under subsection (a) as expenses paid for medical care  
22          shall be reduced by the amount (if any) of the amount  
23          taken into account under section 34A for the taxable  
24          year.”

1 (b) EXCLUSION OF CERTAIN HEALTH INSURANCE  
2 COVERAGE COSTS FROM EMPLOYMENT TAXES.—

3 (1) SOCIAL SECURITY TAXES.—

4 (A) Subsection (a) of section 3121 of the  
5 Internal Revenue Code of 1986 (defining  
6 wages), as amended by section 212(d), is  
7 amended by striking “or” at the end of para-  
8 graph (21), by striking the period at the end of  
9 paragraph (22) and inserting “; or”, and by in-  
10 sserting after paragraph (22) the following new  
11 paragraph:

12 “(23) remuneration paid to or on behalf of an  
13 employee if (and to the extent that) at the time of  
14 payment of such remuneration it is reasonable to be-  
15 lieve that a corresponding exclusion is allowable  
16 under section 106A.”

17 (B) Subsection (a) of section 209 of the  
18 Social Security Act, as amended by section  
19 212(d), is amended by striking “or” at the end  
20 of paragraph (18), by striking the period at the  
21 end of paragraph (19) and inserting “; or”, and  
22 by inserting after paragraph (19) the following  
23 new paragraph:

24 “(20) remuneration paid to or on behalf of an  
25 employee if (and to the extent that) at the time of

1 payment of such remuneration it is reasonable to be-  
2 lieve that a corresponding exclusion is allowable  
3 under section 106A of the Internal Revenue Code of  
4 1986.”

5 (2) RAILROAD RETIREMENT TAX.—Subsection  
6 (e) of section 3231 of such Code (defining com-  
7 pensation), as amended by section 212(d), is amend-  
8 ed by adding at the end the following new para-  
9 graph:

10 “(11) EMPLOYER CONTRIBUTIONS TO MEDICAL  
11 SAVINGS ACCOUNTS.—The term ‘compensation’ shall  
12 not include any payment made to or on behalf of an  
13 employee if (and to the extent that) at the time of  
14 payment of such remuneration it is reasonable to be-  
15 lieve that a corresponding exclusion is allowable  
16 under section 106A.”

17 (3) UNEMPLOYMENT TAX.—Subsection (b) of  
18 section 3306 of such Code (defining wages), as  
19 amended by section 212(d), is amended by striking  
20 “or” at the end of paragraph (16), by striking the  
21 period at the end of paragraph (17) and inserting “;  
22 or”, and by inserting after paragraph (17) the fol-  
23 lowing new paragraph:

24 “(18) remuneration paid to or on behalf of an  
25 employee if (and to the extent that) at the time of

1 payment of such remuneration it is reasonable to be-  
2 lieve that a corresponding exclusion is allowable  
3 under section 106A.”

4 (4) WITHHOLDING TAX.—Subsection (a) of sec-  
5 tion 3401 of such Code (defining wages), as amend-  
6 ed by section 212(d), is amended by striking “or” at  
7 the end of paragraph (20), by striking the period at  
8 the end of paragraph (21) and inserting “; or”, and  
9 by inserting after paragraph (21) the following new  
10 paragraph:

11 “(22) remuneration paid to or on behalf of an  
12 employee if (and to the extent that) at the time of  
13 payment of such remuneration it is reasonable to be-  
14 lieve that a corresponding exclusion is allowable  
15 under section 106A.”

16 (c) CLERICAL AMENDMENT.—The table of sections  
17 for part III of subchapter B of chapter 1 of the Internal  
18 Revenue Code of 1986 is amended by inserting after the  
19 item relating to section 106 the following:

“Sec. 106A. Certain health insurance coverage costs.”

20 (d) EFFECTIVE DATE.—The amendments made by  
21 this section shall apply to taxable years beginning after  
22 the date of the enactment of this Act.

1       **TITLE IV—SMALL BUSINESS**  
2       **HEALTH INSURANCE POOLS**

3       **SEC. 401. PROHIBITION OF RESTRICTIONS ON GROUPS**  
4                               **PURCHASING HEALTH INSURANCE.**

5           (a) IN GENERAL.—No provision of State or local law  
6 shall apply that prohibits 2 or more employers or groups  
7 from obtaining coverage under a multiple employer health  
8 plan.

9           (b) MULTIPLE EMPLOYER HEALTH PLAN.—For pur-  
10 poses of subsection (a), the term “multiple employer  
11 health plan” means a multiple employer welfare arrange-  
12 ment (as defined in section 3(40) of the Employee Retire-  
13 ment Income Security Act of 1974).

14       **SEC. 402. PROHIBITION OF STATE BENEFIT MANDATES FOR**  
15                               **GROUP HEALTH PLANS.**

16           In the case of a group health plan, no provision of  
17 State or local law shall apply that requires the coverage  
18 of 1 or more specific benefits, services, or categories of  
19 health care, or services of any class or type of provider  
20 of health care.

21       **SEC. 403. PROHIBITION OF RESTRICTIONS ON MANAGED**  
22                               **CARE.**

23           (a) PREEMPTION OF STATE LAW PROVISIONS.—Sub-  
24 ject to subsection (c), the following provisions of State law  
25 are preempted and may not be enforced:

1           (1) RESTRICTIONS ON REIMBURSEMENT RATES  
2           OR SELECTIVE CONTRACTING.—Any law that re-  
3           stricts the ability of a group health plan to negotiate  
4           reimbursement rates with providers or to contract  
5           selectively with 1 provider or a limited number of  
6           providers.

7           (2) RESTRICTIONS ON DIFFERENTIAL FINAN-  
8           CIAL INCENTIVES.—Any law that limits the financial  
9           incentives that a group health plan may require a  
10          beneficiary to pay when a non-plan provider is used  
11          on a non-emergency basis.

12          (3) RESTRICTIONS ON UTILIZATION REVIEW  
13          METHODS.—Any law that—

14                (A) prohibits utilization review of any or  
15                all treatments and conditions,

16                (B) requires that such review be made (i)  
17                by a resident of the State in which the treat-  
18                ment is to be offered or by an individual li-  
19                censed in such State, or (ii) by a physician in  
20                any particular specialty or with any board cer-  
21                tified specialty of the same medical specialty as  
22                the provider whose services are being reviewed,

23                (C) requires the use of specified standards  
24                of health care practice in such reviews or re-

1           quires the disclosure of the specific criteria used  
2           in such reviews,

3                   (D) requires payments to providers for the  
4           expenses of responding to utilization review re-  
5           quests, or

6                   (E) imposes liability for delays in perform-  
7           ing such review.

8           Nothing in subparagraph (B) shall be construed as  
9           prohibiting a State from (i) requiring a licensed phy-  
10          sician or other health care professional be available  
11          at some time in the review or appeal process, or (ii)  
12          requiring that any decision in an appeal from such  
13          a review be made by a licensed physician.

14          (b) GAO STUDY.—

15               (1) IN GENERAL.—The Comptroller General of  
16          the United States shall conduct a study of the regu-  
17          latory and legal impediments at the Federal, State,  
18          and local levels of government that restrict the abil-  
19          ity of small businesses and other organizations to  
20          group together voluntarily to allow their employees  
21          or members to pool their health insurance purchases.

22               (2) REPORT.—By not later than 2 years after  
23          the date of the enactment of this Act, the Comptrol-  
24          ler General shall submit a report to Congress on the  
25          study conducted under paragraph (1) and shall in-

1       clude in the report such recommendations (including  
2       whether the provisions of subsection (a) should be  
3       extended) as may be appropriate.

4       (c) SUNSET.—Unless otherwise provided, subsection  
5 (a) shall not apply 5 years after the date of the enactment  
6 of this Act.

7       **TITLE V—ASSISTANCE TO INDIVIDUALS WITH PREEXISTING**  
8       **CONDITIONS IN PURCHASING**  
9       **HEALTH INSURANCE**  
10       **HEALTH INSURANCE**

11       **SEC. 501. PREEXISTING CONDITION INSURANCE POOL AL-**  
12       **LOTMENT PROGRAM.**

13       (a) DEFINITIONS.—As used in this section:

14           (1) CATASTROPHIC HEALTH INSURANCE  
15       PLAN.—The term “catastrophic health insurance  
16       plan” has the meaning given such term by section  
17       220(c)(2) of the Internal Revenue Code of 1986 (de-  
18       termined without regard to subparagraph (B)(i)).

19           (2) PREEXISTING CONDITION.—The term “pre-  
20       existing condition” means, with respect to coverage  
21       under a health insurance plan, a condition that has  
22       been diagnosed or treated during the 6-month period  
23       ending on the day before the first date of such cov-  
24       erage (without regard to any waiting period).

1           (3) PROGRAM ADMINISTRATOR.—The term  
2           “program administrator” means the entity respon-  
3           sible for the administration of the program estab-  
4           lished under subsection (e)(2).

5           (b) ESTABLISHMENT.—The Secretary shall establish  
6           and administer a program to provide allotments to States  
7           to enable such States to operate State-wide insurance risk  
8           pools to provide health insurance coverage to individuals  
9           with preexisting conditions.

10          (c) ALLOTMENTS TO STATES.—The Secretary shall  
11          allot to a State under this section for each fiscal year an  
12          amount equal to the State expected loss amount for such  
13          fiscal year as determined under subsection (e)(3)(B)(v).

14          (d) APPLICATION.—To be eligible to receive an allot-  
15          ment for a fiscal year under this section, a State shall  
16          prepare and submit an application to the Secretary at  
17          such time, in such manner, and containing such informa-  
18          tion as the Secretary may by rule require. Such applica-  
19          tion shall include an assurance by the State that all ad-  
20          ministrative costs of the insurance pool program shall be  
21          borne by the State from resources other than such allot-  
22          ment.

23          (e) STATE PROGRAM.—

24                  (1) USE OF FUNDS.—The State shall use  
25                  amounts received under this section to provide pre-

1       mium assistance under the program established  
2       under paragraph (2).

3           (2) ESTABLISHMENT.—The State shall estab-  
4       lish an insurance pool program to provide premium  
5       assistance to an individual who has a preexisting  
6       condition and who is otherwise unable to purchase  
7       coverage under an affordable health insurance pol-  
8       icy, to enable such individual to obtain such cov-  
9       erage.

10          (3) BID PROCESS.—

11           (A) IN GENERAL.—With respect to a pro-  
12       gram established under paragraph (2), the  
13       State shall, for each fiscal year, accept bids  
14       from private insurance carriers that desire to  
15       administer the program and provide cata-  
16       strophic health insurance plans to individuals  
17       with preexisting conditions under the program.  
18       The State may accept such a bid or, after de-  
19       termining that no such bids are acceptable, ad-  
20       minister the program itself.

21           (B) CONSIDERATION OF BIDS.—In consid-  
22       ering bids submitted under subparagraph (A),  
23       the State, in consultation with private insurance  
24       carriers, shall compile a profile of individuals

1 with preexisting conditions. Such profile shall  
2 consider—

3 (i) the number of individuals who may  
4 be eligible for premium assistance under  
5 the State program for the fiscal year in-  
6 volved;

7 (ii) the estimated cost of providing  
8 medical services for the eligible individuals  
9 for the fiscal year involved;

10 (iii) the estimated amount of pre-  
11 miums to be paid by such eligible individ-  
12 uals for the fiscal year involved;

13 (iv) the estimated amount by which  
14 the medical service costs will exceed the  
15 premiums received for the fiscal year in-  
16 volved;

17 (v) the estimated amount of Federal  
18 assistance needed under this section to  
19 cover the losses estimated under clause  
20 (iv); and

21 (vi) any other information determined  
22 appropriate by the State.

23 (4) PROVISION OF PREMIUM ASSISTANCE.—

24 (A) ELIGIBILITY.—To be eligible to receive  
25 premium assistance under a State program

1 under this section, an individual shall be deter-  
2 mined by the program administrator—

3 (i) to have a preexisting condition;

4 (ii) to be charged under a catastrophic  
5 health insurance plan, a premium which  
6 exceeds 150 percent of the average pre-  
7 mium paid for catastrophic health insur-  
8 ance plans (considering residence, age and  
9 gender);

10 (iii) not to have any avoidable health  
11 conditions, including medical conditions re-  
12 lated to smoking, alcohol abuse, drug  
13 abuse, and other activities harmful to  
14 health, which are the sole reason for the  
15 excess described in clause (ii); and

16 (iv) not to be described in section 601.

17 (B) AMOUNT.—An individual determined  
18 to be eligible under subparagraph (A) shall re-  
19 ceive premium assistance under this section in  
20 an amount that equals the amount by which the  
21 premium paid by such individual for a cata-  
22 strophic health insurance plan exceeds the  
23 greater of—

24 (i) 150 percent of the average pre-  
25 mium paid for catastrophic health insur-

1           ance plans (considering residence, age and  
2           gender), or

3                   (ii) 7.5 percent of the individual or  
4           family adjusted gross income of the indi-  
5           vidual,

6           but only to the extent such excess is not attrib-  
7           utable to any avoidable health conditions, in-  
8           cluding medical conditions related to smoking,  
9           alcohol abuse, drug abuse, and other activities  
10          harmful to health.

11          (f) PAYMENTS.—

12               (1) IN GENERAL.—The Secretary shall pay to  
13          each State for which an application has been ap-  
14          proved under this section for each fiscal year an  
15          amount not to exceed its allotment under subsection  
16          (c) to be expended by the State in accordance with  
17          the terms of the application for the fiscal year for  
18          which the allotment is to be made.

19               (2) METHOD OF PAYMENTS.—The Secretary  
20          may make payments to a State in installments, and  
21          in advance or, by way of reimbursement, with nec-  
22          essary adjustments due to overpayments or under-  
23          payments, as the Secretary may determine appro-  
24          priate.

1           (3) STATE SPENDING OF PAYMENTS.—Pay-  
2           ments to a State from the allotment under sub-  
3           section (c) for any fiscal year must be expended by  
4           the State in that fiscal year or in the succeeding fis-  
5           cal year.

6           (g) AUTHORIZATION OF APPROPRIATIONS.—There  
7           are authorized to be appropriated such sums as may be  
8           necessary to carry out this section.

9           (h) EFFECTIVE DATE.—

10           (1) IN GENERAL.—The provisions of this title  
11           shall apply with respect to payments made to indi-  
12           viduals in calendar years beginning with 1996 or, if  
13           later, with the alternate year.

14           (2) ALTERNATE YEAR.—For purposes of para-  
15           graph (1), the term “alternate year” means any cal-  
16           endar year other than 1996 as determined under  
17           section 1302 of the Comprehensive Family Health  
18           Access and Savings Act.

19           **TITLE VI—ENCOURAGE RESPON-**  
20           **SIBLE BEHAVIOR BY THE FI-**  
21           **NANCIALLY CAPABLE**

22           **SEC. 601. ONE YEAR WINDOW TO PURCHASE HEALTH IN-**  
23           **SURANCE COVERAGE.**

24           Any individual with family income exceeding 200 per-  
25           cent of the income official poverty line (as determined

1 under section 34A of the Internal Revenue Code of 1986),  
2 or who is eligible for a partial or full credit to purchase  
3 a catastrophic health insurance plan under such section,  
4 but who fails to purchase coverage under a health insur-  
5 ance plan providing coverage at least equal to such a cata-  
6 strophic health insurance plan within 1 year of the date  
7 of the enactment of this Act, shall not be eligible for the  
8 insurance pool program under title V of this Act.

9 **SEC. 602. PROHIBITION OF RESTRICTIONS RELATING TO**  
10 **THE USE OF COLLECTION PROCEDURES.**

11 No provision of Federal, State, or local law shall  
12 apply that prohibits the use of any statutory procedure  
13 for the collection of unpaid debts for medical expenses in-  
14 curred by individuals described in section 601.

15 **TITLE VII—ASSISTANCE TO LOW-**  
16 **INCOME WORKERS TO PUR-**  
17 **CHASE HEALTH CARE INSUR-**  
18 **ANCE**

19 **SEC. 701. REFUNDABLE CATASTROPHIC HEALTH INSUR-**  
20 **ANCE PLAN CREDIT.**

21 (a) IN GENERAL.—Subpart C of part IV of sub-  
22 chapter A of chapter 1 of the Internal Revenue Code of  
23 1986 (relating to refundable personal credits) is amended  
24 by inserting after section 34 the following new section:

1 **“SEC. 34A. CATASTROPHIC HEALTH INSURANCE PLAN PRE-**  
2 **MIUMS.**

3 “(a) ALLOWANCE OF CREDIT.—In the case of a  
4 qualified individual, there shall be allowed as a credit  
5 against the tax imposed by this subtitle for the taxable  
6 year an amount equal to the applicable percentage of the  
7 premiums for a catastrophic health insurance plan paid  
8 by such individual during the taxable year.

9 “(b) QUALIFIED INDIVIDUALS.—For purposes of this  
10 section:

11 “(1) IN GENERAL.—The term ‘qualified individ-  
12 ual’ means the taxpayer, the spouse of the taxpayer,  
13 and each dependent of the taxpayer (as defined in  
14 section 152) who is enrolled in a catastrophic health  
15 insurance plan.

16 “(2) FEDERALLY COVERED INDIVIDUALS.—The  
17 term ‘qualified individual’ does not include any indi-  
18 vidual whose medical care is covered under titles  
19 XIX and XVIII of the Social Security Act.

20 “(3) SPECIAL RULE IN THE CASE OF CHILD OF  
21 DIVORCED PARENTS, ETC.—Any child to whom sec-  
22 tion 152(e) applies shall be treated as a dependent  
23 of both parents.

24 “(4) MARRIAGE RULES.—The determination of  
25 whether an individual is married at any time during  
26 the taxable year shall be made in accordance with

1 the provisions of section 6013(d) (relating to deter-  
2 mination of status as husband and wife).

3 “(c) APPLICABLE PERCENTAGE.—For purposes of  
4 subsection (a), the applicable percentage for any taxable  
5 year is 100 percent reduced (but not below zero percent)  
6 by 1 percentage point for each 1 percentage point (or por-  
7 tion thereof) the qualified individual’s family income ex-  
8 ceeds 100 percent of the income official poverty line (as  
9 defined by the Office of Management and Budget, and re-  
10 vised annually in accordance with section 673(2) of the  
11 Omnibus Budget Reconciliation Act of 1981) applicable  
12 to a family of the size involved.

13 “(d) CATASTROPHIC HEALTH INSURANCE PLAN.—  
14 For purposes of this section, the term ‘catastrophic health  
15 insurance plan’ means a health plan covering specified ex-  
16 penses incurred by an individual for medical care (as de-  
17 fined in section 220(c)(2)(B)(ii)) for such individual and  
18 the spouse and dependents (as so defined) of such individ-  
19 ual only to the extent such expenses covered by the plan  
20 for any calendar year exceed the greater of—

21 “(1) 20 percent of the adjusted gross income of  
22 such individual for such year, or

23 “(2) \$3,000.

24 “(e) OTHER DEFINITIONS AND SPECIAL RULES.—  
25 For purposes of this section:

1 “(1) DETERMINATIONS OF INCOME.—

2 “(A) IN GENERAL.—The term ‘income’  
3 means adjusted gross income (as defined in sec-  
4 tion 62(a))—

5 “(i) determined without regard to sec-  
6 tions 135, 162(l), 911, 931, and 933; and

7 “(ii) increased by—

8 “(I) the amount of interest re-  
9 ceived or accrued which is exempt  
10 from tax, plus

11 “(II) the amount of social secu-  
12 rity benefits (described in section  
13 86(d)) which is not includible in gross  
14 income under section 86.

15 “(B) FAMILY INCOME.—The term ‘family  
16 income’ means, with respect to a family, the  
17 sum of the income for all members of the fam-  
18 ily, not including the income of a dependent  
19 child with respect to which no return is re-  
20 quired.

21 “(C) FAMILY SIZE.—The family size to be  
22 applied under this section, with respect to fam-  
23 ily income, is the number of individuals in-  
24 cluded in the family for purposes of coverage  
25 under a catastrophic health insurance plan.

1           “(2) COORDINATION WITH ADVANCE PAYMENT  
2           AND MINIMUM TAX.—Rules similar to the rules of  
3           subsections (g) and (h) of section 32 shall apply to  
4           any credit to which this section applies.

5           “(f) REGULATIONS.—The Secretary shall prescribe  
6           such regulations as may be necessary to carry out the pur-  
7           poses of this section.

8           “(g) APPLICATION OF SECTION.—

9           “(1) IN GENERAL.—This section shall apply  
10          with respect to—

11                 “(A) any individual with a filing status de-  
12                 scribed in subsection (a), (b), or (d) of section  
13                 1 and whose family income is less than 100 per-  
14                 cent of the income official poverty line (as de-  
15                 fined by the Office of Management and Budget,  
16                 and revised annually in accordance with section  
17                 673(2) of the Omnibus Budget Reconciliation  
18                 Act of 1981) applicable to a family of the size  
19                 involved, in any taxable year beginning with  
20                 1997 or, if later, the alternate year,

21                 “(B) any individual with a filing status de-  
22                 scribed in subsection (c) of section 1 and whose  
23                 family income is less than 100 percent of such  
24                 income official poverty line, in any taxable year

1 beginning with 1998 or, if later, the alternate  
2 year,

3 “(C) any individual with a filing status de-  
4 scribed in subsection (a), (b), or (d) of section  
5 1 and whose family income is equal to or ex-  
6 ceeds 100 percent of such income official pov-  
7 erty line, but only to the extent of 33 percent  
8 of the credit allowable under this section, in any  
9 taxable year beginning with 1999 or, if later,  
10 the alternate year, and

11 “(D) any individual with a filing status de-  
12 scribed in subsection (a), (b), (c), or (d) of sec-  
13 tion 1 and whose family income is equal to or  
14 exceeds 100 percent of such income official pov-  
15 erty line, in any taxable year beginning with  
16 2000 or, if later, the alternate year.

17 “(2) ALTERNATE YEAR.—For purposes of para-  
18 graph (1), the term ‘alternate year’ means any tax-  
19 able year other than the taxable year described the  
20 applicable subparagraph of paragraph (1) as deter-  
21 mined under section 1302 of the Comprehensive  
22 Family Health Access and Savings Act.

23 (b) ADVANCE PAYMENT OF CREDIT.—Chapter 25 of  
24 the Internal Revenue Code of 1986 (relating to general

1 provisions relating to employment taxes) is amended by  
2 inserting after section 3507 the following new section:

3 **“SEC. 3507A. ADVANCE PAYMENT OF CATASTROPHIC**  
4 **HEALTH INSURANCE PLAN PREMIUMS CRED-**  
5 **IT.**

6 “(a) GENERAL RULE.—Except as otherwise provided  
7 in this section, every employer making payment of wages  
8 with respect to whom a catastrophic health insurance plan  
9 eligibility certificate is in effect shall, at the time of paying  
10 such wages, make an additional payment equal to such  
11 employee’s catastrophic health insurance plan advance  
12 amount.

13 “(b) CATASTROPHIC HEALTH INSURANCE PLAN ELI-  
14 GIBILITY CERTIFICATE.—For purposes of this title, a cat-  
15 astrophic health insurance plan eligibility certificate is a  
16 statement furnished by an employee to the employer  
17 which—

18 “(1) certifies that the employee will be eligible  
19 to receive the credit provided by section 34A for the  
20 taxable year,

21 “(2) certifies that the employee does not have  
22 a catastrophic health insurance plan eligibility cer-  
23 tificate in effect for the calendar year with respect  
24 to the payment of wages by another employer,

1           “(3) states whether or not the employee’s  
2 spouse has a catastrophic health insurance plan eli-  
3 gibility certificate in effect, and

4           “(4) estimates the amount of premiums for a  
5 catastrophic health insurance plan (as defined in  
6 section 34A(d)) for the calendar year.

7 For purposes of this section, a certificate shall be treated  
8 as being in effect with respect to a spouse if such a certifi-  
9 cate will be in effect on the first status determination date  
10 following the date on which the employee furnishes the  
11 statement in question.

12       “(c) CATASTROPHIC HEALTH INSURANCE PLAN AD-  
13 VANCE AMOUNT.—

14           “(1) IN GENERAL.—For purposes of this title,  
15 the term ‘catastrophic health insurance plan advance  
16 amount’ means, with respect to any payroll period,  
17 the amount determined—

18           “(A) on the basis of the employee’s wages  
19 from the employer for such period,

20           “(B) on the basis of the employee’s esti-  
21 mated premiums for a catastrophic health in-  
22 surance plan (as so defined) included in the cat-  
23 astrophic health insurance plan eligibility cer-  
24 tificate, and

1           “(C) in accordance with tables provided by  
2           the Secretary.

3           “(2) ADVANCE AMOUNT TABLES.—The tables  
4           referred to in paragraph (1)(C) shall be similar in  
5           form to the tables prescribed under section 3402  
6           and, to the maximum extent feasible, shall be coordi-  
7           nated with such tables and the tables prescribed  
8           under section 3507(c).

9           “(d) OTHER RULES.—For purposes of this section,  
10          rules similar to the rules of subsections (d) and (e) of sec-  
11          tion 3507 shall apply.

12          “(e) REGULATIONS.—The Secretary shall prescribe  
13          such regulations as may be necessary to carry out the pur-  
14          poses of this section.”

15          (c) CREDIT AMOUNT NOT ALLOWED AS MEDICAL  
16          EXPENSE DEDUCTION.—Section 213 of the Internal Rev-  
17          enue Code of 1986 (relating to medical, dental, etc., ex-  
18          penses), as amended by section 212(c), is amended by  
19          adding at the end the following new subsection:

20          “(h) COORDINATION WITH CATASTROPHIC HEALTH  
21          INSURANCE PLAN PREMIUMS CREDIT.—The amount oth-  
22          erwise taken into account under subsection (a) as expenses  
23          paid for medical care shall be reduced by the amount (if  
24          any) of the amount taken into account under section 34A  
25          for the taxable year.”

1 (d) CLERICAL AMENDMENTS.—

2 (1) The table of sections for subpart A of part  
3 IV of subchapter A of chapter 1 of the Internal Rev-  
4 enue Code of 1986 is amended by inserting after the  
5 item relating to section 34 the following new item:

“Sec. 34A. Catastrophic health insurance plan premiums.”

6 (2) The table of sections for chapter 25 of such  
7 Code is amended by adding after the item relating  
8 to section 3507 the following new item:

“Sec. 3507A. Advance payment of catastrophic health insurance  
plan premiums credit.”

9 **SEC. 702. PROHIBITION OF RESTRICTIONS RELATING TO**  
10 **THE USE OF COLLECTION PROCEDURES.**

11 No provision of Federal, State, or local law shall  
12 apply that prohibits the use of any statutory procedure  
13 for the collection of unpaid debts for medical expenses in-  
14 curred by individuals who are eligible for the credit al-  
15 lowed under section 34A of the Internal Revenue Code of  
16 1986, but who fail to claim such credit.

17 **TITLE VIII—REWARD PREVEN-**  
18 **TIVE MEDICINE AND**  
19 **HEALTHY LIFESTYLES**

20 **SEC. 801. REWARD PREVENTIVE MEDICINE AND HEALTHY**  
21 **LIFESTYLES.**

22 In the case of any health insurance plan, no provision  
23 of State or local law shall apply that restricts the reduc-

1 tion of premiums or the allowance of incentives with re-  
 2 spect to such plans for individuals who pursue healthy life-  
 3 styles.

4 **TITLE IX—REFORM MEDICAID**  
 5 **AND EXPAND CHOICES**  
 6 **UNDER MEDICARE**

7 **Subtitle A—Medicaid**

8 **SEC. 901. CAP ON FEDERAL PAYMENTS MADE FOR MEDI-**  
 9 **CAL ASSISTANCE UNDER THE MEDICAID PRO-**  
 10 **GRAM.**

11 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et  
 12 seq.) is amended by redesignating section 1931 as section  
 13 1932 and by inserting after section 1930 the following new  
 14 section:

15 “CAP ON FEDERAL PAYMENT MADE FOR MEDICAL  
 16 ASSISTANCE

17 “SEC. 1931. (a) ANNUAL FEDERAL CAP.—For pur-  
 18 poses of furnishing medical assistance to eligible individ-  
 19 uals, the Secretary shall pay to a State for a fiscal year  
 20 under section 1903 an amount that does not exceed the  
 21 State total funding amount determined under subsection  
 22 (b).

23 “(b) STATE TOTAL FUNDING AMOUNT.—

24 “(1) IN GENERAL.—A State’s total funding  
 25 amount for a fiscal year is an amount equal to the  
 26 sum of—

1           “(A) the State’s acute care funding  
2 amount for the fiscal year determined under  
3 subsection (c); and

4           “(B) the State’s long-term care funding  
5 amount for the fiscal year determined under  
6 subsection (d).

7           “(2) ESTIMATIONS OF AND ADJUSTMENTS TO  
8 STATE TOTAL FUNDING AMOUNT.—The Secretary  
9 shall—

10           “(A) establish a process for estimating the  
11 State total funding amount under this sub-  
12 section at the beginning of each fiscal year and  
13 adjusting such amount during such fiscal year;  
14 and

15           “(B) notify each State of the estimations  
16 and adjustments referred to in subparagraph  
17 (A).

18           “(c) STATE ACUTE CARE FUNDING AMOUNT.—

19           “(1) IN GENERAL.—A State’s acute care fund-  
20 ing amount for a fiscal year is an amount equal to  
21 the product of—

22           “(A) the per capita acute care funding  
23 amount determined under paragraph (2) for the  
24 State for such fiscal year, multiplied by

1           “(B) the total number of eligible individ-  
2           uals receiving medical assistance in the form of  
3           acute medical services in the State during the  
4           fiscal year.

5           “(2) PER CAPITA ACUTE CARE FUNDING  
6           AMOUNT.—

7           “(A) IN GENERAL.—The Secretary shall  
8           calculate for each State a per capita acute care  
9           funding amount in accordance with subpara-  
10          graph (B) for each fiscal year.

11          “(B) DETERMINATION OF PER CAPITA  
12          ACUTE CARE FUNDING AMOUNTS.—

13                 “(i) IN GENERAL.—The per capita  
14                 acute care funding amount for a State  
15                 shall be—

16                         “(I) for fiscal year 1995, an  
17                         amount equal to the base acute care  
18                         per capita funding amount (as deter-  
19                         mined under clause (ii)) updated by  
20                         the estimated change in the medical  
21                         consumer price index through the  
22                         midpoint of fiscal year 1995; and

23                         “(II) for fiscal year 1996 and  
24                         succeeding fiscal years, an amount  
25                         equal to the amount determined under

1 this clause for the previous fiscal year  
2 updated through the midpoint of the  
3 fiscal year by the estimated percent-  
4 age change in the medical consumer  
5 price index during the 12-month pe-  
6 riod ending at that midpoint, with ap-  
7 propriate adjustments to reflect pre-  
8 vious underestimations or overesti-  
9 mations under this clause in the pro-  
10 jected percentage change in the medi-  
11 cal consumer price index.

12 “(ii) BASE PER CAPITA ACUTE CARE  
13 FUNDING AMOUNT.—The base per capita  
14 acute care funding amount for a State is  
15 an amount equal to the quotient of—

16 “(I) the total amount of Federal  
17 funds paid to such State under sec-  
18 tion 1903 for fiscal year 1993 for fur-  
19 nishing medical assistance in the form  
20 of acute medical services to eligible in-  
21 dividuals; divided by

22 “(II) the total number of eligible  
23 individuals who received medical as-  
24 sistance in the form of acute medical

1 services in such State during fiscal  
2 year 1993.

3 “(d) STATE LONG-TERM CARE FUNDING  
4 AMOUNT.—

5 “(1) IN GENERAL.—A State’s long-term care  
6 funding amount for a fiscal year is an amount equal  
7 to the product of—

8 “(A) the per capita long-term care funding  
9 amount determined under paragraph (2) for the  
10 State for such fiscal year, multiplied by

11 “(B) the total number of eligible individ-  
12 uals receiving medical assistance in the form of  
13 long-term care services in the State during the  
14 fiscal year.

15 “(2) PER CAPITA LONG-TERM CARE FUNDING  
16 AMOUNT.—

17 “(A) IN GENERAL.—The Secretary shall  
18 calculate for each State a per capita long-term  
19 care funding amount in accordance with sub-  
20 paragraph (B) for each fiscal year.

21 “(B) DETERMINATION OF PER CAPITA  
22 LONG-TERM CARE FUNDING AMOUNTS.—

23 “(i) IN GENERAL.—The per capita  
24 long-term care funding amount for a State  
25 shall be—

1           “(I) for fiscal year 1995, an  
2           amount equal to the base long-term  
3           care per capita funding amount (as  
4           determined under clause (ii)) updated  
5           by the estimated change in the medi-  
6           cal consumer price index through the  
7           midpoint of fiscal year 1995; and

8           “(II) for fiscal year 1996 and  
9           succeeding fiscal years, an amount  
10          equal to the amount determined under  
11          this clause for the previous fiscal year  
12          updated through the midpoint of the  
13          fiscal year by the estimated percent-  
14          age change in the medical consumer  
15          price index during the 12-month pe-  
16          riod ending at that midpoint, with ap-  
17          propriate adjustments to reflect pre-  
18          vious underestimations or overesti-  
19          mations under this clause in the pro-  
20          jected percentage change in the medi-  
21          cal consumer price index.

22          “(ii) BASE PER CAPITA LONG-TERM  
23          CARE FUNDING AMOUNT.—The base per  
24          capita long-term care funding amount for

1 a State is an amount equal to the quotient  
2 of—

3 “(I) the total amount of Federal  
4 funds paid to such State under sec-  
5 tion 1903 for fiscal year 1993 for fur-  
6 nishing medical assistance in the form  
7 of long-term care services to eligible  
8 individuals; divided by

9 “(II) the total number of eligible  
10 individuals who received medical as-  
11 sistance in the form of long-term care  
12 medical services in such State during  
13 fiscal year 1993.

14 “(e) DEFINITIONS.—For purposes of this section:

15 “(1) ACUTE MEDICAL SERVICES.—The term  
16 ‘acute medical services’ means all of the care and  
17 services furnished to individuals eligible under a  
18 State plan under this title other than long-term care  
19 services.

20 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
21 individual’ means an individual who is a member of  
22 any group of individuals described in section  
23 1902(a)(10) that is eligible to receive medical assist-  
24 ance under the State plan under this title.

1           “(3) LONG-TERM CARE SERVICES.—The term  
2           ‘long-term care services’ means the following care  
3           and services furnished to individuals eligible under a  
4           State plan under this title:

5                   “(A) Nursing facility services (as defined  
6                   in section 1905(f)).

7                   “(B) Intermediate care facility for the  
8                   mentally retarded services (as defined in section  
9                   1905(d)).

10                  “(C) Personal care services (as described  
11                  in section 1905(a)(24)).

12                  “(D) Private duty nursing services (as re-  
13                  ferred to in section 1905(a)(8)).

14                  “(E) Home or community-based services  
15                  furnished under a waiver granted under sub-  
16                  section (c), (d), or (e) of section 1915.

17                  “(F) Home and community care furnished  
18                  to functionally disabled elderly individuals  
19                  under section 1929.

20                  “(G) Community supported living arrange-  
21                  ments services under section 1930.

22                  “(H) Case-management services (as de-  
23                  scribed in section 1915(g)(2)).

24                  “(I) Home health care services (as referred  
25                  to in section 1905(a)(7)).

1           “(J) Hospice care.

2           “(4) MEDICAL CONSUMER PRICE INDEX.—The  
3 term ‘medical consumer price index’ means the  
4 consumer price index for medical services as deter-  
5 mined by the Bureau of Labor Statistics.”

6           (b) REQUIRING STATE MAINTENANCE OF EFFORT.—  
7 Section 1902(a) (42 U.S.C. 1369a(a)) is amended—

8           (1) by striking “and” at the end of paragraph  
9 (61);

10          (2) by striking the period at the end of para-  
11 graph (62) and inserting “; and”; and

12          (3) by adding at the end the following new  
13 paragraph:

14          “(63) provide that the State will continue to  
15 make eligible for medical assistance under section  
16 1902(a)(10) any class or category of individuals eli-  
17 gible for medical assistance under such section dur-  
18 ing fiscal year 1993.”

19          (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall be effective with respect to fiscal years  
21 beginning on or after October 1, 1994.

22 **SEC. 902. WAIVERS FOR FURNISHING MEDICAL ASSIST-**  
23 **ANCE UNDER THE MEDICAID PROGRAM.**

24          (a) IN GENERAL.—Title XIX of the Social Security  
25 Act (42 U.S.C. 1396 et seq.), as amended by section 901,

1 is amended by redesignating section 1932 as section 1933  
2 and by inserting after section 1931 the following new sec-  
3 tion:

4 “WAIVERS FOR FURNISHING MEDICAL ASSISTANCE  
5 UNDER THE MEDICAID PROGRAM

6 “SEC. 1932. (a) IN GENERAL.—The Secretary shall  
7 establish a process under which a State with a State plan  
8 approved under this title may apply for waivers of any  
9 of the requirements under this title in order to establish  
10 innovative and cost-effective programs for furnishing med-  
11 ical assistance to eligible individuals (as defined in section  
12 1931(e)(2)).

13 “(b) APPLICATION FOR WAIVERS.—

14 “(1) IN GENERAL.—In order to receive a waiver  
15 under subsection (a), a State shall submit an appli-  
16 cation to the Secretary at such time and containing  
17 such information as the Secretary determines appro-  
18 priate.

19 “(2) APPROVAL OF APPLICATION.—

20 “(A) INITIAL REVIEW.—Within 60 days  
21 after an application is submitted by the State  
22 under this subsection, the Secretary shall review  
23 and approve such application or provide the  
24 State with a list of the modifications that are  
25 necessary for such application to be approved.

1           “(B) ADDITIONAL REVIEW.—Within 60  
2           days after a State resubmits any application  
3           under this subsection, the Secretary shall review  
4           and approve such application or provide the  
5           State with a summary of which items included  
6           on the list provided to the State under subpara-  
7           graph (A) remain unsatisfied. A State may re-  
8           submit an application under this subparagraph  
9           as many times as necessary to gain approval.

10          “(c) DURATION OF WAIVERS.—Except as provided in  
11          subsection (d), any waiver under this section shall be  
12          granted for a period of 5 years, and renewed for subse-  
13          quent 5-year periods, unless the Secretary determines that  
14          the State has failed to furnish medical assistance in ac-  
15          cordance with the terms of the waiver and any provisions  
16          of this title with respect to which the Secretary has not  
17          granted a waiver.

18          “(d) TERMINATION OF WAIVERS.—The Secretary  
19          may terminate a waiver granted under this section at any  
20          time if the Secretary determines that the State has failed  
21          to furnish medical assistance in accordance with the terms  
22          of the waiver and any provisions of this title with respect  
23          to which the Secretary has not granted a waiver.

24          “(e) REPORTS.—The State shall evaluate the pro-  
25          grams operated under a waiver granted under this section

1 and submit reports to the Secretary at such times and  
2 containing such information as the Secretary shall re-  
3 quire.”

4 (b) EFFECTIVE DATE.—The amendment made by  
5 subsection (a) shall be effective with respect to fiscal years  
6 beginning on or after October 1, 1994.

## 7 **Subtitle B—Medicare**

### 8 **SEC. 951. INDIVIDUAL ELECTION FOR TYPE OF COVERAGE.**

9 (a) ELECTION FOR NEW ELIGIBLES.—

10 (1) IN GENERAL.—Title XVIII of the Social Se-  
11 curity Act (42 U.S.C. 1395 et seq.) is amended by  
12 adding after section 1804 the following new section:

13 “INDIVIDUAL ELECTION FOR TYPE OF COVERAGE

14 “SEC. 1805. (a) An individual may enroll with a pri-  
15 vate health care arrangement under section 1893 or an  
16 eligible organization under section 1876 only if such indi-  
17 vidual has elected to enroll with such an arrangement or  
18 organization within 1 year after the date that the individ-  
19 ual—

20 “(1) becomes entitled to benefits under part A  
21 of this title, or

22 “(2) foregoes a health benefit plan operated,  
23 sponsored, or contributed to, by the individual’s em-  
24 ployer or former employer (or the employer or  
25 former employer of the individual’s spouse) where  
26 such plan was the individual’s primary insurer.

1       “(b) If an individual makes an election under sub-  
2 section (a), such individual shall be entitled to payment  
3 under this title only if such individual remains enrolled  
4 with an arrangement or organization described in such  
5 subsection.”

6           (2) EFFECTIVE DATE.—The amendment made  
7 by paragraph (1) shall apply with respect to individ-  
8 uals who become entitled to benefits under part A of  
9 title XVIII of the Social Security Act on or after Oc-  
10 tober 1, 1994.

11       (b) ELECTION FOR CURRENT ELIGIBLES.—

12           (1) ENROLLMENT WITH A PRIVATE HEALTH  
13 CARE ARRANGEMENT OR ELIGIBLE ORGANIZA-  
14 TION.—

15           (A) IN GENERAL.—If an individual is enti-  
16 tled to benefits under part A of title XVIII of  
17 the Social Security Act on or before September  
18 30, 1994, such individual may elect to enroll  
19 with a private health care arrangement under  
20 section 1893 of such Act or an eligible organi-  
21 zation under section 1876 of such Act only if  
22 such election is made on or before March 31,  
23 1995.

24           (B) PAYMENT.—If an individual makes an  
25 election under subparagraph (A), such individ-

1           ual shall be entitled to payment under title  
2           XVIII of the Social Security Act only if such  
3           individual remains enrolled with an arrange-  
4           ment or organization described in such subpara-  
5           graph.

6           (2) DECISION TO RETURN TO FEE FOR SERVICE  
7           PLAN.—If an individual is enrolled with an eligible  
8           organization under section 1876 of the Social Secu-  
9           rity Act (42 U.S.C. 1395mm) on or before Septem-  
10          ber 30, 1994, such individual may terminate the in-  
11          dividual’s enrollment with such organization on or  
12          before March 31, 1995, without being subject to the  
13          payment limitation described in paragraph (1)(B).

14          (3) EFFECTIVE DATE.—This subsection shall  
15          take effect on October 1, 1994.

16 **SEC. 952. HEALTH CARE COVERAGE UNDER A PRIVATE**  
17 **HEALTH CARE ARRANGEMENT.**

18          (a) IN GENERAL.—Part C of title XVIII of the Social  
19          Security Act (42 U.S.C. 1395x et seq.) is amended by add-  
20          ing at the end the following new section:

21          “PAYMENTS TO PRIVATE HEALTH CARE ARRANGEMENTS

22          “SEC. 1893. (a) PAYMENTS.—

23                  “(1) IN GENERAL.—The Secretary shall make  
24          payment as specified in subsection (c) for each indi-  
25          vidual who is enrolled with a private health care ar-  
26          rangement.

1           “(2) SOLE PAYMENTS.—Payments to an indi-  
2           vidual under this section shall be in lieu of the  
3           amounts that would otherwise be payable pursuant  
4           to sections 1814(b) and 1833(a).

5           “(b) CERTIFICATION.—

6           “(1) IN GENERAL.—An individual who is en-  
7           rolled with a private health care arrangement shall  
8           certify to the Secretary, by not later than December  
9           15 of each year, the individual’s enrollment for the  
10          coming calendar year. Such certification shall indi-  
11          cate the individual’s annual premium amount.

12          “(2) FAILURE TO CERTIFY.—For purposes of  
13          determining payment under subsection (c), an indi-  
14          vidual who fails to provide the certification described  
15          in paragraph (1) shall be deemed to be enrolled with  
16          the private health care arrangement at the same  
17          premium for which the Secretary last received a cer-  
18          tification.

19          “(c) PAYMENT AMOUNT SPECIFIED.—

20          “(1) PRIVATE HEALTH CARE ARRANGEMENT.—

21                  “(A) IN GENERAL.—In January of each  
22                  year, the Secretary shall pay the private health  
23                  care arrangement certified by the individual  
24                  under subsection (b)(1), the lesser of—

1           “(i) the individual’s annual premium  
2           amount, or

3           “(ii) the per capita amount specified  
4           under paragraph (2).

5           “(B) RETURN OF PAYMENT.—In the event  
6           of the death of an individual, the private health  
7           care arrangement certified by the individual  
8           under subsection (b)(1) shall reimburse the Sec-  
9           retary for a prorated portion of the amount re-  
10          ceived under subparagraph (A), less any  
11          amount expended by the private health care ar-  
12          rangement for the health care expenses for such  
13          individual. Such amount (if any) shall be depos-  
14          ited in the Federal Hospital Insurance Trust  
15          Fund and the Federal Supplementary Medical  
16          Insurance Trust Fund in the same proportion  
17          as such payment was paid by each trust fund  
18          under subsection (e).

19          “(2) PER CAPITA AMOUNT.—

20          “(A) IN GENERAL.—The Secretary shall  
21          annually determine, and shall announce (in a  
22          manner intended to provide notice to interested  
23          parties) not later than September 7 before the  
24          calendar year concerned, the per capita amount.

1           “(B) DETERMINATION OF PER CAPITA  
2 RATE OF PAYMENT.—The per capita amount  
3 for each group of individuals (based on resi-  
4 dency, age, and gender) is equal to—

5                   “(i) the total estimated government  
6 expenditures for all benefits under parts A  
7 and B of this title in the coming calendar  
8 year for such group (excluding any pre-  
9 miums, deductibles, and copayments paid  
10 by individuals for benefits under part B),  
11 divided by

12                   “(ii) the total estimated number of in-  
13 dividuals in such group expected to be enti-  
14 tled to benefits under part A and enrolled  
15 in part B in the coming calendar year.

16           “(3) ADDITIONAL AMOUNTS FOR CERTAIN INDI-  
17 VIDUALS.—

18           “(A) LOW-COST PLANS.—The Secretary  
19 shall pay annually to an individual enrolled with  
20 a private health care arrangement one-half of  
21 the excess (if any) of—

22                   “(i) the per capita amount under  
23 paragraph (2), over

24                   “(ii) the annual premium for the indi-  
25 vidual’s private health care arrangement

1 (or in the case of a private health care ar-  
2 rangement that is a catastrophic health in-  
3 surance plan, the annual premium for such  
4 plan and the annual deductible amount for  
5 such plan).

6 “(B) LONG TERM CARE PLAN.—The Sec-  
7 retary shall pay annually to an individual who  
8 has received payment under subparagraph (A)  
9 and is enrolled with a long term care plan, an  
10 additional payment equal to the amount re-  
11 ceived by such individual under subparagraph  
12 (A).

13 “(d) DEFINITIONS.—For purposes of this section:

14 “(1) CATASTROPHIC HEALTH INSURANCE  
15 PLAN.—The term ‘catastrophic health insurance  
16 plan’ has the meaning given to such term by section  
17 220(c)(2)(A) of the Internal Revenue Code of 1986.

18 “(2) LONG TERM CARE PLAN.—The term ‘long  
19 term care plan’ means a plan which covers services  
20 of the type identified in section 1931(e)(3).

21 “(3) MEDICAL SAVINGS ACCOUNT.—The term  
22 ‘medical savings account’ has the meaning given to  
23 such term by section 220(d)(1) of the Internal Reve-  
24 nue Code of 1986.

1           “(4) PRIVATE HEALTH CARE ARRANGEMENT.—

2           The term ‘private health care arrangement’ means—

3                   “(A) any arrangement which offers at least

4                   the health care services described in section

5                   1876(b)(2)(A), or

6                   “(B) a catastrophic health insurance plan

7                   in connection with a medical savings account.

8           “(e) SOURCE OF PAYMENT.—The payment to an in-

9           dividual under this section shall be made from the Federal

10          Hospital Insurance Trust Fund and the Federal Supple-

11          mentary Medical Insurance Trust Fund. The proportion

12          of the payment to be paid by each trust fund shall be de-

13          termined each year by the Secretary based on the relative

14          proportion of government expenditures that benefits from

15          each fund contribute to the per capita amount determined

16          under subsection (b)(2)(B).”

17          (b) EFFECTIVE DATE.—The amendment made by

18          subsection (a) shall apply to payments made on or after

19          October 1, 1994.

1 **TITLE X—ENHANCED EFFI-**  
2 **CIENCY THROUGH PAPER-**  
3 **WORK REDUCTION**

4 **SEC. 1001. FEDERAL PAPERWORK REDUCTION AND EFFI-**  
5 **CIENCY REQUIREMENTS.**

6 (a) IN GENERAL.—The Secretary of Health and  
7 Human Services (hereafter referred to in this title as the  
8 “Secretary”) shall, in consultation with the Director of the  
9 Office of Management and Budget, the Secretary of Veter-  
10 ans Affairs, the Secretary of Defense, the Director of Per-  
11 sonnel Management, and other appropriate Federal offi-  
12 cials, adopt standards to reduce the administrative and  
13 paperwork burdens of all Federal health care programs  
14 by—

15 (1) 50 percent within the 2-year period follow-  
16 ing the date of the enactment of this Act, and

17 (2) an additional 50 percent reduction from the  
18 balance specified in (1) over a subsequent 3-year pe-  
19 riod,

20 for a total reduction of 75 percent over the 5-year period  
21 following the date of the enactment of this Act.

22 (b) INITIAL REDUCTION.—In order to achieve a pa-  
23 perwork reduction described in subsection (a)(1), the Sec-  
24 retary, shall adopt standards for Federal health care pro-  
25 grams relating to each of the following:

1           (1) Data elements for use in paper and elec-  
2           tronic claims processing under health insurance  
3           plans, as well as for use in utilization review and  
4           management of care (including data fields, formats,  
5           and medical nomenclature, and including plan bene-  
6           fit and insurance information).

7           (2) Uniform claims forms (including uniform  
8           procedure and bill codes for use with such forms and  
9           including information on other health insurance  
10          plans that may be liable for benefits).

11          (3) Uniform electronic transmission of the data  
12          elements (for purposes of billing and utilization re-  
13          view).

14 Standards under paragraph (3) relating to electronic  
15 transmission of data elements for claims for services shall  
16 supersede (to the extent specified in such standards) the  
17 standards adopted under paragraph (2) relating to the  
18 submission of paper claims for such services. Standards  
19 under paragraph (3) shall include protections to assure  
20 the confidentiality of patient-specific information and to  
21 protect against the unauthorized use and disclosure of in-  
22 formation.

23          (c) SUBSEQUENT REDUCTION.—In order to achieve  
24 a further paperwork reduction described in subsection  
25 (a)(2), the Secretary shall modify by regulation the stand-

1 ards adopted under subsection (b). The modification of the  
2 standards may include such recommendations as reported  
3 by the Standardized Form Commission in section 1003,  
4 or any other provisions necessary to meet the goals for  
5 reduction in the paperwork burden of Federal health care  
6 programs.

7 (d) DEFINITION.—For purposes of this section, the  
8 term “Federal health care program” means all Federal  
9 programs related to health care, including programs de-  
10 scribed in—

11 (1) title XVIII or XIX of the Social Security  
12 Act,

13 (2) the Public Health Service Act,

14 (3) chapter 55 of title 10, United States Code,

15 (4) chapter 17 of title 38, United States Code,

16 (5) chapter 89 of title 5, United States Code,

17 or

18 (6) the Indian Health Care Improvement Act.

19 **SEC. 1002. STATE PAPERWORK REDUCTION AND EFFI-**  
20 **CIENCY REQUIREMENTS.**

21 (a) IN GENERAL.—In order to be eligible for Federal  
22 funds in connection with any State-administered health  
23 care program, each State shall standardize the processing  
24 of paper and electronic claims to reduce the administrative  
25 and paperwork burdens on such programs by 75 percent

1 during the 5-year period following the date of the enact-  
2 ment of this Act.

3 (b) ENFORCEMENT.—

4 (1) INTERIM EVALUATION.—If at the end of the  
5 4-year period following the date of the enactment of  
6 this Act the Secretary determines that a State has  
7 not achieved substantial progress toward the reduc-  
8 tions required under subsection (a), the Secretary  
9 shall notify such State regarding the proportion of  
10 required reductions achieved and the further reduc-  
11 tion necessary to achieve compliance with subsection  
12 (a).

13 (2) FINAL COMPLIANCE.—If at the end of the  
14 5-year period following the date of the enactment of  
15 this Act the Secretary determines that a State has  
16 not achieved the reductions required under sub-  
17 section (a), the Secretary shall reduce Federal pay-  
18 ments for health care programs administered by  
19 such State by 10 percent. For each year that such  
20 State fails to comply with the requirements of sub-  
21 section (a), Federal payments for health care pro-  
22 grams administered by the State shall be reduced by  
23 an additional 10 percent.

24 (3) WAIVERS OF PAYMENT REDUCTIONS.—Any  
25 State subject to a reduction in Federal payments

1 under paragraph (2) may appeal to the Secretary for  
2 a 1-year waiver of such reduction. In granting such  
3 a waiver, the Secretary shall make a determination  
4 of the good faith effort of such State to comply with  
5 the requirements of subsection (a), taking into ac-  
6 count the technical, practical, and financial capabili-  
7 ties of the State in meeting such requirements.

8 **SEC. 1003. STANDARDIZED FORMS COMMISSION.**

9 (a) IN GENERAL.—

10 (1) ESTABLISHMENT.—Not later than 12  
11 months after the date of the enactment of this Act,  
12 the Secretary shall establish a Standardized Forms  
13 Commission (hereafter referred to in this section as  
14 the “Commission”) which shall make recommenda-  
15 tions on the standardization of paper and electronic  
16 claims processing so as to reduce the paperwork bur-  
17 den associated with, and enhance the efficiency and  
18 productivity of, such claims processing.

19 (2) MEMBERSHIP.—

20 (A) IN GENERAL.—The Commission shall  
21 be composed of at least 12 but not more than  
22 20 representatives of private health care provid-  
23 ers and private insurers.

24 (B) CHAIR.—The Secretary shall appoint a  
25 Chair of the Commission.

1           (3) REPORT ON FINDINGS AND RECOMMENDA-  
2           TIONS.—Not later than 24 months after the date of  
3           the enactment of this Act, the Chair of the Commis-  
4           sion shall report to the Secretary on the findings  
5           and recommendations of the Commission.

6           (4) PROHIBITION OF COMPENSATION.—Mem-  
7           bers of the Commission shall serve without pay ex-  
8           cept for reimbursement for travel expenses, includ-  
9           ing per diem in lieu of subsistence, in accordance  
10          with sections 5702 and 5703 of title 5, United  
11          States Code.

12          (5) STAFF OF FEDERAL AGENCIES.—Upon re-  
13          quest of the Chair, the head of any Federal depart-  
14          ment or agency shall detail any of the personnel of  
15          that department or agency to the Commission to as-  
16          sist it in carrying out its duties under this section.

17          (6) OBTAINING OFFICIAL DATA.—The Commis-  
18          sion may secure directly from any department or  
19          agency of the United States information necessary  
20          to enable it to carry out this section.

21          (7) ADMINISTRATIVE SUPPORT SERVICES.—  
22          Upon request of the Chair, the Administrator of  
23          General Services shall provide to the Commission the  
24          administrative support services necessary for the

1 Commission to carry out its responsibilities under  
2 this section.

3 (b) LEGISLATIVE PROPOSAL.—

4 (1) IN GENERAL.—

5 (A) DEVELOPMENT OF IMPLEMENTING  
6 BILL.—Not later than 3 months after the Com-  
7 mission has submitted its findings and rec-  
8 ommendations to the Secretary, the Secretary  
9 shall take such recommendations and submit  
10 them to Congress in the form of an implement-  
11 ing bill which contains the provisions necessary  
12 or appropriate to implement the recommenda-  
13 tions by either repealing or amending existing  
14 laws or providing new statutory authority.

15 (B) CONSIDERATION OF IMPLEMENTING  
16 BILL.—The implementing bill described in sub-  
17 paragraph (A) shall be considered by Congress  
18 under the procedures for consideration de-  
19 scribed in paragraph (2).

20 (2) CONGRESSIONAL CONSIDERATION.—

21 (A) RULES OF HOUSE OF REPRESENTA-  
22 TIVES AND SENATE.—This paragraph is en-  
23 acted by Congress—

24 (i) as an exercise of the rulemaking  
25 power of the House of Representatives and

1 the Senate, respectively, and as such is  
2 deemed a part of the rules of each House,  
3 respectively, but applicable only with re-  
4 spect to the procedure to be followed in  
5 that House in the case of an implementing  
6 bill described in paragraph (1)(A), and su-  
7 persedes other rules only to the extent that  
8 such rules are inconsistent therewith; and

9 (ii) with full recognition of the con-  
10 stitutional right of either House to change  
11 the rules (so far as relating to the proce-  
12 dure of that House) at any time, in the  
13 same manner and to the same extent as in  
14 the case of any other rule of that House.

15 (B) INTRODUCTION AND REFERRAL.—On  
16 the day on which the implementing bill de-  
17 scribed in paragraph (1)(A) is transmitted to  
18 the House of Representatives and the Senate,  
19 such bill shall be introduced (by request) in the  
20 House of Representatives by the Majority Lead-  
21 er of the House, for himself and the Minority  
22 Leader of the House, or by Members of the  
23 House designated by the Majority Leader and  
24 Minority Leader of the House and shall be in-  
25 troduced (by request) in the Senate by the Ma-

1 jority Leader of the Senate, for himself and the  
2 Minority Leader of the Senate, or by Members  
3 of the Senate designated by the Majority Lead-  
4 er and Minority Leader of the Senate. If either  
5 House is not in session on the day on which the  
6 implementing bill is transmitted, the bill shall  
7 be introduced in the House, as provided in the  
8 preceding sentence, on the first day thereafter  
9 on which the House is in session. The imple-  
10 menting bill introduced in the House of Rep-  
11 resentatives and the Senate shall be referred to  
12 the appropriate committees of each House.

13 (C) AMENDMENTS PROHIBITED.—No  
14 amendment to an implementing bill shall be in  
15 order in either the House of Representatives or  
16 the Senate and no motion to suspend the appli-  
17 cation of this paragraph shall be in order in ei-  
18 ther House, nor shall it be in order in either  
19 House for the Presiding Officer to entertain a  
20 request to suspend the application of this para-  
21 graph by unanimous consent.

22 (D) PERIOD FOR COMMITTEE AND FLOOR  
23 CONSIDERATION.—

24 (i) IN GENERAL.—Except as provided  
25 in clause (ii), if the committee or commit-

1           tees of either House to which an imple-  
2           menting bill has been referred have not re-  
3           ported it at the close of the 45th day after  
4           its introduction, such committee or com-  
5           mittees shall be automatically discharged  
6           from further consideration of the imple-  
7           menting bill and it shall be placed on the  
8           appropriate calendar. A vote on final pas-  
9           sage of the implementing bill shall be  
10          taken in each House on or before the close  
11          of the 45th day after the implementing bill  
12          is reported by the committees or committee  
13          of that House to which it was referred, or  
14          after such committee or committees have  
15          been discharged from further consideration  
16          of the implementing bill. If prior to the  
17          passage by 1 House of an implementing  
18          bill of that House, that House receives the  
19          same implementing bill from the other  
20          House then—

21                   (I) the procedure in that House  
22                   shall be the same as if no implement-  
23                   ing bill had been received from the  
24                   other House; but

1 (II) the vote on final passage  
2 shall be on the implementing bill of  
3 the other House.

4 (ii) COMPUTATION OF DAYS.—For  
5 purposes of clause (i), in computing a  
6 number of days in either House, there  
7 shall be excluded—

8 (I) the days on which either  
9 House is not in session because of an  
10 adjournment of more than 3 days to  
11 a day certain, or an adjournment of  
12 the Congress sine die, and

13 (II) any Saturday and Sunday  
14 not excluded under subclause (I) when  
15 either House is not in session.

16 (E) FLOOR CONSIDERATION IN THE  
17 HOUSE OF REPRESENTATIVES.—

18 (i) MOTION TO PROCEED.—A motion  
19 in the House of Representatives to proceed  
20 to the consideration of an implementing  
21 bill shall be highly privileged and not de-  
22 batable. An amendment to the motion shall  
23 not be in order, nor shall it be in order to  
24 move to reconsider the vote by which the  
25 motion is agreed to or disagreed to.

1           (ii) DEBATE.—Debate in the House of  
2           Representatives on an implementing bill  
3           shall be limited to not more than 20 hours,  
4           which shall be divided equally between  
5           those favoring and those opposing the bill.  
6           A motion further to limit debate shall not  
7           be debatable. It shall not be in order to  
8           move to recommit an implementing bill or  
9           to move to reconsider the vote by which an  
10          implementing bill is agreed to or disagreed  
11          to.

12          (iii) MOTION TO POSTPONE.—Motions  
13          to postpone, made in the House of Rep-  
14          resentatives with respect to the consider-  
15          ation of an implementing bill, and motions  
16          to proceed to the consideration of other  
17          business, shall be decided without debate.

18          (iv) APPEALS.—All appeals from the  
19          decisions of the Chair relating to the appli-  
20          cation of the Rules of the House of Rep-  
21          resentatives to the procedure relating to an  
22          implementing bill shall be decided without  
23          debate.

24          (v) GENERAL RULES APPLY.—Except  
25          to the extent specifically provided in the

1 preceding provisions of this subparagraph,  
2 consideration of an implementing bill shall  
3 be governed by the Rules of the House of  
4 Representatives applicable to other bills  
5 and resolutions in similar circumstances.

6 (F) FLOOR CONSIDERATION IN THE SEN-  
7 ATE.—

8 (i) MOTION TO PROCEED.—A motion in  
9 the Senate to proceed to the consideration  
10 of an implementing bill shall be privileged  
11 and not debatable. An amendment to the  
12 motion shall not be in order, nor shall it be  
13 in order to move to reconsider the vote by  
14 which the motion is agreed to or disagreed  
15 to.

16 (ii) GENERAL DEBATE.—Debate in  
17 the Senate on an implementing bill, and all  
18 debatable motions and appeals in connec-  
19 tion therewith, shall be limited to not more  
20 than 20 hours. The time shall be equally  
21 divided between, and controlled by, the  
22 Majority Leader and the Minority Leader  
23 or their designees.

24 (iii) DEBATE OF MOTIONS AND AP-  
25 PEALS.—Debate in the Senate on any de-

1           debatable motion or appeal in connection  
2           with an implementing bill shall be limited  
3           to not more than 1 hour, to be equally di-  
4           vided between, and controlled by, the  
5           mover and the manager of the implement-  
6           ing bill, except that in the event the man-  
7           ager of the implementing bill is in favor of  
8           any such motion or appeal, the time in op-  
9           position thereto, shall be controlled by the  
10          Minority Leader or his designee. Such  
11          leaders, or either of them, may, from time  
12          under their control on the passage of an  
13          implementing bill, allot additional time to  
14          any Senator during the consideration of  
15          any debatable motion or appeal.

16                   (iv) OTHER MOTIONS.—A motion in  
17                   the Senate to further limit debate is not  
18                   debatable. A motion to recommit an imple-  
19                   menting bill is not in order.

20           (c) FAILURE TO COMPLY WITH RECOMMENDATIONS  
21   ENACTED.—A health care provider or health care insurer  
22   that fails to comply with any recommendations of the  
23   Commission that are enacted in accordance with sub-  
24   section (b) and that are applicable to such provider or in-  
25   surer shall be ineligible for payments of claims submitted

1 under any provision of the Social Security Act or the Pub-  
2 lic Health Service Act.

3 **TITLE XI—MEANINGFUL**  
4 **MEDICAL LIABILITY REFORM**

5 **SEC. 1101. APPLICABILITY AND PREEMPTION.**

6 (a) **APPLICABILITY.**—This title shall apply with re-  
7 spect to any medical malpractice liability claim and to any  
8 medical malpractice liability action brought in any State  
9 or Federal court, except that this title shall not apply to  
10 a claim or action for damages arising from a vaccine-relat-  
11 ed injury or death to the extent that title XXI of the Pub-  
12 lic Health Service Act applies to the claim or action.

13 (b) **PREEMPTION.**—

14 (1) **IN GENERAL.**—The provisions of this title  
15 shall preempt any State or local law to the extent  
16 such law is inconsistent with the limitations con-  
17 tained in such provisions. The provisions of this title  
18 shall not preempt any State law that provides for  
19 defenses or places limitations on a person’s liability  
20 in addition to those contained in this title, places  
21 greater limitations on the amount of attorneys’ fees  
22 and expenses that can be collected, or otherwise im-  
23 poses greater restrictions than those provided in this  
24 title.

1           (2) NEGOTIATED LIABILITY.—The provisions of  
2 this title shall preempt any Federal, State or local  
3 law to the extent that such law prohibits a health  
4 care provider and a purchaser of health care from  
5 voluntarily entering into a contractual agreement in  
6 which the provider offers reduced fees for medical  
7 services in exchange for a prearranged limit on the  
8 amount of any award in a medical malpractice liabil-  
9 ity action resulting from the provision of such serv-  
10 ices or a limit on the cause of action that may be  
11 maintained with respect to such services.

12           (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
13 OF LAW OR VENUE.—Nothing in subsection (b) shall be  
14 construed to—

15           (1) waive or affect any defense of sovereign im-  
16 munity asserted by any State under any provision of  
17 law;

18           (2) waive or affect any defense of sovereign im-  
19 munity asserted by the United States;

20           (3) affect the applicability of any provision of  
21 the Foreign Sovereign Immunities Act of 1976;

22           (4) preempt State choice-of-law rules with re-  
23 spect to claims brought by a foreign nation or a citi-  
24 zen of a foreign nation; or

1           (5) affect the right of any court to transfer  
2           venue or to apply the law of a foreign nation or to  
3           dismiss a claim of a foreign nation or of a citizen  
4           of a foreign nation on the ground of inconvenient  
5           forum.

6           (d) FEDERAL COURT JURISDICTION NOT ESTAB-  
7           LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in  
8           this title shall be construed to establish any jurisdiction  
9           in the district courts of the United States over medical  
10          malpractice liability actions on the basis of section 1331  
11          or 1337 of title 28, United States Code.

12          **SEC. 1102. STATUTE OF LIMITATIONS.**

13          (a) IN GENERAL.—Except as provided in subsection  
14          (b), no medical malpractice liability action shall be initi-  
15          ated after the expiration of the 2-year period that begins  
16          on the later of the date that the alleged injury that is the  
17          subject of the claim was discovered, or the date on which  
18          such injury should reasonably have been discovered. In no  
19          event shall any such action be initiated after the expiration  
20          of the 4-year period that begins on the date on which the  
21          alleged injury occurred.

22          (b) EXCEPTION FOR CERTAIN MINORS.—In the case  
23          of an alleged injury suffered by a minor who has not at-  
24          tained 6 years of age, no medical malpractice liability ac-  
25          tion shall be initiated after the expiration of the 2-year

1 period that begins on the date on which the alleged injury  
2 was discovered, or the date on which such injury should  
3 reasonably have been discovered. In no event shall any  
4 such action be initiated after the expiration of the 4-year  
5 period that begins on the date on which the alleged injury  
6 occurred, or the date on which the minor attains 8 years  
7 of age, whichever is later.

8 **SEC. 1103. SCOPE OF LIABILITY.**

9 (a) IN GENERAL.—With respect to economic and  
10 noneconomic damages, the liability of each defendant in  
11 a medical malpractice liability action shall be several only  
12 and may not be joint. Such a defendant shall be liable  
13 only for the amount of economic or noneconomic damages  
14 allocated to the defendant in direct proportion to such de-  
15 fendant's percentage of fault or responsibility for the in-  
16 jury suffered by the claimant.

17 (b) DETERMINATION OF PERCENTAGE OF LIABIL-  
18 ITY.—The trier of fact in a medical malpractice liability  
19 action shall determine the extent of each defendant's fault  
20 or responsibility for the economic or noneconomic damages  
21 suffered by the claimant, and shall assign a percentage  
22 of responsibility for such injury to each such defendant.

1 **SEC. 1104. DISCOVERY; FAILURE TO MAKE OR COOPERATE**  
2 **IN DISCOVERY.**

3 (a) IN GENERAL.—All requests for discovery pursu-  
4 ant to a medical malpractice liability action shall identify  
5 the relevant portion of the complaint, answer or other  
6 pleading to which responses to the discovery requests are  
7 expected to relate.

8 (b) FEES AND EXPENSES.—With respect to any mo-  
9 tion for an order compelling discovery that is made pursu-  
10 ant to a medical malpractice liability action, the court  
11 shall award the prevailing party reasonable fees and other  
12 expenses incurred by that party in bringing or defending  
13 against the motion, including reasonable attorney fees, un-  
14 less the court finds that the position of the unsuccessful  
15 party was substantially justified or that special cir-  
16 cumstances make such an award unjust.

17 **SEC. 1105. LIMITATION ON NONECONOMIC DAMAGES.**

18 The total amount of noneconomic damages that may  
19 be awarded to a claimant and the members of the claim-  
20 ant's family for losses resulting from the injury which is  
21 the subject of a medical malpractice liability action may  
22 not exceed \$250,000, regardless of the number of parties  
23 against whom the action is brought or the number of ac-  
24 tions brought with respect to such injury.

1 **SEC. 1106. TREATMENT OF PAYMENTS FOR FUTURE ECO-**  
2 **NOMIC LOSSES.**

3 (a) PROHIBITING SINGLE LUMP-SUM PAYMENT.—In  
4 any medical malpractice liability action in which the dam-  
5 ages awarded for any economic losses to be incurred after  
6 the date on which the judgment is entered exceeds  
7 \$100,000, a defendant may not be required to pay such  
8 damages in a single, lump-sum payment, but shall be per-  
9 mitted to make such payments periodically based on pro-  
10 jections of the amount of damages expected to be incurred  
11 by the claimant at appropriate intervals, as determined by  
12 the court.

13 (b) USE OF ANNUITIES OR TRUSTS.—The court may  
14 require that a defendant in a medical malpractice liability  
15 action purchase an annuity or fund a reversionary trust  
16 to make periodic payments under subsection as provided  
17 for in subsection (a) if the court determines that a reason-  
18 able basis exists for concluding that the defendant may  
19 be unable or otherwise fail to make the required periodic  
20 payments.

21 (c) REQUIREMENT OF PERIODIC PAYMENT AS FINAL  
22 ORDER.—A judgment of a court awarding periodic pay-  
23 ments under this section may not be reopened at any time  
24 to contest, amend, or modify the schedule or amount of  
25 the payments in the absence of fraud or any other basis

1 under which a party may obtain relief from a final judg-  
2 ment.

3 **SEC. 1107. TREATMENT OF COSTS AND ATTORNEY'S FEES.**

4 (a) COSTS AND FEES, GENERALLY.—

5 (1) COURT DISCRETION.—A court in a medical  
6 malpractice liability action may, as a condition of  
7 the initiation of such an action, require an undertak-  
8 ing for the payment of the costs associated with  
9 such action, including reasonable attorneys' fees.

10 (2) PAYMENT OF COSTS.—If a judgment in a  
11 medical malpractice liability action is rendered  
12 against a party to such action, upon a motion by the  
13 prevailing party to such action, the court shall re-  
14 quire the party against whom the judgment was ren-  
15 dered to pay to such prevailing party the costs and  
16 fees incurred by such prevailing party under the ac-  
17 tion, including reasonable attorneys' fees and other  
18 expenses. The court may waive the application of  
19 this paragraph if the court finds that the position  
20 maintained by the party against whom such judg-  
21 ment was rendered under such action was substan-  
22 tially justified or that special circumstances make  
23 such an award unjust.

24 (3) APPLICATION FOR RECOVERY OF COSTS.—

25 A party to a medical malpractice liability action who

1 is seeking an award of costs and fees as provided for  
2 in paragraph (2) shall, not later than 30 days after  
3 the date on which the final, nonappealable judgment  
4 is entered with respect to such action, submit to the  
5 appropriate court an application for the recovery of  
6 costs and fees. Such application shall contain—

7 (A) a certification that the submitting  
8 party is a prevailing party and is eligible to re-  
9 ceive costs and fees under paragraph (2);

10 (B) a description of the amount of costs  
11 and fees sought, including an itemized state-  
12 ment from any attorney or expert witness rep-  
13 resenting or appearing on behalf of such party  
14 stating the actual time expended and the rate  
15 at which fees and other expenses were com-  
16 puted; and

17 (C) a description of the reasons why the  
18 position of the party against whom the judg-  
19 ment was rendered was not substantially justi-  
20 fied.

21 In determining whether or not the position of the  
22 nonprevailing party was substantially justified the  
23 court shall consider only the record presented in the  
24 action maintained for the costs and fees.

1 (4) AMOUNT OF AWARD.—In making a decision  
2 on an application submitted under paragraph (3),  
3 the court may—

4 (A) assess the amount to be awarded  
5 under this subsection against the party against  
6 whom the judgment was rendered or against  
7 the attorney (or attorneys) of such party; and

8 (B) reduce the amount to be awarded pur-  
9 suant to this subsection, or deny an award, to  
10 the extent that the prevailing party, during the  
11 course of the proceedings, engaged in conduct  
12 which unnecessarily and unreasonably length-  
13 ened the time for, or increased the costs of, the  
14 final resolution of the matter in controversy.

15 (b) ATTORNEY'S FEES.—

16 (1) CONTINGENCY FEES.—An attorney who  
17 represents, on a contingency fee basis, a claimant in  
18 a medical malpractice liability claim may not charge,  
19 demand, receive, or collect for services rendered in  
20 connection with such claim in excess of the following  
21 amount recovered by judgment or settlement under  
22 such claim:

23 (A) 25 percent of the first \$150,000 (or  
24 portion thereof) recovered; plus

1 (B) 15 percent of any amount in excess of  
2 \$150,000 recovered.

3 (2) RECORDS.—

4 (A) IN GENERAL.—With respect to a medi-  
5 cal malpractice liability action, in order to re-  
6 ceive an award of attorneys' fees as provided  
7 for in this title, the attorney of record of a  
8 party to such action shall have maintained ac-  
9 curate, complete records of hours worked on the  
10 action regardless of the fee arrangement en-  
11 tered into by the attorney with such party, in-  
12 cluding records of other attorneys, legal staff,  
13 expert witnesses and others who worked on the  
14 action on behalf of such attorney.

15 (B) CALCULATION.—The court shall deter-  
16 mine the amount of reasonable attorneys' fees  
17 and expenses that shall be awarded in a medical  
18 malpractice liability action under this title on  
19 the basis of an hourly rate or as a percentage  
20 of the total damages awarded under such action  
21 for economic and noneconomic losses. Such  
22 amount shall be indexed to account for infla-  
23 tion. The amount of attorneys' fees and ex-  
24 penses as determined by the court may not ex-

1           ceed an amount that would be considered rea-  
2           sonable based on the following:

3                   (i) The time, labor, and skill nec-  
4                   essary to properly perform the legal serv-  
5                   ices required by the action.

6                   (ii) The novelty and difficulty of the  
7                   questions involved in the action.

8                   (iii) The likelihood, if apparent to the  
9                   client, that the acceptance of employment  
10                  with respect to the client's action will pre-  
11                  clude other employment by the attorney.

12                  (iv) The fee customarily charged in  
13                  the locality for similar legal services.

14                  (v) The amount involved in the action  
15                  and the results obtained.

16                  (vi) The time limitations imposed by  
17                  the client or by the circumstances of the  
18                  action.

19                  (vii) The nature and length of the  
20                  professional relationship between the attor-  
21                  ney and the client.

22                  (viii) The experience, reputation, and  
23                  ability of the attorney performing the serv-  
24                  ices in connection with the action.

1 **SEC. 1108. CONTRIBUTION AND INDEMNIFICATION.**

2 (a) RECOVERY.—With respect to a medical mal-  
3 practice liability action, each nonsettling party may re-  
4 cover contribution and indemnification from any other  
5 such nonsettling party who, if joined in the original action,  
6 would have been liable for such damages.

7 (b) RELEASE, DISMISSAL, SETTLEMENT.—A party  
8 who is released or dismissed (with or without prejudice)  
9 from, or who, in good faith prior to a verdict or judgment,  
10 settles a medical malpractice liability action shall, upon  
11 the execution of the release, dismissal or settlement agree-  
12 ment, be discharged from all claims for contribution or  
13 indemnification brought by nonsettling or other settling  
14 parties to such action. Any party to such action who as-  
15 serts a lack of good faith shall have the burden of proof  
16 concerning such good faith issue.

17 **SEC. 1109. COLLATERAL SOURCES.**

18 (a) IN GENERAL.—The total amount of damages re-  
19 ceived by a claimant in a medical malpractice liability ac-  
20 tion shall be reduced, in accordance with subsection (b),  
21 by any other payment that has been made, or that will  
22 be made, to such claimant to compensate such claimant  
23 for an injury that was part of such action, including pay-  
24 ments—

25 (1) under Federal or State disability or sickness  
26 programs;

1 (2) under Federal, State, or private health in-  
2 surance programs;

3 (3) under private disability insurance programs;

4 (4) under employer wage continuation pro-  
5 grams; and

6 (5) from any other source that are intended to  
7 compensate such claimant for such injury.

8 (b) AMOUNT OF REDUCTION.—The amount by which  
9 an award of damages to a claimant for an injury shall  
10 be reduced under subsection (a) shall be—

11 (1) the total amount of any payments (other  
12 than such award) that have been made, or that will  
13 be made, to such claimant to compensate such  
14 claimant for such injury; and

15 (2) the amount paid by such claimant (or by  
16 the spouse, parent, or legal guardian of such claim-  
17 ant) to secure the payments described in paragraph  
18 (1).

19 **SEC. 1110. DAMAGES RELATING TO MEDICAL PRODUCT LI-**  
20 **ABILITY CLAIMS.**

21 (a) IN GENERAL.—Noneconomic damages may not  
22 be awarded with respect to any medical product liability  
23 claim alleged against a medical product producer if—

24 (1) the drug or device that is the subject of  
25 such claim—

1 (A) was subject to approval under section  
2 505, or premarket approval under section 515,  
3 of the Federal Food, Drug, and Cosmetic Act  
4 by the Food and Drug Administration with re-  
5 spect to—

6 (i) the safety of the formulation or  
7 performance of the aspect of the drug or  
8 device; or

9 (ii) the adequacy of the packaging or  
10 labeling of the drug or device, and

11 (B) was approved by the Food and Drug  
12 Administration; or

13 (2) the drug or device is generally recognized as  
14 safe and effective pursuant to conditions established  
15 by the Food and Drug Administration and applica-  
16 ble regulations, including packaging and labeling  
17 regulations.

18 (b) EXCEPTION IN CASE OF WITHHELD INFORMA-  
19 TION, MISREPRESENTATION, OR ILLEGAL PAYMENT.—

20 The provisions of subsection (a) shall not apply if it is  
21 determined on the basis of clear and convincing evidence  
22 that the medical product producer—

23 (1) withheld from or misrepresented to the  
24 Food and Drug Administration information concern-  
25 ing such drug or device that is required to be sub-

1       mitted under the Federal Food, Drug, and Cosmetic  
2       Act or section 352 of the Public Health Service Act  
3       and that is material and relevant to the action in-  
4       volved; or

5               (2) made an illegal payment to an official of the  
6       Food and Drug Administration for the purpose of  
7       securing approval of the drug or device.

8       (c) DEFINITION.—As used in this section, the term  
9       “clear and convincing evidence” is that measure or degree  
10      of proof that will produce in the mind of the trier of fact  
11      a firm belief or conviction as to the truth of the allegations  
12      sought to be established, except that such measure or de-  
13      gree of proof is more than that required under preponder-  
14      ance of the evidence, but less than that required for proof  
15      beyond a reasonable doubt.

16      **SEC. 1111. CLASS ACTIONS.**

17           (a) RECOVERY BY NAMED CLAIMANTS IN CLASS AC-  
18      TIONS.—In any medical malpractice liability action that  
19      is certified as a class action pursuant to Rule 23 of the  
20      Federal Rules of Civil Procedure, the share of damages  
21      under any final judgment or any settlement that is award-  
22      ed to any party serving as a representative claimant shall  
23      be calculated in the same manner as the shares of the  
24      final judgment or settlement awarded to all other members  
25      of the claimant class. The preceding sentence may not be

1 construed to limit the award to a representative claimant  
2 of reasonable compensation, costs, and expenses relating  
3 to the representation of the class.

4 (b) PROHIBITION OF CONFLICTS OF INTEREST.—In  
5 any medical malpractice liability action that is certified as  
6 a class action pursuant to Rule 23 of the Federal Rules  
7 of Civil Procedure, if a party is represented by any attor-  
8 ney who has a beneficial interest in the subject of the liti-  
9 gation, the court shall make a determination of whether  
10 such interest constitutes a conflict of interest sufficient to  
11 disqualify the attorney from representing the party.

12 (c) RECEIPT OF REFERRAL FEES.—In any medical  
13 liability action that is certified as a class action pursuant  
14 to Rule 23 of the Federal Rules of Civil Procedure, an  
15 attorney may not represent the class if the attorney has  
16 paid or is obligated to pay a fee to a third party who as-  
17 sisted the attorney in obtaining the representation of any  
18 party to the action. An attorney who knowingly violates  
19 this subsection shall be barred from representing the party  
20 in such action or any action to which this title applies.

21 **SEC. 1112. DEFINITIONS.**

22 (1) CLAIMANT.—The term “claimant” means  
23 any person who alleges a medical malpractice liabil-  
24 ity claim, and any person on whose behalf such a  
25 claim is alleged, including the decedent in the case

1 of an action brought through or on behalf of an es-  
2 tate.

3 (2) COMMERCIAL LOSS.—The term “commercial  
4 loss” means loss, including damage to the product  
5 itself, which is not harm described in subparagraph  
6 (A) or (B) of paragraph (5), and which is of a kind  
7 for which there is a remedy under applicable con-  
8 tract or commercial law.

9 (3) ECONOMIC DAMAGES.—The term “economic  
10 damages” means damages paid to compensate an in-  
11 dividual for hospital and other medical expenses, lost  
12 wages, lost employment, and other pecuniary losses.

13 (4) HEALTH CARE PROFESSIONAL.—The term  
14 “health care professional” means any individual who  
15 provides health care services in a State and who is  
16 required by the laws or regulations of the State to  
17 be licensed or certified by the State to provide such  
18 services in the State.

19 (5) HARM.—The term “harm” means—

20 (A) the personal physical illness, injury, or  
21 death of a claimant;

22 (B) the mental anguish or emotional harm  
23 of a claimant that is caused by or causing the  
24 claimant personal physical illness or injury; or

1           (C) the physical damage caused by a medi-  
2           cal product to property other than the medical  
3           product itself.

4           Such term does not include commercial loss or loss  
5           or damage to a medical product.

6           (6) HEALTH CARE PROVIDER.—The term  
7           “health care provider” means any organization or  
8           institution that is engaged in the delivery of health  
9           care services in a State and that is required by the  
10          laws or regulations of the State to be licensed or cer-  
11          tified by the State to engage in the delivery of such  
12          services in the State.

13          (7) INJURY.—The term “injury” means any ill-  
14          ness, disease, or other harm that is the subject of  
15          a medical malpractice liability action or a medical  
16          malpractice liability claim.

17          (8) MEDICAL MALPRACTICE LIABILITY AC-  
18          TION.—The term “medical malpractice liability ac-  
19          tion” means a civil action brought in a State or Fed-  
20          eral court against a health care provider or health  
21          care professional in which the plaintiff alleges a  
22          medical malpractice liability claim, but does not in-  
23          clude any action in which the plaintiff’s sole allega-  
24          tion is an allegation of an intentional tort.

1           (9) MEDICAL MALPRACTICE LIABILITY  
2 CLAIM.—The term “medical malpractice liability  
3 claim” means a claim in which the claimant alleges  
4 that injury was caused by the provision of (or the  
5 failure to provide) health care services or the use of  
6 a medical product.

7           (10) MEDICAL PRODUCT.—

8           (A) IN GENERAL.—The term “medical  
9 product” means, with respect to the allegation  
10 of a claimant, a drug (as defined in section  
11 201(g)(1) of the Federal Food, Drug, and Cos-  
12 metic Act (21 U.S.C. 321(g)(1)) or a medical  
13 device (as defined in section 201(h) of the Fed-  
14 eral Food, Drug, and Cosmetic Act (21 U.S.C.  
15 321(h)) if—

16                   (i) such drug or device was subject to  
17 premarket approval under section 505,  
18 507, or 515 of the Federal Food, Drug,  
19 and Cosmetic Act (21 U.S.C. 355, 357, or  
20 360e) or section 351 of the Public Health  
21 Service Act (42 U.S.C. 262) with respect  
22 to the safety of the formulation or per-  
23 formance of the aspect of such drug or de-  
24 vice which is the subject of the claimant’s  
25 allegation or the adequacy of the packag-

1 ing or labeling of such drug or device, and  
2 such drug or device is approved by the  
3 Food and Drug Administration; or

4 (ii) the drug or device is generally rec-  
5 ognized as safe and effective under regula-  
6 tions issued by the Secretary of Health  
7 and Human Services under section 201(p)  
8 of the Federal Food, Drug, and Cosmetic  
9 Act (21 U.S.C. 321(p)).

10 (B) EXCEPTION IN CASE OF MISREPRE-  
11 SENTATION OR FRAUD.—Notwithstanding sub-  
12 paragraph (A), the term “medical product”  
13 shall not include any product described in such  
14 subparagraph if the claimant shows that the  
15 product is approved by the Food and Drug Ad-  
16 ministration for marketing as a result of with-  
17 held information, misrepresentation, or an ille-  
18 gal payment by manufacturer of the product.

19 (11) NONECONOMIC DAMAGES.—The term  
20 “noneconomic damages” means damages paid to  
21 compensate an individual for losses for physical and  
22 emotional pain, suffering, inconvenience, physical  
23 impairment, mental anguish, emotional distress, dis-  
24 figurement, loss of enjoyment of life, loss of society  
25 and companionship, loss of consortium, injury to

1 reputation, humiliation, and other noneconomic in-  
2 jury.

3 (12) PERSON.—The term “person” means any  
4 individual, corporation, company, association, firm,  
5 partnership, society, joint stock company, or any  
6 other entity, including any governmental entity.

7 **SEC. 1113. SEVERABILITY.**

8 If any provision of this title or the application of any  
9 provision to any person or circumstance is held invalid,  
10 the remainder of this title and the application of such pro-  
11 visions to any other person or circumstance shall not be  
12 affected by such invalidation.

13 **SEC. 1114. EFFECTIVE DATE.**

14 This title shall apply to all medical malpractice liabil-  
15 ity actions commenced on or after the date of enactment  
16 of this Act.

17 **TITLE XII—ANTITRUST**  
18 **REFORMS**

19 **SEC. 1201. ESTABLISHMENT OF LIMITED EXEMPTION PRO-**  
20 **GRAM FOR HEALTH CARE JOINT VENTURES.**

21 (a) ESTABLISHMENT.—

22 (1) IN GENERAL.—Not later than 6 months  
23 after the date of the enactment of this Act, the At-  
24 torney General, after consultation with the Secretary  
25 of Health and Human Services and the Interagency

1       Advisory Committee on Competition, Antitrust Pol-  
2       icy, and Health Care, shall promulgate specific  
3       guidelines under which a health care joint venture  
4       may submit an application requesting that the At-  
5       torney General provide the entities participating in  
6       the joint venture with an exemption under which  
7       (notwithstanding any other provision of law)—

8               (A) monetary recovery on a claim under  
9               the antitrust laws shall be limited to actual  
10              damages if the claim results from conduct with-  
11              in the scope of the joint venture that occurs  
12              while the exemption is in effect; and

13             (B) the conduct of the entity in making or  
14             performing a contract to carry out the joint  
15             venture shall not be deemed illegal per se under  
16             the antitrust laws but shall be judged on the  
17             basis of its reasonableness, taking into account  
18             all relevant factors affecting competition, in-  
19             cluding (but not limited to) effects on competi-  
20             tion in properly defined, relevant research, de-  
21             velopment, product, process, and service mar-  
22             kets (taking into consideration worldwide capac-  
23             ity to the extent that it may be appropriate in  
24             the circumstances).

1           (2) DEADLINE FOR RESPONSE.—The Attorney  
2           General, after consultation with the Secretary and  
3           the Advisory Committee, shall approve or disapprove  
4           the application of a health care joint venture for an  
5           exemption under this subsection not later than 30  
6           days after the Attorney General receives the joint  
7           venture’s application.

8           (3) PROVIDING REASONS FOR DISAPPROVAL.—  
9           If the Attorney General disapproves the application  
10          of a health care joint venture for an exemption  
11          under this subsection, the Attorney General shall  
12          provide the joint venture with a statement explaining  
13          the reasons for the Attorney General’s disapproval.

14          (b) REQUIREMENTS FOR APPROVAL.—For purposes  
15          of subsection (a), the Attorney General shall approve the  
16          application of a health care joint venture for an exemption  
17          under subsection (a) if an entity participating in the joint  
18          venture submits to the Attorney General an application  
19          not later than 30 days after the entity has entered into  
20          a written agreement to participate in the joint venture (or  
21          not later than 30 days after the date of the enactment  
22          of this Act in the case of a joint venture in effect as of  
23          such date) that contains the following information and as-  
24          surances:

1           (1) The identities of the parties to the joint  
2 venture.

3           (2) The nature, objectives, and planned activi-  
4 ties of the joint venture.

5           (3) Assurances that the entities participating in  
6 the joint venture shall notify the Attorney General  
7 of any changes in the information described in para-  
8 graphs (1) and (2) during the period for which the  
9 exemption is in effect.

10 (c) REVOCATION OF EXEMPTION.—

11           (1) IN GENERAL.—The Attorney General, after  
12 consultation with the Secretary, may revoke an ex-  
13 emption provided to a health care joint venture  
14 under this section if, at any time during which the  
15 exemption is in effect, the Attorney General finds  
16 that the joint venture no longer meets the applicable  
17 requirements for approval under subsection (b), ex-  
18 cept that the Attorney General may not revoke such  
19 an exemption if the failure of the health care joint  
20 venture to meet such requirements is merely tech-  
21 nical in nature.

22           (2) TIMING.—The revocation of an exemption  
23 under paragraph (1) shall apply only to conduct of  
24 the health care joint venture occurring after the ex-  
25 emption is no longer in effect.

1 (d) WITHDRAWAL OF APPLICATION.—Any party that  
2 submits an application under this section may withdraw  
3 such application at any time before the Attorney General’s  
4 response to the application.

5 (e) REQUIREMENTS RELATING TO NOTICE AND PUB-  
6 LICATION OF EXEMPTIONS AND RELATED INFORMA-  
7 TION.—

8 (1) PUBLICATION OF APPROVED APPLICATIONS  
9 FOR EXEMPTIONS IN FEDERAL REGISTER.—

10 (A) IN GENERAL.—With respect to each  
11 exemption for a health care joint venture pro-  
12 vided under subsection (a), the Attorney Gen-  
13 eral (acting jointly with the Secretary) shall—

14 (i) prepare a notice with respect to  
15 the joint venture that identifies the parties  
16 to the venture and that describes the  
17 planned activities of the venture;

18 (ii) submit the notice to the entities  
19 participating in the joint venture; and

20 (iii) after submitting the notice to  
21 such entities (but not later than 30 days  
22 after approving the application for the ex-  
23 emption for the joint venture), publish the  
24 notice in the Federal Register.

1 (B) EFFECT OF PUBLICATION.—An ex-  
2 emption provided by the Attorney General  
3 under subsection (a) shall take effect as of the  
4 date of the publication in the Federal Register  
5 of the notice with respect to the exemption pur-  
6 suant to subparagraph (A).

7 (2) WAIVER OF DISCLOSURE REQUIREMENTS  
8 FOR INFORMATION RELATING TO APPLICATIONS FOR  
9 EXEMPTIONS.—

10 (A) IN GENERAL.—All information and  
11 documentary material submitted as part of an  
12 application of a health care joint venture for an  
13 exemption under subsection (a), together with  
14 any other information obtained by the Attorney  
15 General, the Secretary, or the Advisory Com-  
16 mittee in the course of any investigation, ad-  
17 ministrative proceeding, or case with respect to  
18 a potential violation of the antitrust laws by the  
19 joint venture with respect to which the exemp-  
20 tion applies, shall be exempt from disclosure  
21 under section 552 of title 5, United States  
22 Code, and shall not be made publicly available  
23 by any agency of the United States to which  
24 such section applies, except as relevant to a law  
25 enforcement investigation or in a judicial or ad-

1           ministrative proceeding in which such informa-  
2           tion and material is subject to any protective  
3           order.

4           (B) EXCEPTION FOR INFORMATION IN-  
5           CLUDED IN FEDERAL REGISTER NOTICE.—Sub-  
6           paragraph (A) shall not apply with respect to  
7           information contained in a notice published in  
8           the Federal Register pursuant to paragraph  
9           (1).

10          (3) USE OF INFORMATION TO SUPPORT OR AN-  
11          SWER CLAIMS UNDER ANTITRUST LAWS.—

12           (A) IN GENERAL.—Except as provided in  
13           subparagraph (B), the fact of disclosure of con-  
14           duct under an application for an exemption  
15           under subsection (a) and the fact of publication  
16           of a notice in the Federal Register under para-  
17           graph (1) shall be admissible into evidence in  
18           any judicial or administrative proceeding for the  
19           sole purpose of establishing that a person is en-  
20           titled to the protections provided by an exemp-  
21           tion granted under subsection (a).

22           (B) EFFECT OF REJECTED APPLICA-  
23           TION.—If the Attorney General denies, in whole  
24           or in part, an application for an exemption  
25           under subsection (a), or revokes an exemption

1 under such section, neither the negative deter-  
2 mination nor the statement of reasons therefor  
3 shall be admissible into evidence in any admin-  
4 istrative or judicial proceeding for the purpose  
5 of supporting or answering any claim under the  
6 antitrust laws.

7 **SEC. 1202. ISSUANCE OF HEALTH CARE CERTIFICATES OF**  
8 **PUBLIC ADVANTAGE.**

9 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The  
10 Attorney General, after consultation with the Secretary  
11 and the Advisory Committee, shall issue in accordance  
12 with this section a certificate of public advantage to each  
13 eligible health care joint venture that complies with the  
14 requirements in effect under this section on or after the  
15 expiration of the 1-year period that begins on the date  
16 of the enactment of this Act (without regard to whether  
17 or not the Attorney General has promulgated regulations  
18 to carry out this section by such date). Such venture, and  
19 the parties to such venture, shall not be liable under any  
20 of the antitrust laws for conduct described in such certifi-  
21 cate and engaged in by such venture if such conduct oc-  
22 curs while such certificate is in effect.

23 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF  
24 CERTIFICATES.—

1           (1) STANDARDS TO BE MET.—The Attorney  
2           General shall issue a certificate to an eligible health  
3           care joint venture if the Attorney General finds  
4           that—

5                   (A) the benefits that are likely to result  
6                   from carrying out the venture outweigh the re-  
7                   duction in competition (if any) that is likely to  
8                   result from the venture, and

9                   (B) such reduction in competition is rea-  
10                  sonably necessary to obtain such benefits.

11          (2) FACTORS TO BE CONSIDERED.—

12                  (A) WEIGHING OF BENEFITS AGAINST RE-  
13                  DUCTION IN COMPETITION.—For purposes of  
14                  making the finding described in paragraph  
15                  (1)(A), the Attorney General shall consider  
16                  whether the venture is likely —

17                          (i) to maintain or to increase the  
18                          quality of health care,

19                          (ii) to increase access to health care,

20                          (iii) to achieve cost efficiencies that  
21                          will be passed on to health care consumers,  
22                          such as economies of scale, reduced trans-  
23                          action costs, and reduced administrative  
24                          costs,

1 (iv) to preserve the operation of  
2 health care facilities located in underserved  
3 geographical areas,

4 (v) to improve utilization of health  
5 care resources, and

6 (vi) to reduce inefficient health care  
7 resource duplication.

8 (B) NECESSITY OF REDUCTION IN COM-  
9 PETITION.—For purposes of making the finding  
10 described in paragraph (1)(B), the Attorney  
11 General shall consider—

12 (i) the ability of the providers of  
13 health care services that are (or likely to  
14 be) affected by the health care joint ven-  
15 ture and the entities responsible for mak-  
16 ing payments to such providers to nego-  
17 tiate societally optimal payment and serv-  
18 ice arrangements,

19 (ii) the effects of the health care joint  
20 venture on premiums and other charges  
21 imposed by the entities described in clause  
22 (i), and

23 (iii) the availability of equally effi-  
24 cient, less restrictive alternatives to achieve

1           the benefits that are intended to be  
2           achieved by carrying out the venture.

3           (c) ESTABLISHMENT OF CRITERIA AND PROCE-  
4 DURES.—Subject to subsections (d) and (e), not later than  
5 1 year after the date of the enactment of this Act, the  
6 Attorney General and the Secretary shall establish jointly  
7 by rule the criteria and procedures applicable to the issu-  
8 ance of certificates under subsection (a). The rules shall  
9 specify the form and content of the application to be sub-  
10 mitted to the Attorney General to request a certificate,  
11 the information required to be submitted in support of  
12 such application, the procedures applicable to denying and  
13 to revoking a certificate, and the procedures applicable to  
14 the administrative appeal (if such appeal is authorized by  
15 rule) of the denial and the revocation of a certificate. Such  
16 information may include the terms of the health care joint  
17 venture (in the case of a venture in existence as of the  
18 time of the application) and implementation plan for the  
19 joint venture.

20           (d) ELIGIBLE HEALTH CARE JOINT VENTURE.—To  
21 be an eligible health care joint venture for purposes of this  
22 section, a health care joint venture shall submit to the At-  
23 torney General an application that complies with the rules  
24 in effect under subsection (c) and that includes—

1           (1) an agreement by the parties to the venture  
2           that the venture will not foreclose competition by en-  
3           tering into contracts that prevent health care provid-  
4           ers from providing health care in competition with  
5           the venture,

6           (2) an agreement that the venture will submit  
7           to the Attorney General annually a report that de-  
8           scribes the operations of the venture and informa-  
9           tion regarding the impact of the venture on health  
10          care and on competition in health care, and

11          (3) an agreement that the parties to the ven-  
12          ture will notify the Attorney General and the Sec-  
13          retary of the termination of the venture not later  
14          than 30 days after such termination occurs.

15          (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—  
16          Not later than 30 days after an eligible health care joint  
17          venture submits to the Attorney General an application  
18          that complies with the rules in effect under subsection (c)  
19          and with subsection (d), the Attorney General shall issue  
20          or deny the issuance of such certificate. If, before the expi-  
21          ration of such 30-day period, the Attorney General fails  
22          to issue or deny the issuance of such certificate, the Attor-  
23          ney General shall be deemed to have issued such certifi-  
24          cate.

1 (f) REVOCATION OF CERTIFICATE.—Whenever the  
2 Attorney General finds that a health care joint venture  
3 with respect to which a certificate is in effect does not  
4 meet the standards specified in subsection (b), the Attor-  
5 ney General shall revoke such certificate.

6 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

7 (1) DENIAL AND REVOCATION OF CERTIFI-  
8 CATES.—If the Attorney General denies an applica-  
9 tion for a certificate or revokes a certificate, the At-  
10 torney General shall include in the notice of denial  
11 or revocation a statement of the reasons relied upon  
12 for the denial or revocation of such certificate.

13 (2) JUDICIAL REVIEW.—

14 (A) AFTER ADMINISTRATIVE PROCEED-  
15 ING.—(i) If the Attorney General denies an ap-  
16 plication submitted or revokes a certificate is-  
17 sued under this section after an opportunity for  
18 hearing on the record, then any party to the  
19 health care joint venture involved may com-  
20 mence a civil action, not later than 60 days  
21 after receiving notice of the denial or revoca-  
22 tion, in an appropriate district court of the  
23 United States for review of the record of such  
24 denial or revocation.

1           (ii) As part of the Attorney General's an-  
2           swer, the Attorney General shall file in such  
3           court a certified copy of the record on which  
4           such denial or revocation is based. The findings  
5           of fact of the Attorney General may be set aside  
6           only if found to be unsupported by substantial  
7           evidence in such record taken as a whole.

8           (B) DENIAL OR REVOCATION WITHOUT AD-  
9           MINISTRATIVE PROCEEDING.—If the Attorney  
10          General denies an application submitted or re-  
11          vokes a certificate issued under this section  
12          without an opportunity for hearing on the  
13          record, then any party to the health care joint  
14          venture involved may commence a civil action,  
15          not later than 60 days after receiving notice of  
16          the denial or revocation, in an appropriate dis-  
17          trict court of the United States for de novo re-  
18          view of such denial or revocation.

19          (h) EXEMPTION.—A person shall not be liable under  
20          any of the antitrust laws for conduct necessary—

21               (1) to prepare, agree to prepare, or attempt to  
22               agree to prepare an application to request a certifi-  
23               cate under this section, or

1           (2) to attempt to enter into any health care  
2 joint venture with respect to which such a certificate  
3 is in effect.

4 **SEC. 1203. INTERAGENCY ADVISORY COMMITTEE ON COM-**  
5 **PETITION, ANTITRUST POLICY, AND HEALTH**  
6 **CARE.**

7           (a) ESTABLISHMENT.—There is hereby established  
8 the Interagency Advisory Committee on Competition,  
9 Antitrust Policy, and Health Care. The Advisory Commit-  
10 tee shall be composed of—

11           (1) the Secretary of Health and Human Serv-  
12 ices (or the designee of the Secretary);

13           (2) the Attorney General (or the designee of the  
14 Attorney General);

15           (3) the Director of the Office of Management  
16 and Budget (or the designee of the Director); and

17           (4) a representative of the Federal Trade Com-  
18 mission.

19           (b) DUTIES.—The duties of the Advisory Committee  
20 are—

21           (1) to discuss and evaluate competition and  
22 antitrust policy, and their implications with respect  
23 to the performance of health care markets;

24           (2) to analyze the effectiveness of health care  
25 joint ventures receiving exemptions under the pro-

1       gram established under section 1201(a) or certifi-  
2       cates under section 1202 in reducing the costs of  
3       and expanding access to the health care services that  
4       are the subject of such ventures; and

5               (3) to make such recommendations to Congress  
6       not later than 2 years after the date of the enact-  
7       ment of this Act (and at such subsequent periods as  
8       the Advisory Committee considers appropriate) re-  
9       garding modifications to the program established  
10      under section 1201(a) or to section 1202 as the Ad-  
11      visory Committee considers appropriate, including  
12      modifications relating to the costs to health care  
13      providers of obtaining an exemption for a joint ven-  
14      ture under such program.

15 **SEC. 1204. DEFINITIONS.**

16       For purposes of this title:

17               (1) The term “Advisory Committee” means the  
18       Interagency Advisory Committee on Competition,  
19       Antitrust Policy, and Health Care established under  
20       section 1203.

21               (2) The term “antitrust laws”—

22                       (A) has the meaning given it in subsection  
23                       (a) of the first section of the Clayton Act (15  
24                       U.S.C. 12(a)), except that such term includes  
25                       section 5 of the Federal Trade Commission Act

1 (15 U.S.C. 45) to the extent such section ap-  
2 plies to unfair methods of competition; and

3 (B) includes any State law similar to the  
4 laws referred to in subparagraph (A).

5 (3) The term “certificate” means a certificate  
6 of public advantage authorized to be issued under  
7 section 1202(a).

8 (4) The term “health care joint venture” means  
9 an agreement (whether existing or proposed) be-  
10 tween 2 or more providers of health care services  
11 that is entered into solely for the purpose of sharing  
12 in the provision of health care services and that in-  
13 volves substantial integration or financial risk-shar-  
14 ing between the parties, but does not include the ex-  
15 changing of information, the entering into of any  
16 agreement, or the engagement in any other conduct  
17 that is not reasonably required to carry out such  
18 agreement.

19 (5) The term “health care services” includes  
20 services related to the delivery or administration of  
21 health care services.

22 (6) The term “liable” means liable for any civil  
23 or criminal violation of the antitrust laws.

24 (7) The term “provider of health care services”  
25 means any individual or entity that is engaged in the

1 delivery of health care services in a State and that  
2 is required by State law or regulation to be licensed  
3 or certified by the State to engage in the delivery of  
4 such services in the State.

5 **TITLE XIII—EXPENDITURE TAR-**  
6 **GETS FOR THE MEDICAID**  
7 **AND MEDICARE PROGRAMS**

8 **SEC. 1301. DETERMINATION OF EXPENDITURES UNDER**  
9 **THE MEDICAID AND MEDICARE PROGRAMS.**

10 (a) DETERMINATION OF EXCESS EXPENDITURES.—

11 (1) IN GENERAL.—Not later than 30 days after  
12 the end of each fiscal year beginning with fiscal year  
13 1995, the Director of the Office of Management and  
14 Budget (hereafter referred to in this title as the  
15 “Director”), in consultation with the Secretary, shall  
16 determine the amount of medicaid excess expendi-  
17 tures and medicare excess expenditures for such fis-  
18 cal year.

19 (2) DEFINITIONS.—For purposes of this title—

20 (A) MEDICAID EXCESS EXPENDITURES.—

21 The term “medicaid excess expenditures” for a  
22 fiscal year means the amount by which the Fed-  
23 eral expenditures under the medicaid program  
24 for such fiscal year exceed the target expendi-

1           ture for such program as determined under  
2           subsection (b)(1) for such fiscal year.

3           (B) MEDICARE EXCESS EXPENDITURES.—  
4           The term “medicare excess expenditures” for a  
5           fiscal year means the amount by which the ex-  
6           penditures under the medicare program for  
7           such fiscal year exceed the target expenditure  
8           for such program as determined under sub-  
9           section (b)(2) for such fiscal year.

10          (C) MEDICAID PROGRAM.—The term  
11          “medicaid program” means the program under  
12          title XIX of the Social Security Act.

13          (D) MEDICARE PROGRAM.—The term  
14          “medicare program” means the program under  
15          title XVIII of the Social Security Act.

16       (b) TARGET EXPENDITURES.—

17           (1) MEDICAID PROGRAM.—

18           (A) IN GENERAL.—The target expenditure  
19           determined under this paragraph for the medic-  
20           aid program for a fiscal year shall be an  
21           amount equal to the applicable percentage of  
22           the total Federal expenditures under the medic-  
23           aid program for the previous fiscal year.

1 (B) MEDICAID APPLICABLE PERCENT-  
2 AGE.—For purposes of subparagraph (A), the  
3 medicaid applicable percentage is—

4 (i) 106.8 percent for the determina-  
5 tion with respect to fiscal year 1995;

6 (ii) 106.9 percent for the determina-  
7 tion with respect to fiscal year 1996; and

8 (iii) 107 percent for the determination  
9 with respect to fiscal year 1997 and suc-  
10 ceeding fiscal years.

11 (2) MEDICARE PROGRAM.—

12 (A) IN GENERAL.—The target expenditure  
13 determined under this paragraph for the medi-  
14 care program for a fiscal year shall be an  
15 amount equal to the applicable percentage of  
16 the total expenditures under the medicare pro-  
17 gram for the previous fiscal year.

18 (B) MEDICARE APPLICABLE PERCENT-  
19 AGE.—For purposes of subparagraph (A), the  
20 medicare applicable percentage is—

21 (i) 109.4 percent for the determina-  
22 tion with respect to fiscal year 1995;

23 (ii) 108.9 percent for the determina-  
24 tion with respect to fiscal year 1996;

- 1 (iii) 108.5 percent for the determina-  
2 tion with respect to fiscal year 1997; and  
3 (iv) 108 percent for the determination  
4 with respect to fiscal year 1998 and suc-  
5 ceeding fiscal years.

6 **SEC. 1302. DELAY OF HEALTH INSURANCE BENEFITS DUE**  
7 **TO EXCESS EXPENDITURES.**

8 (a) IN GENERAL.—If the Director determines that  
9 there are medicaid or medicare excess expenditures for a  
10 fiscal year under section 1301, any category of health in-  
11 surance benefit described in subsection (b) that is effective  
12 in the taxable or calendar year (whichever is applicable)  
13 beginning after such fiscal year may be delayed until the  
14 following year. This subsection shall be applied only to so  
15 many of the categories of health insurance benefits de-  
16 scribed in subsection (b) in the order in which such cat-  
17 egories are listed such that the savings resulting from such  
18 delay at least equal the costs of the medicaid and medicare  
19 excess expenditures.

20 (b) HEALTH INSURANCE BENEFITS.—The categories  
21 of health insurance benefits described in this subsection  
22 are as follows:

- 23 (1) The tax credit under section 34A of the In-  
24 ternal Revenue Code of 1986 applicable to individ-

1 uals described in subparagraphs (C) and (D) of sec-  
2 tion 34A(g)(1).

3 (2) The tax credit under section 34A of the In-  
4 ternal Revenue Code of 1986 applicable to individ-  
5 uals described in subparagraph (B) of section  
6 34A(g)(1).

7 (3) The tax credit under section 34A of the In-  
8 ternal Revenue Code of 1986 applicable to individ-  
9 uals described in subparagraph (A) of section  
10 34A(g)(1).

11 (4) The tax exclusion under section 106A of the  
12 Internal Revenue Code of 1986.

13 (5) Assistance to individuals with preexisting  
14 conditions in purchasing health insurance under sec-  
15 tion 501.

○