

103^D CONGRESS
2^D SESSION

H. R. 4840

To provide for reform of health insurance, including tax benefits relating to health insurance and medical malpractice and antitrust reform.

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 1994

Mr. SAM JOHNSON of Texas (for himself, Mr. DOOLITTLE, and Mr. HUTCHINSON) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Education and Labor, Ways and Means, and the Judiciary

A BILL

To provide for reform of health insurance, including tax benefits relating to health insurance and medical malpractice and antitrust reform.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 (a) SHORT TITLE.—This Act may be cited as “The
5 Prescription for Health Act of 1994”.

6 (b) TABLE OF CONTENTS.—

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1 **TITLE I—INSURANCE REFORMS**
2 **Subtitle A—Reform of Insured Mar-**
3 **ket for Employers and Individ-**
4 **uals**

5 **PART 1—GENERAL REFORMS**

6 **SEC. 101. ASSURANCE OF RENEWABILITY OF COVERAGE.**

7 (a) IN GENERAL.—An insurer may not cancel cov-
8 erage or deny renewal of coverage of health insurance with
9 respect to an employer or an individual other than—

10 (1) for nonpayment of premiums,

11 (2) for fraud or other misrepresentations,

12 (3) for noncompliance with plan provisions, or

13 (4) because the insurer is ceasing to provide
14 any health insurance in the State, or, in the case of
15 a health maintenance organization, in a geographic
16 area with respect to employer or individuals, respec-
17 tively.

18 (b) LIMITATION ON MARKET REENTRY.—If an in-
19 surer terminates the offering of health insurance plans in
20 an area with respect to the market for employers or indi-
21 viduals, the insurer may not offer such a health insurance
22 plan to any employer or individual, respectively, in the
23 area until 5 years after the date of the termination.

1 **SEC. 102. LIMITATION ON ANNUAL PREMIUM INCREASES.**

2 An insurer may not provide for an increase in the
3 premium charged an employer or an individual for health
4 insurance in a percentage that exceeds the percentage
5 change in the premium charged any other employer or in-
6 dividual with the same characteristics, for similar benefits,
7 and for the same area.

8 **SEC. 103. ASSURANCE OF CONTINUITY OF COVERAGE.**

9 (a) IN GENERAL.—No insurer shall deny health in-
10 surance coverage to any employer or individual, and no
11 sponsor of a group health plan shall deny coverage to an
12 eligible individual, on the basis of health status or pre-
13 existing condition, if the employer or individual was cov-
14 ered by health insurance or a group health plan for the
15 same condition by another insurer or group health plan
16 for a period of not less than 12 months within the 15-
17 month period ending with the month in which the applica-
18 tion for coverage is made.

19 (b) PREEXISTING CONDITIONS.—An insurer or spon-
20 sor of a group health plan shall waive any period applica-
21 ble to a preexisting condition under health insurance or
22 a group health plan if the employer or individual was cov-
23 ered by health insurance or a group health plan for the
24 same condition by another insurer or sponsor of a group
25 health plan for a period of not less than 12 months within

1 the 15-month period ending with the month in which the
2 application for coverage is made.

3 (c) APPLICATION OF CAPACITY LIMITS.—Subsection
4 (a) shall not apply if the insurer has reached its capacity
5 to provide additional health insurance coverage and has
6 stopped providing any new health insurance coverage in
7 the State involved.

8 **SEC. 104. LIMITATION ON CONTINUATION PREMIUMS.**

9 The premium charged by an insurer with respect to
10 an employer or an individual covered under health insur-
11 ance by another insurer for a period of not less than 12
12 consecutive months may not exceed the greater of the
13 amount charged during the previous rating period or the
14 premium charged to any other employer or individual with
15 the same characteristics, for similar benefits, and for the
16 same area.

17 **SEC. 105. BASIS FOR VARIATIONS IN PREMIUMS.**

18 Nothing in sections 102 and 104 shall be construed
19 as prohibiting variations in health insurance premiums
20 among employers or individuals based on differences in
21 covered services, age, gender, family composition, geo-
22 graphic area, or group size.

23 **SEC. 106. DISCLOSURE OF RATING PRACTICES.**

24 An insurer shall upon request fully disclose all actu-
25 arial assumptions and methods used in establishing its

1 premiums for health insurance at the time it offers, or
2 renews coverage to any employer or individual.

3 **SEC. 107. ENFORCEMENT.**

4 Any insurer or sponsor of a group health plan which
5 fails to comply with the provisions of this part shall be
6 subject to a civil money penalty of \$250,000 for each indi-
7 vidual for each violation. The provisions of section 1128A
8 of the Social Security Act (other than subsections (a) and
9 (b)) shall apply to civil money penalties under this section
10 in the same manner as they apply to a penalty or proceed-
11 ing under section 1128A(a) of such Act.

12 **SEC. 108. DEFINITIONS.**

13 For purposes of this title:

14 (1)(A) The term “health insurance” means any
15 contract of health insurance, including any hospital
16 or medical service policy or certificate, hospital or
17 medical service plan contract, or health maintenance
18 organization group contract, that is provided by an
19 insurer, other than health insurance described in
20 subparagraph (B).

21 (B) The term “health insurance” does not in-
22 clude any of the following (or any combination there-
23 of):

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.

10 (v) Automobile medical-payment in-
11 surance.

12 (vi) Coverage for a specified disease
13 or illness.

14 (vii) A hospital or fixed indemnity pol-
15 icy (unless the Secretary determines that
16 such a policy provides sufficiently com-
17 prehensive coverage of a benefit so that it
18 should be treated as a health benefit plan).

19 (viii) Credit insurance.

20 (2) The term "insurer" means a licensed insur-
21 ance company, a prepaid hospital or medical service
22 plan, a health maintenance organization, or multiple
23 employer health plan (as defined in section 3(40) of
24 the Employee Retirement Income Security Act of

1 1974) regulated under State or Federal law for sol-
2 vency.

3 (3) The term “employer” has the meaning
4 given such term under section 3(5) of the Employee
5 Retirement Income Security Act of 1974.

6 (4) The term “group health plan” has the
7 meaning given such term in section 5000(b)(1) of
8 the Internal Revenue Code of 1986.

9 **SEC. 109. EFFECTIVE DATE.**

10 This part shall first apply to plan years beginning
11 after the date of the enactment of this Act.

12 **PART 2—STATE PREEMPTIONS**

13 **SEC. 111. PROHIBITION OF STATE BENEFIT MANDATE.**

14 No provision of State or local law shall apply to any
15 insurer that requires the coverage under health insurance
16 of any specific benefits, services, or categories of health
17 care, or services of any class or type of provider of health
18 care.

19 **SEC. 112. ELIMINATION OF RESTRICTIONS ON GROUP PUR-**
20 **CHASE OF INSURANCE.**

21 No provision of State or local law shall apply that
22 prohibits 2 or more employers or groups from obtaining
23 coverage under a multiple health insurance plan.

1 **SEC. 113. EFFECTIVE DATE.**

2 This part shall take effect on the date of the enact-
3 ment of this Act.

4 **Subtitle B—ERISA and Internal**
5 **Revenue Code Requirements**

6 **SEC. 131. CLARIFICATION OF ERISA PREEMPTION.**

7 (a) IN GENERAL.—Section 514(b)(6)(A) of the Em-
8 ployee Retirement Income Security Act of 1974 (29
9 U.S.C. 1144(b)(6)(A)) is amended—

10 (1) in clause (i), by striking “in the case” and
11 inserting “In the case”, and by striking in subclause
12 (ii) “, and” and inserting a period; and

13 (2) in clause (ii), by striking “in the case” and
14 inserting “In the case”, and by adding at the end
15 the following new sentence: “For purposes of this
16 clause, a State law which regulates insurance shall
17 not be treated as inconsistent with the preceding
18 sections of this title solely because such law provides
19 standards described in clause (i)(I) and provisions
20 described in clause (i)(II).”.

21 (b) EFFECTIVE DATE.—The amendments made by
22 subsection (b) shall apply to plan years beginning after
23 the date of the enactment of this Act.

1 **SEC. 132. SOLVENCY REQUIREMENTS FOR SINGLE-EM-**
2 **PLOYER PLANS.**

3 (a) IN GENERAL.—Section 609 of the Employee Re-
4 tirement Income Security Act of 1974 (29 U.S.C. 1168)
5 is amended—

6 (1) by redesignating subsection (e) as sub-
7 section (f); and

8 (2) by inserting after subsection (d) the follow-
9 ing new subsection:

10 “(e) SOLVENCY REQUIREMENTS FOR SINGLE-EM-
11 PLOYER PLANS.—

12 “(1) IN GENERAL.—The Secretary shall pre-
13 scribe by regulation—

14 “(A) solvency standards for group health
15 plans that are single-employer plans which will
16 ensure that benefits under such plans will be
17 provided in full when due, and

18 “(B) rules for monitoring and enforcing
19 compliance with such standards.

20 “(2) TREATMENT OF EXCESS OR STOP-LOSS
21 COVERAGE.—In prescribing solvency standards pur-
22 suant to paragraph (1), the Secretary shall take into
23 consideration the extent to which a plan’s potential
24 liabilities are covered by excess or stop-loss coverage.

25 “(3) ASSETS HELD IN TRUST.—For purposes of
26 complying with regulations prescribing solvency

1 standards pursuant to paragraph (1), the plan spon-
2 sor of each group health plan shall, in accordance
3 with such regulations, take such steps as are nec-
4 essary to ensure that plan assets held for the pur-
5 pose of complying with such solvency standards are
6 held in trust under the plan and are available solely
7 for such purpose.”.

8 (b) DEADLINE FOR ISSUANCE OF REGULATIONS.—
9 Not later than one year after the date of the enactment
10 of this Act, the Secretary of Labor (in consultation with
11 the Secretary of Health and Human Services) shall issue
12 final regulations carrying out the requirements of the
13 amendments made by subsection (a).

14 **SEC. 133. CLARIFICATION OF VEBA CONTRIBUTIONS.**

15 Paragraph (1) of section 419A(c) of the Internal Rev-
16 enue Code of 1986 (relating to qualified asset account;
17 limitation on additions to account) is amended by striking
18 “and” at the end of subparagraph (A), by striking the
19 period at the end of subparagraph (B) and inserting “,
20 and”, and by adding at the end the following new subpara-
21 graph:

22 “(C) in the case of an account providing
23 medical benefits, compliance with Federal or
24 State solvency requirements.”

TITLE II—TAX FAIRNESS**SEC. 201. INDIVIDUALS ALLOWED DEDUCTION FROM
GROSS INCOME FOR COST OF HEALTH INSUR-
ANCE AND CONTRIBUTIONS TO MEDICAL
SAVINGS ACCOUNTS.**

(a) IN GENERAL.—Subsection (a) of section 62 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (15) the following new paragraph:

“(16) MEDICAL EXPENSES ATTRIBUTABLE TO HEALTH PLAN COVERAGE.—

“(A) IN GENERAL.—The deduction allowed by section 213 for—

“(i) amounts paid for coverage under any health plan, and

“(ii) contributions to any medical savings account (as defined in section 7524).

“(B) EXCEPTION.—Subparagraph (A)(i) shall not apply to coverage of an individual who has coverage described in section 213(f)(3)(B).”.

(b) REVISION OF MEDICAL EXPENSE DEDUCTION.—Subsection (a) of section 213 of such Code is amended to read as follows:

“(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the amount equal to the sum of—

1 “(1) the amounts paid during the taxable year
2 for coverage of the taxpayer, his spouse, and de-
3 pendents (as defined in section 152) under any
4 health plan,

5 “(2) in the case of a taxpayer who is an eligible
6 individual (as defined in subsection (f)), the amounts
7 paid in cash during the taxable year by or on behalf
8 of such taxpayer to a medical savings account for
9 the benefit of the taxpayer, his spouse, and depend-
10 ents (as so defined) if such spouse and dependents
11 are eligible individuals, and

12 “(3) the expenses (other than expenses de-
13 scribed in paragraph (1)) paid during the taxable
14 year, not compensated by insurance or otherwise, for
15 medical care of the taxpayer, his spouse, and de-
16 pendents (as so defined) to the extent such expenses
17 exceed 7.5 percent of the adjusted gross income of
18 the taxpayer.

19 Paragraph (1) shall not apply if the taxpayer, or the
20 spouse of the taxpayer, is eligible to participate in any
21 health plan maintained by any employer of such taxpayer
22 or spouse.”

23 (c) DEFINITIONS AND SPECIAL RULES RELATING TO
24 MEDICAL SAVINGS ACCOUNTS.—Section 213 of such Code

1 is amended by adding at the end the following new sub-
2 section:

3 “(f) DEFINITIONS AND SPECIAL RULES RELATING
4 TO MEDICAL SAVINGS ACCOUNTS.—

5 “(1) ONLY 1 ACCOUNT PER FAMILY.—Except as
6 provided in regulations prescribed by this Secretary,
7 no deduction shall be allowed under subsection
8 (a)(2) for amounts paid to any medical savings ac-
9 count for the benefit of an individual, such individ-
10 ual’s spouse, or any dependent of such individual or
11 spouse if such individual, spouse, or dependent is a
12 beneficiary of any other medical savings account.

13 “(2) DOLLAR LIMITATION.—The amount allow-
14 able as a deduction under subsection (a)(2) for the
15 taxable year shall not exceed the lesser of—

16 “(A) the lowest deductible under any cata-
17 strophic health plan providing coverage to any
18 beneficiary of the medical savings account, or

19 “(B)(i) \$2,500, or

20 “(ii) \$5,000 if the catastrophic health plan
21 covering the taxpayer provides coverage for
22 more than 1 individual.

23 A beneficiary of such account who has attained age
24 65 before the close of the taxable year shall not be

1 taken into account in determining the limitation
2 under the preceding sentence.

3 “(3) ELIGIBLE INDIVIDUAL.—For purposes of
4 this subsection—

5 “(A) IN GENERAL.—The term ‘eligible in-
6 dividual’ means any individual who is covered
7 under a catastrophic health plan throughout the
8 calendar year in which or with which the tax-
9 able year ends.

10 “(B) LIMITATION.—Such term does not in-
11 clude an individual who is 65 years of age or
12 older, unless the individual is covered under a
13 catastrophic health plan that is a primary plan
14 (within the meaning of section 1862(b)(2)(A) of
15 the Social Security Act).

16 “(4) CATASTROPHIC HEALTH PLAN.—For pur-
17 poses of this subsection—

18 “(A) IN GENERAL.—The term ‘cata-
19 strophic health plan’ means a health plan cover-
20 ing specified expenses incurred by an individual
21 for medical care for such individual and the
22 spouse and dependents (as defined in section
23 152) of such individual only to the extent such
24 expenses covered by the plan for any calendar
25 year exceed \$1,800 (\$3,600 if the catastrophic

1 health plan covering the taxpayer provides cov-
2 erage for more than 1 individual) or such high-
3 er amounts as may be specified by the plan.

4 “(B) COST-OF-LIVING ADJUSTMENT.—In
5 the case of any calendar year after 1994, each
6 dollar amount in subparagraph (A) shall be in-
7 creased by an amount equal to—

8 “(i) such dollar amount, multiplied by

9 “(ii) the cost-of-living adjustment de-
10 termined under section 1(f)(3) for such
11 calendar year.

12 If any increase under the preceding sentence is
13 not a multiple of \$50, such increase shall be
14 rounded to the nearest multiple of \$50.

15 “(5) NO DEDUCTION FOR MEDICAL EXPENSES
16 PAID FROM ACCOUNT.—The amount otherwise taken
17 into account under subsection (a) as expenses paid
18 for medical care shall be reduced by the amount (if
19 any) of the distributions from any medical savings
20 account of the taxpayer during the taxable year
21 which is not includible in gross income by reason of
22 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 such
3 Code is amended by striking “or” at the end of
4 paragraph (20), by striking the period at the
5 end of paragraph (21) and inserting “; or”, and
6 by inserting after paragraph (21) the following
7 new paragraph:

8 “(22) remuneration paid to or on behalf of
9 an employee if (and to the extent that) at the
10 time of payment of such remuneration it is rea-
11 sonable to believe that a corresponding deduc-
12 tion is allowable under section 213(a)(2).”

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

19 “(19) remuneration paid to or on behalf of an
20 employee if (and to the extent that) at the time of
21 payment of such remuneration it is reasonable to be-
22 lieve that a corresponding deduction is allowable
23 under section 213(a)(2) of the Internal Revenue
24 Code of 1986.”

1 (2) RAILROAD RETIREMENT TAX.—Subsection
2 (e) of section 3231 of such Code is amended by add-
3 ing at the end thereof the following new paragraph:

4 “(10) EMPLOYER CONTRIBUTIONS TO MEDICAL
5 SAVINGS ACCOUNTS.—The term ‘compensation’ shall
6 not include any payment made to or on behalf of an
7 employee if (and to the extent that) at the time of
8 payment of such remuneration it is reasonable to be-
9 lieve that a corresponding deduction is allowable
10 under section 213(a)(2).”

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

17 “(17) remuneration paid to or on behalf of
18 an employee if (and to the extent that) at the
19 time of payment of such remuneration it is rea-
20 sonable to believe that a corresponding deduc-
21 tion is allowable under section 213(a)(2).”

22 (4) WITHHOLDING TAX.—Subsection (a) of sec-
23 tion 3401 of such Code is amended by striking “or”
24 at the end of paragraph (19), by striking the period
25 at the end of paragraph (20) and inserting “; or”,

1 and by inserting after paragraph (20) the following
2 new paragraph:

3 “(21) remuneration paid to or on behalf of
4 an employee if (and to the extent that) at the
5 time of payment of such remuneration it is rea-
6 sonable to believe that a corresponding deduc-
7 tion is allowable under section 213(a)(2).”

8 (e) REFUNDABLE INCOME TAX CREDIT EQUIVALENT
9 TO EXEMPTION FROM FICA TAXES FOR
10 NONEMPLOYMENT-RELATED PURCHASES OF HEALTH
11 PLAN COVERAGE AND CONTRIBUTIONS TO MEDICAL SAV-
12 INGS ACCOUNTS.—

13 (1) IN GENERAL.—Subpart C of part IV of sub-
14 chapter A of chapter 1 of such Code (relating to re-
15 fundable credits) is amended by redesignating sec-
16 tion 35 as section 36 and by inserting after section
17 34 the following new section:

18 **“SEC. 35. FICA TAXES ON AMOUNTS USED TO PAY FOR PUR-**
19 **CHASE OF HEALTH PLAN COVERAGE AND TO**
20 **MAKE CONTRIBUTIONS TO MEDICAL SAVINGS**
21 **ACCOUNTS.**

22 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
23 dividual, there shall be allowed as a credit against the tax
24 imposed by this subtitle for the taxable year an amount
25 equal to the allocable FICA tax for such year.

1 “(b) ALLOCABLE FICA TAX.—For purposes of this
2 section, the term ‘allocable FICA tax’ means, for any tax-
3 able year, the sum of—

4 “(1) 2.9 percent of the amounts described in
5 subsection (c) for the calendar year ending with or
6 within such taxable year, and

7 “(2) the sum of the amounts by which the taxes
8 imposed by sections 3101(a) and 3111(a) would
9 have been reduced for such calendar year if the con-
10 tribution and benefit base (as determined under sec-
11 tion 230 of the Social Security Act) for such cal-
12 endar year were reduced by the aggregate of the
13 amounts described in subsection (c).

14 “(c) AMOUNTS DESCRIBED.—

15 “(1) IN GENERAL.—The amounts described in
16 this subsection are—

17 “(A) the amounts paid for coverage of the
18 taxpayer, his spouse, and dependents (as de-
19 fined in section 152) under any health plan,
20 and

21 “(B) in the case of a taxpayer who is an
22 eligible individual (as defined in section 213(f)),
23 the amounts paid in cash by or on behalf of
24 such taxpayer to a medical savings account for
25 the benefit of the taxpayer, his spouse, and de-

1 pendents (as so defined) if such spouse and de-
2 pendents are eligible individuals.

3 Subparagraph (A) shall not apply if the taxpayer, or
4 the spouse of the taxpayer, is eligible to participate
5 in any health plan maintained by any employer of
6 such taxpayer or spouse.

7 “(2) LIMITATIONS.—

8 “(A) IN GENERAL.—An amount shall be
9 treated as not described in this subsection if the
10 taxpayer’s wages (as defined in section 3121)
11 were reduced by reason of such amount.

12 “(B) MEDICAL SAVINGS ACCOUNTS.—An
13 amount shall be treated as not described in this
14 subsection if a deduction is not allowed for such
15 amount under section 213(a)(2).”

16 (2) CONFORMING AMENDMENT.—Paragraph (2)
17 of section 1324(b) of title 31, United States Code,
18 is amended by inserting before the period “or from
19 section 35 of such Code”.

20 (3) CLERICAL AMENDMENT.—The table of sec-
21 tions for subpart C of part IV of subchapter A of
22 chapter 1 of such Code is amended by striking the
23 item relating to section 35 and inserting the follow-
24 ing:

 “Sec. 35. FICA taxes on amounts used to pay for purchase of
 health plan coverage and to make contributions to
 medical savings accounts.

“Sec. 36. Overpayments of tax.”

1 (f) CONFORMING AMENDMENT.—Section 162 of such
2 Code is amended by striking subsection (l).

3 (g) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to taxable years beginning after
5 December 31, 1994.

6 **TITLE III—MEDICAL SAVINGS**
7 **ACCOUNTS**

8 **SEC. 301. MEDICAL SAVINGS ACCOUNTS.**

9 (a) IN GENERAL.—Chapter 77 of the Internal Reve-
10 nue Code of 1986 is amended by adding at the end the
11 following new section:

12 **“SEC. 7524. MEDICAL SAVINGS ACCOUNTS.**

13 “(a) MEDICAL SAVINGS ACCOUNTS.—For purposes
14 of this title—

15 “(1) MEDICAL SAVINGS ACCOUNT.—

16 “(A) IN GENERAL.—The term ‘medical
17 savings account’ means a trust created or orga-
18 nized in the United States exclusively for the
19 purpose of paying the medical expenses of the
20 beneficiaries of such trust, but only if the writ-
21 ten governing instrument creating the trust
22 meets the following requirements:

23 “(i) Except in the case of a rollover
24 contribution described in subsection (b)(4),
25 no contribution will be accepted unless it is

1 in cash, and contributions will not be ac-
2 cepted in excess of the amount allowed as
3 a deduction under section 213(a)(2) for
4 the taxable year.

5 “(ii) The trustee is a bank (as defined
6 in section 408(n)) or another person who
7 demonstrates to the satisfaction of the
8 Secretary that the manner in which such
9 person will administer the trust will be
10 consistent with the requirements of this
11 section.

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

14 “(iv) The assets of the trust will not
15 be commingled with other property except
16 in a common trust fund or common invest-
17 ment fund.

18 “(v) The interest of an individual in
19 the balance in his account is nonforfeit-
20 able.

21 “(vi) Under regulations prescribed by
22 the Secretary, rules similar to the rules of
23 section 401(a)(9) shall apply to the dis-
24 tribution of the entire interest of bene-
25 ficiaries of such trust.

1 “(B) TREATMENT OF COMPARABLE AC-
2 COUNTS HELD BY INSURANCE COMPANIES.—
3 For purposes of this section, an account held by
4 an insurance company in the United States
5 shall be treated as a medical savings account
6 (and such company shall be treated as a bank)
7 if—

8 “(i) such account is part of a health
9 insurance plan that includes a catastrophic
10 health plan (as defined in section
11 213(f)(4)),

12 “(ii) such account is exclusively for
13 the purpose of paying the medical expenses
14 of the beneficiaries of such account who
15 are covered under such catastrophic health
16 plan, and

17 “(iii) the written instrument govern-
18 ing the account meets the requirements of
19 clauses (i), (v), and (vi) of subparagraph
20 (A).

21 “(2) MEDICAL EXPENSES.—The term ‘medical
22 expenses’ means, with respect to an individual,
23 amounts paid or incurred by such individual for—

24 “(A) medical care (as defined in section
25 213), or

1 “(B) long-term care (as defined in para-
2 graph (3)),
3 for such individual, the spouse of such individual,
4 and any dependent (as defined in section 152) of
5 such individual, but only to the extent such amounts
6 are not compensated for by insurance or otherwise.

7 “(3) LONG-TERM CARE.—

8 “(A) IN GENERAL.—The term ‘long-term
9 care’ means diagnostic, preventive, therapeutic,
10 rehabilitative, maintenance, or personal care
11 services which are required by, and provided to,
12 a chronically ill individual, which have as their
13 primary purpose the direct provision of needed
14 assistance with 1 or more activities of daily liv-
15 ing (or the alleviation of the conditions neces-
16 sitating such assistance) that the individual is
17 certified under subparagraph (B) as being un-
18 able to perform, and which are provided in a
19 setting other than an acute care unit of a hos-
20 pital pursuant to a continuing plan of care pre-
21 scribed by a physician or registered professional
22 nurse. Such term does not include food or lodg-
23 ing provided in an institutional or other setting,
24 or basic living services associated with the
25 maintenance of a household or participation in

1 community life, such as case management,
2 transportation or legal services, or the perform-
3 ance of home maintenance or household chores.

4 “(B) CHRONICALLY ILL INDIVIDUAL.—The
5 term ‘chronically ill individual’ means an indi-
6 vidual who is certified by a physician or reg-
7 istered professional nurse as being unable to
8 perform at least 3 activities of daily living with-
9 out substantial assistance from another individ-
10 ual. For purposes of this paragraph, the term
11 ‘activities of daily living’ means bathing, dress-
12 ing, eating, toileting, transferring, and walking.

13 “(4) TIME WHEN CONTRIBUTIONS DEEMED
14 MADE.—A contribution shall be deemed to be made
15 on the last day of the preceding taxable year if the
16 contribution is made on account of such taxable year
17 and is made not later than the time prescribed by
18 law for filing the return for such taxable year (not
19 including extensions thereof).

20 “(b) TAX TREATMENT OF DISTRIBUTIONS.—

21 “(1) IN GENERAL.—Any amount paid or dis-
22 tributed out of a medical savings account shall be in-
23 cluded in the gross income of the individual for
24 whose benefit such account was established unless

1 such amount is used exclusively to pay the medical
2 expenses of such individual.

3 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
4 FORE DUE DATE OF RETURN.—Paragraph (1) shall
5 not apply to the distribution of any contribution paid
6 during a taxable year to a medical savings account
7 to the extent that such contribution exceeds the
8 amount allowable as a deduction under section
9 213(a)(2) if—

10 “(A) such distribution is received by the
11 individual on or before the last day prescribed
12 by law (including extensions of time) for filing
13 such individual’s return for such taxable year,
14 and

15 “(B) such distribution is accompanied by
16 the amount of net income attributable to such
17 excess contribution.

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

21 “(3) PENALTY FOR DISTRIBUTIONS NOT USED
22 FOR MEDICAL EXPENSES.—

23 “(A) IN GENERAL.—The tax imposed by
24 chapter 1 for any taxable year in which there
25 is a payment or distribution from a medical

1 savings account which is not used to pay the
2 medical expenses of the individual for whose
3 benefit the account was established shall be in-
4 creased by 10 percent of the amount of such
5 payment or distribution which is includible in
6 gross income under paragraph (1).

7 “(B) ACCOUNT BALANCE LIMITATION.—

8 If—

9 “(i) the tax imposed by this chapter is
10 required to be increased under subpara-
11 graph (A) by reason of a distribution, and

12 “(ii) after such distribution, the ag-
13 gregate balance of all medical savings ac-
14 counts established for the benefit of the in-
15 dividual, is less than the amount of the de-
16 ductible under the catastrophic health plan
17 covering such individual,

18 subparagraph (A) shall be applied by substitut-
19 ing ‘50 percent’ for ‘10 percent’.

20 “(4) ROLLOVERS.—Paragraph (1) shall not
21 apply to any amount paid or distributed out of a
22 medical savings account to the individual for whose
23 benefit the account is maintained if the entire
24 amount received (including money and any other
25 property) is paid into another medical savings ac-

1 count for the benefit of such individual not later
2 than the 60th day after the day on which he received
3 the payment or distribution.

4 “(5) PENALTY FOR MANDATORY DISTRIBUTIONS NOT MADE FROM ACCOUNT.—

5
6 “(A) IN GENERAL.—If during any taxable
7 year—

8 “(i) there is a payment of a manda-
9 tory distribution expense incurred by a
10 beneficiary of a medical savings account,
11 and

12 “(ii) the person making such payment
13 is not reimbursed for such payment with a
14 distribution from such account before the
15 60th day after such payment,

16 the taxpayer’s tax imposed by this chapter for
17 such taxable year shall be increased by 100 per-
18 cent of the excess of the amount of such pay-
19 ment over the amount of reimbursement made
20 before such 60th day.

21 “(B) MANDATORY DISTRIBUTION EX-
22 PENSE.—For purposes of subparagraph (A),
23 the term ‘mandatory distribution expense’
24 means any expense incurred which may be
25 counted towards a deductible, or for a

1 copayment or coinsurance, under the cata-
2 strophic health plan covering such beneficiary.

3 “(c) TAX TREATMENT OF ACCOUNTS.—

4 “(1) EXEMPTION FROM TAX.—Any medical sav-
5 ings account is exempt from taxation under this sub-
6 title unless such account has ceased to be a medical
7 savings account by reason of paragraph (2) or (3).
8 Notwithstanding the preceding sentence, any such
9 account shall be subject to the taxes imposed by sec-
10 tion 511 (relating to imposition of tax on unrelated
11 business income of charitable, etc. organizations).

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

14 “(A) IN GENERAL.—If, during any taxable
15 year of the individual for whose benefit the
16 medical savings account was established, such
17 individual engages in any transaction prohibited
18 by section 4975 with respect to the account, the
19 account ceases to be a medical savings account
20 as of the first day of that taxable year.

21 “(B) ACCOUNT TREATED AS DISTRIBUTING
22 ALL ITS ASSETS.—In any case in which any ac-
23 count ceases to be a medical savings account by
24 reason of subparagraph (A) on the first day of
25 any taxable year, paragraph (1) of subsection

1 (b) shall be applied as if there were a distribu-
2 tion on such first day in an amount equal to
3 the fair market value (on such first day) of all
4 assets in the account (on such first day) and no
5 portion of such distribution were used to pay
6 medical expenses.

7 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
8 RITY.—If, during any taxable year, the individual for
9 whose benefit a medical savings account was estab-
10 lished uses the account or any portion thereof as se-
11 curity for a loan, the portion so used is treated as
12 distributed to that individual and not used to pay
13 medical expenses.

14 “(d) CUSTODIAL ACCOUNTS.—For purposes of this
15 section, a custodial account shall be treated as a trust if—

16 “(1) the assets of such account are held by a
17 bank (as defined in section 408(n)) or another per-
18 son who demonstrates to the satisfaction of the Sec-
19 retary that the manner in which he will administer
20 the account will be consistent with the requirements
21 of this section, and

22 “(2) the custodial account would, except for the
23 fact that it is not a trust, constitute a medical sav-
24 ings account described in subsection (a).

1 For purposes of this title, in the case of a custodial ac-
2 count treated as a trust by reason of the preceding sen-
3 tence, the custodian of such account shall be treated as
4 the trustee thereof.

5 “(e) REPORTS.—The trustee of a medical savings ac-
6 count shall make such reports regarding such account to
7 the Secretary and to the individual for whose benefit the
8 account is maintained with respect to contributions, dis-
9 tributions, and such other matters as the Secretary may
10 require under regulations. The reports required by this
11 subsection shall be filed at such time and in such manner
12 and furnished to such individuals at such time and in such
13 manner as may be required by those regulations.”

14 (b) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
15 of such Code (relating to tax on excess contributions to
16 individual retirement accounts, certain section 403(b) con-
17 tracts, and certain individual retirement annuities) is
18 amended—

19 (1) by inserting “**MEDICAL SAVINGS AC-**
20 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
21 such section,

22 (2) by redesignating paragraph (2) of sub-
23 section (a) as paragraph (3) and by inserting after
24 paragraph (1) the following:

1 “(2) a medical savings account (within the
2 meaning of section 7524(a)),”,

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

5 (4) by adding at the end thereof the following
6 new subsection:

7 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS
8 ACCOUNTS.—For purposes of this section, in the case of
9 a medical savings account (within the meaning of section
10 7524(a)), the term ‘excess contributions’ means the
11 amount by which the amount contributed for the taxable
12 year to the account exceeds the amount allowable as a de-
13 duction under section 213(a)(2) for such taxable year. For
14 purposes of this subsection, any contribution which is dis-
15 tributed out of the medical savings account in a distribu-
16 tion to which section 7524(b)(2) applies shall be treated
17 as an amount not contributed.”

18 (c) TAX ON PROHIBITED TRANSACTIONS.—Section
19 4975 of such Code (relating to prohibited transactions)
20 is amended—

21 (1) by adding at the end of subsection (c) the
22 following new paragraph:

23 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
24 COUNTS.—An individual for whose benefit a medical
25 savings account (within the meaning of section

1 7524(a)) is established shall be exempt from the tax
2 imposed by this section with respect to any trans-
3 action concerning such account (which would other-
4 wise be taxable under this section) if, with respect
5 to such transaction, the account ceases to be a medi-
6 cal savings account by reason of the application of
7 section 7524(b)(2)(A) to such account.”, and

8 (2) by inserting “or a medical savings account
9 described in section 7524(a)” in subsection (e)(1)
10 after “described in section 408(a)”.

11 (d) FAILURE TO PROVIDE REPORTS ON MEDICAL
12 SAVINGS ACCOUNTS.—Section 6693 of such Code (relat-
13 ing to failure to provide reports on individual retirement
14 account or annuities) is amended—

15 (1) by inserting “**OR ON MEDICAL SAVINGS**
16 **ACCOUNTS**” after “**ANNUITIES**” in the heading of
17 such section, and

18 (2) by adding at the end of subsection (a) the
19 following: “The person required by section 7524(e)
20 to file a report regarding a medical savings account
21 at the time and in the manner required by such sec-
22 tion shall pay a penalty of \$50 for each failure un-
23 less it is shown that such failure is due to reasonable
24 cause.”

25 (e) CLERICAL AMENDMENTS.—

1 (1) The table of sections for chapter 77 of such
2 Code is amended by adding at the end the following:

“Sec. 7524. Medical savings accounts.”

3 (2) The table of sections for chapter 43 of such
4 Code is amended by striking the item relating to sec-
5 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.”

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

10 (f) EFFECTIVE DATE.—The amendments made by
11 this section shall apply to taxable years beginning after
12 December 31, 1994.

13 **TITLE IV—MEDICAL** 14 **MALPRACTICE**

15 **SEC. 401. APPLICABILITY AND PREEMPTION.**

16 (a) APPLICABILITY.—This title shall apply with re-
17 spect to any medical malpractice liability claim and to any
18 medical malpractice liability action brought in any State
19 or Federal court, except that this title shall not apply to
20 a claim or action for damages arising from a vaccine-relat-
21 ed injury or death to the extent that title XXI of the Pub-
22 lic Health Service Act applies to the claim or action.

1 (b) PREEMPTION.—

2 (1) IN GENERAL.—The provisions of this title
3 shall preempt any State or local law to the extent
4 such law is inconsistent with the limitations con-
5 tained in such provisions. The provisions of this title
6 shall not preempt any State law that provides for
7 defenses or places limitations on a person’s liability
8 in addition to those contained in this title, places
9 greater limitations on the amount of attorneys’ fees
10 and expenses that can be collected, or otherwise im-
11 poses greater restrictions than those provided in this
12 title.

13 (2) NEGOTIATED LIABILITY.—The provisions of
14 this title shall preempt any Federal, State or local
15 law to the extent that such law prohibits a health
16 care provider and a purchaser of health care from
17 voluntarily entering into a contractual agreement in
18 which the provider offers reduced fees for medical
19 services in exchange for a prearranged limit on the
20 amount of any award in a medical malpractice liabil-
21 ity action resulting from the provision of such serv-
22 ices or a limit on the cause of action that may be
23 maintained with respect to such services.

1 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
2 OF LAW OR VENUE.—Nothing in subsection (b) shall be
3 construed to—

4 (1) waive or affect any defense of sovereign im-
5 munity asserted by any State under any provision of
6 law;

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

9 (3) affect the applicability of any provision of
10 the Foreign Sovereign Immunities Act of 1976;

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

14 (5) affect the right of any court to transfer
15 venue or to apply the law of a foreign nation or to
16 dismiss a claim of a foreign nation or of a citizen
17 of a foreign nation on the ground of inconvenient
18 forum.

19 (d) FEDERAL COURT JURISDICTION NOT ESTAB-
20 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in
21 this title shall be construed to establish any jurisdiction
22 in the district courts of the United States over medical
23 malpractice liability actions on the basis of section 1331
24 or 1337 of title 28, United States Code.

1 **SEC. 402. STATUTE OF LIMITATIONS.**

2 (a) IN GENERAL.—Except as provided in subsection
3 (b), no medical malpractice liability action shall be initi-
4 ated after the expiration of the 2-year period that begins
5 on the later of the date that the alleged injury that is the
6 subject of the claim was discovered, or the date on which
7 such injury should reasonably have been discovered. In no
8 event shall any such action be initiated after the expiration
9 of the 4-year period that begins on the date on which the
10 alleged injury occurred.

11 (b) EXCEPTION FOR CERTAIN MINORS.—In the case
12 of an alleged injury suffered by a minor who has not at-
13 tained 6 years of age, no medical malpractice liability ac-
14 tion shall be initiated after the expiration of the 2-year
15 period that begins on the date on which the alleged injury
16 was discovered, or the date on which such injury should
17 reasonably have been discovered. In no event shall any
18 such action be initiated after the expiration of the 4-year
19 period that begins on the date on which the alleged injury
20 occurred, or the date on which the minor attains 8 years
21 of age, whichever is later.

22 **SEC. 403. SCOPE OF LIABILITY.**

23 (a) IN GENERAL.—With respect to economic and
24 noneconomic damages, the liability of each defendant in
25 a medical malpractice liability action shall be several only
26 and may not be joint. Such a defendant shall be liable

1 only for the amount of economic or noneconomic damages
2 allocated to the defendant in direct proportion to such de-
3 fendant's percentage of fault or responsibility for the in-
4 jury suffered by the claimant.

5 (b) DETERMINATION OF PERCENTAGE OF LIABIL-
6 ITY.—The trier of fact in a medical malpractice liability
7 action shall determine the extent of each defendant's fault
8 or responsibility for the economic or noneconomic damages
9 suffered by the claimant, and shall assign a percentage
10 of responsibility for such injury to each such defendant.

11 **SEC. 404. LIMITATION ON NONECONOMIC DAMAGES.**

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

19 **SEC. 405. TREATMENT OF PAYMENTS FOR FUTURE ECO-**
20 **NOMIC LOSSES.**

21 (a) PROHIBITING SINGLE LUMP-SUM PAYMENT.—In
22 any medical malpractice liability action in which the dam-
23 ages awarded for any economic losses to be incurred after
24 the date on which the judgment is entered exceeds
25 \$100,000, a defendant may not be required to pay such

1 damages in a single, lump-sum payment, but shall be per-
2 mitted to make such payments periodically based on pro-
3 jections of the amount of damages expected to be incurred
4 by the claimant at appropriate intervals, as determined by
5 the court.

6 (b) USE OF ANNUITIES OR TRUSTS.—The court may
7 require that a defendant in a medical malpractice liability
8 action purchase an annuity or fund a reversionary trust
9 to make periodic payments under subsection as provided
10 for in subsection (a) if the court determines that a reason-
11 able basis exists for concluding that the defendant may
12 be unable or otherwise fail to make the required periodic
13 payments.

14 (c) REQUIREMENT OF PERIODIC PAYMENT AS FINAL
15 ORDER.—A judgment of a court awarding periodic pay-
16 ments under this section may not be reopened at any time
17 to contest, amend, or modify the schedule or amount of
18 the payments in the absence of fraud or any other basis
19 under which a party may obtain relief from a final judg-
20 ment.

21 **SEC. 406. TREATMENT OF COSTS AND ATTORNEY'S FEES.**

22 (a) COURT DISCRETION.—A court in a medical mal-
23 practice liability action may, as a condition of the initi-
24 ation of such an action, require an undertaking for the

1 payment of the costs associated with such action, includ-
2 ing reasonable attorneys' fees.

3 (b) PAYMENT OF COSTS.—If a judgment in a medical
4 malpractice liability action is rendered against a party to
5 such action, upon a motion by the prevailing party to such
6 action, the court shall require the party against whom the
7 judgment was rendered to pay to such prevailing party
8 the costs and fees incurred by such prevailing party under
9 the action, including reasonable attorneys' fees and other
10 expenses. The court may waive the application of this
11 paragraph if the court finds that the position maintained
12 by the party against whom such judgment was rendered
13 under such action was substantially justified or that spe-
14 cial circumstances make such an award unjust.

15 (c) APPLICATION FOR RECOVERY OF COSTS.—A
16 party to a medical malpractice liability action who is seek-
17 ing an award of costs and fees as provided for in sub-
18 section (b) shall, not later than 30 days after the date
19 on which the final, nonappealable judgment is entered
20 with respect to such action, submit to the appropriate
21 court an application for the recovery of costs and fees.
22 Such application shall contain—

23 (1) a certification that the submitting party is
24 a prevailing party and is eligible to receive costs and
25 fees under subsection (b);

1 (2) a description of the amount of costs and
2 fees sought, including an itemized statement from
3 any attorney or expert witness representing or ap-
4 pearing on behalf of such party stating the actual
5 time expended and the rate at which fees and other
6 expenses were computed; and

7 (3) a description of the reasons why the posi-
8 tion of the party against whom the judgment was
9 rendered was not substantially justified.

10 In determining whether or not the position of the
11 nonprevailing party was substantially justified the court
12 shall consider only the record presented in the action
13 maintained for the costs and fees.

14 (d) AMOUNT OF AWARD.—In making a decision on
15 an application submitted under subsection (c), the court
16 may—

17 (1) assess the amount to be awarded under this
18 section against the party against whom the judg-
19 ment was rendered or against the attorney (or attor-
20 neys) of such party; and

21 (2) reduce the amount to be awarded pursuant
22 to this section, or deny an award, to the extent that
23 the prevailing party, during the course of the pro-
24 ceedings, engaged in conduct which unnecessarily
25 and unreasonably lengthened the time for, or in-

1 creased the costs of, the final resolution of the mat-
2 ter in controversy.

3 **SEC. 407. COLLATERAL SOURCES.**

4 (a) IN GENERAL.—The total amount of damages re-
5 ceived by a claimant in a medical malpractice liability ac-
6 tion shall be reduced, in accordance with subsection (b),
7 by any other payment that has been made, or that will
8 be made, to such claimant to compensate such claimant
9 for an injury that was part of such action, including
10 payments—

11 (1) under Federal or State disability or sickness
12 programs;

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

15 (3) under private disability insurance programs;

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

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

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

23 (1) the total amount of any payments (other
24 than such award) that have been made, or that will

1 be made, to such claimant to compensate such
2 claimant for such injury; and

3 (2) the amount paid by such claimant (or by
4 the spouse, parent, or legal guardian of such claim-
5 ant) to secure the payments described in paragraph
6 (1).

7 **SEC. 408. DAMAGES RELATING TO MEDICAL PRODUCT**
8 **LIABILITY CLAIMS.**

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

12 (1) the drug or device that is the subject of
13 such claim—

14 (A) was subject to approval under section
15 505, or premarket approval under section 515,
16 of the Federal Food, Drug, and Cosmetic Act
17 by the Food and Drug Administration with re-
18 spect to—

19 (i) the safety of the formulation or
20 performance of the aspect of the drug or
21 device; or

22 (ii) the adequacy of the packaging or
23 labeling of the drug or device, and

24 (B) was approved by the Food and Drug
25 Administration; or

1 (2) the drug or device is generally recognized as
2 safe and effective pursuant to conditions established
3 by the Food and Drug Administration and applica-
4 ble regulations, including packaging and labeling
5 regulations.

6 (b) EXCEPTION IN CASE OF WITHHELD INFORMA-
7 TION, MISREPRESENTATION, OR ILLEGAL PAYMENT.—
8 The provisions of subsection (a) shall not apply if it is
9 determined on the basis of clear and convincing evidence
10 that the medical product producer—

11 (1) withheld from or misrepresented to the
12 Food and Drug Administration information concern-
13 ing such drug or device that is required to be sub-
14 mitted under the Federal Food, Drug, and Cosmetic
15 Act or section 352 of the Public Health Service Act
16 and that is material and relevant to the action in-
17 volved; or

18 (2) made an illegal payment to an official of the
19 Food and Drug Administration for the purpose of
20 securing approval of the drug or device.

21 (c) DEFINITION.—As used in this section, the term
22 “clear and convincing evidence” is that measure or degree
23 of proof that will produce in the mind of the trier of fact
24 a firm belief or conviction as to the truth of the allegations
25 sought to be established, except that such measure or de-

1 gree of proof is more than that required under preponder-
2 ance of the evidence, but less than that required for proof
3 beyond a reasonable doubt.

4 **SEC. 409. DEFINITIONS.**

5 (1) CLAIMANT.—The term “claimant” means
6 any person who alleges a medical malpractice liabil-
7 ity claim, and any person on whose behalf such a
8 claim is alleged, including the decedent in the case
9 of an action brought through or on behalf of an
10 estate.

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

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

21 (4) HEALTH CARE PROFESSIONAL.—The term
22 “health care professional” means any individual who
23 provides health care services in a State and who is
24 required by the laws or regulations of the State to

1 be licensed or certified by the State to provide such
2 services in the State.

3 (5) HARM.—The term “harm” means—

4 (A) the personal physical illness, injury, or
5 death of a claimant;

6 (B) the mental anguish or emotional harm
7 of a claimant that is caused by or causing the
8 claimant personal physical illness or injury; or

9 (C) the physical damage caused by a medi-
10 cal product to property other than the medical
11 product itself.

12 Such term does not include commercial loss or loss
13 or damage to a medical product.

14 (6) HEALTH CARE PROVIDER.—The term
15 “health care provider” means any organization or
16 institution that is engaged in the delivery of health
17 care services in a State and that is required by the
18 laws or regulations of the State to be licensed or cer-
19 tified by the State to engage in the delivery of such
20 services in the State.

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

1 (8) MEDICAL MALPRACTICE LIABILITY AC-
2 TION.—The term “medical malpractice liability ac-
3 tion” means a civil action brought in a State or Fed-
4 eral court against a health care provider or health
5 care professional in which the plaintiff alleges a
6 medical malpractice liability claim, but does not in-
7 clude any action in which the plaintiff’s sole allega-
8 tion is an allegation of an intentional tort.

9 (9) MEDICAL MALPRACTICE LIABILITY
10 CLAIM.—The term “medical malpractice liability
11 claim” means a claim in which the claimant alleges
12 that injury was caused by the provision of (or the
13 failure to provide) health care services or the use of
14 a medical product.

15 (10) MEDICAL PRODUCT.—

16 (A) IN GENERAL.—The term “medical
17 product” means, with respect to the allegation
18 of a claimant, a drug (as defined in section
19 201(g)(1) of the Federal Food, Drug, and Cos-
20 metic Act (21 U.S.C. 321(g)(1)) or a medical
21 device (as defined in section 201(h) of the Fed-
22 eral Food, Drug, and Cosmetic Act (21 U.S.C.
23 321(h)) if—

24 (i) such drug or device was subject to
25 premarket approval under section 505,

1 507, or 515 of the Federal Food, Drug,
2 and Cosmetic Act (21 U.S.C. 355, 357, or
3 360e) or section 351 of the Public Health
4 Service Act (42 U.S.C. 262) with respect
5 to the safety of the formulation or per-
6 formance of the aspect of such drug or de-
7 vice which is the subject of the claimant's
8 allegation or the adequacy of the packag-
9 ing or labeling of such drug or device, and
10 such drug or device is approved by the
11 Food and Drug Administration; or

12 (ii) the drug or device is generally rec-
13 ognized as safe and effective under regula-
14 tions issued by the Secretary of Health
15 and Human Services under section 201(p)
16 of the Federal Food, Drug, and Cosmetic
17 Act (21 U.S.C. 321(p)).

18 (B) EXCEPTION IN CASE OF MISREPRE-
19 SENTATION OR FRAUD.—Notwithstanding sub-
20 paragraph (A), the term “medical product”
21 shall not include any product described in such
22 subparagraph if the claimant shows that the
23 product is approved by the Food and Drug Ad-
24 ministration for marketing as a result of with-

1 held information, misrepresentation, or an ille-
2 gal payment by manufacturer of the product.

3 (11) NONECONOMIC DAMAGES.—The term
4 “noneconomic damages” means damages paid to
5 compensate an individual for losses for physical and
6 emotional pain, suffering, inconvenience, physical
7 impairment, mental anguish, emotional distress, dis-
8 figurement, loss of enjoyment of life, loss of society
9 and companionship, loss of consortium, injury to
10 reputation, humiliation, and other noneconomic in-
11 jury.

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

16 **SEC. 410. EFFECTIVE DATE.**

17 This title shall apply to all medical malpractice liabil-
18 ity actions commenced on or after the date of enactment
19 of this Act.

20 **TITLE V—ANTITRUST REFORM**

21 **SEC. 501. PUBLICATION OF ANTITRUST GUIDELINES ON**
22 **ACTIVITIES OF HEALTH PLANS.**

23 (a) IN GENERAL.—The Attorney General shall pro-
24 vide for the development and publication of explicit guide-
25 lines on the application of antitrust laws to the activities

1 of health plans. The guidelines shall be designed to facili-
2 tate the development and operation of plans, consistent
3 with the antitrust laws.

4 (b) REVIEW PROCESS.—The Attorney General shall
5 establish a review process under which the administrator
6 or sponsor of a health plan (or organization that proposes
7 to administer or sponsor a health plan) may submit a re-
8 quest to Attorney General to obtain a prompt opinion (but
9 in no event later than 90 days after the Attorney General
10 receives the request) from the Department of Justice on
11 the plan’s conformity with the Federal antitrust laws.

12 (c) DEFINITIONS.—In this section—

13 (1) the term “antitrust laws”—

14 (A) has the meaning given it in subsection
15 (a) of the first section of the Clayton Act (15
16 U.S.C. 12(a)), except that such term includes
17 section 5 of the Federal Trade Commission Act
18 (15 U.S.C. 45) to the extent such section ap-
19 plies to unfair methods of competition, and

20 (B) includes any State law similar to the
21 laws referred to in subparagraph (A); and

22 (2) the term “health plan” means any contract
23 or arrangement under which an entity bears all or
24 part of the cost of providing health care items and
25 services, including a hospital or medical expense in-

1 curred policy or certificate, hospital or medical serv-
2 ice plan contract, or health maintenance subscriber
3 contract, but does not include—

4 (A) coverage only for accident, dental, vi-
5 sion, disability, or long term care, medicare
6 supplemental health insurance, or any combina-
7 tion thereof,

8 (B) coverage issued as a supplement to li-
9 ability insurance,

10 (C) workers' compensation or similar in-
11 surance, or

12 (D) automobile medical-payment insur-
13 ance.

14 **SEC. 502. ISSUANCE OF HEALTH CARE CERTIFICATES OF**
15 **PUBLIC ADVANTAGE.**

16 (a) ISSUANCE AND EFFECT OF CERTIFICATE.—The
17 Attorney General, after consultation with the Secretary of
18 Health and Human Services, shall issue in accordance
19 with this section a certificate of public advantage to each
20 eligible health care collaborative activity that complies
21 with the requirements in effect under this section on or
22 after the expiration of the 1-year period that begins on
23 the date of the enactment of this Act (without regard to
24 whether or not the Attorney General has promulgated reg-
25 ulations to carry out this section by such date). Such ac-

1 tivity, and the parties to such activity, shall not be liable
2 under any of the antitrust laws for conduct described in
3 such certificate and engaged in by such activity if such
4 conduct occurs while such certificate is in effect.

5 (b) REQUIREMENTS APPLICABLE TO ISSUANCE OF
6 CERTIFICATES.—

7 (1) STANDARDS TO BE MET.—The Attorney
8 General shall issue a certificate to an eligible health
9 care collaborative activity if the Attorney General
10 finds that—

11 (A) the benefits that are likely to result
12 from carrying out the activity outweigh the re-
13 duction in competition (if any) that is likely to
14 result from the activity, and

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

17 (2) FACTORS TO BE CONSIDERED.—

18 (A) WEIGHING OF BENEFITS AGAINST RE-
19 Duction IN COMPETITION.—For purposes of
20 making the finding described in paragraph
21 (1)(A), the Attorney General shall consider
22 whether the activity is likely—

23 (i) to maintain or to increase the
24 quality of health care,

25 (ii) to increase access to health care,

1 (iii) to achieve cost efficiencies that
2 will be passed on to health care consumers,
3 such as economies of scale, reduced trans-
4 action costs, and reduced administrative
5 costs,

6 (iv) to preserve the operation of
7 health care facilities located in underserved
8 geographical areas,

9 (v) to improve utilization of health
10 care resources, and

11 (vi) to reduce inefficient health care
12 resource duplication.

13 (B) NECESSITY OF REDUCTION IN COM-
14 PETITION.—For purposes of making the finding
15 described in paragraph (1)(B), the Attorney
16 General shall consider the availability of equally
17 efficient, less restrictive alternatives to achieve
18 the benefits that are intended to be achieved by
19 carrying out the activity.

20 (c) ESTABLISHMENT OF CRITERIA AND PROCE-
21 DURES.—Subject to subsections (d) and (e), not later than
22 1 year after the date of the enactment of this Act, the
23 Attorney General and the Secretary shall establish jointly
24 by rule the criteria and procedures applicable to the issu-
25 ance of certificates under subsection (a). The rules shall

1 specify the form and content of the application to be sub-
2 mitted to the Attorney General to request a certificate,
3 the information required to be submitted in support of
4 such application, the procedures applicable to denying and
5 to revoking a certificate, and the procedures applicable to
6 the administrative appeal (if such appeal is authorized by
7 rule) of the denial and the revocation of a certificate. Such
8 information may include the terms of the health care col-
9 laborative activity (in the case of an activity in existence
10 as of the time of the application) and implementation plan
11 for the collaborative activity.

12 (d) ELIGIBLE HEALTH CARE COLLABORATIVE AC-
13 TIVITY.—To be an eligible health care collaborative activ-
14 ity for purposes of this section, a health care collaborative
15 activity shall submit to the Attorney General an applica-
16 tion that complies with the rules in effect under subsection
17 (c) and that includes—

18 (1) an agreement by the parties to the activity
19 that the activity will not foreclose competition by en-
20 tering into contracts that prevent health care provid-
21 ers from providing health care in competition with
22 the activity,

23 (2) an agreement that the activity will submit
24 to the Attorney General annually a report that de-
25 scribes the operations of the activity and information

1 regarding the impact of the activity on health care
2 and on competition in health care, and

3 (3) an agreement that the parties to the activity
4 will notify the Attorney General and the Secretary of
5 the termination of the activity not later than 30
6 days after such termination occurs.

7 (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—
8 Not later than 90 days after an eligible health care col-
9 laborative activity submits to the Attorney General an ap-
10 plication that complies with the rules in effect under sub-
11 section (c) and with subsection (d), the Attorney General
12 shall issue or deny the issuance of such certificate. If, be-
13 fore the expiration of such 90-day period, the Attorney
14 General fails to issue or deny the issuance of such certifi-
15 cate, the Attorney General shall be deemed to have issued
16 such certificate.

17 (f) REVOCATION OF CERTIFICATE.—Whenever the
18 Attorney General finds that a health care collaborative ac-
19 tivity with respect to which a certificate is in effect does
20 not meet the standards specified in subsection (b), the At-
21 torney General shall revoke such certificate.

22 (g) WRITTEN REASONS; JUDICIAL REVIEW.—

23 (1) DENIAL AND REVOCATION OF CERTIFI-
24 CATES.—If the Attorney General denies an applica-
25 tion for a certificate or revokes a certificate, the At-

1 torney General shall include in the notice of denial
2 or revocation a statement of the reasons relied upon
3 for the denial or revocation of such certificate.

4 (2) JUDICIAL REVIEW.—

5 (A) AFTER ADMINISTRATIVE PROCEED-
6 ING.—(i) If the Attorney General denies an ap-
7 plication submitted or revokes a certificate is-
8 sued under this section after an opportunity for
9 hearing on the record, then any party to the
10 health care collaborative activity involved may
11 commence a civil action, not later than 60 days
12 after receiving notice of the denial or revoca-
13 tion, in an appropriate district court of the
14 United States for review of the record of such
15 denial or revocation.

16 (ii) As part of the Attorney General's an-
17 swer, the Attorney General shall file in such
18 court a certified copy of the record on which
19 such denial or revocation is based. The findings
20 of fact of the Attorney General may be set aside
21 only if found to be unsupported by substantial
22 evidence in such record taken as a whole.

23 (B) DENIAL OR REVOCATION WITHOUT AD-
24 MINISTRATIVE PROCEEDING.—If the Attorney
25 General denies an application submitted or re-

1 vokes a certificate issued under this section
2 without an opportunity for hearing on the
3 record, then any party to the health care col-
4 laborative activity involved may commence a
5 civil action, not later than 60 days after receiv-
6 ing notice of the denial or revocation, in an ap-
7 propriate district court of the United States for
8 de novo review of such denial or revocation.

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

11 (1) to prepare, agree to prepare, or attempt to
12 agree to prepare an application to request a certifi-
13 cate under this section, or

14 (2) to attempt to enter into any health care col-
15 laborative activity with respect to which such a cer-
16 tificate is in effect.

17 (i) DEFINITIONS.—In this section:

18 (1) The term “antitrust laws” has the meaning
19 given it in section 501(c)(1).

20 (2) The term “certificate” means a certificate
21 of public advantage authorized to be issued under
22 subsection (a).

23 (3) The term “health care collaborative activ-
24 ity” means an agreement (whether existing or pro-
25 posed) between 2 or more providers of health care

1 services that is entered into solely for the purpose of
2 sharing in the provision of health care services and
3 that involves substantial integration or financial
4 risk-sharing between the parties, but does not in-
5 clude the exchanging of information, the entering
6 into of any agreement, or the engagement in any
7 other conduct that is not reasonably required to
8 carry out such agreement.

9 (4) The term “health care services” includes
10 services related to the delivery or administration of
11 health care services.

12 (5) The term “liable” means liable for any civil
13 or criminal violation of the antitrust laws.

14 (6) The term “provider of health care services”
15 means any individual or entity that is engaged in the
16 delivery of health care services in a State and that
17 is required by State law or regulation to be licensed
18 or certified by the State to engage in the delivery of
19 such services in the State.

20 **TITLE VI—CONSUMER** 21 **INFORMATION**

22 **SEC. 601. REQUIREMENT FOR DISCLOSURE OF PRICES FOR** 23 **HEALTH CARE SERVICES.**

24 (a) IN GENERAL.—Except as provided in subsection
25 (b), each hospital, physician, or other provider of a health

1 care item or service shall make available to an individual,
2 before providing any health care item or service to the in-
3 dividual in the United States, a list of all applicable fees
4 and charges for the item or service. In the case of provi-
5 sion of items and services for which the particular services
6 to be provided are not readily determinable in advance,
7 the health care provider may use such estimates as the
8 Secretary of Health and Human Services may permit.

9 (b) EXCEPTION FOR EMERGENCIES.—Subsection (a)
10 shall not apply in the case of emergency treatment and
11 such other extenuating circumstances as the Secretary
12 may provide by regulation.

13 (c) ENFORCEMENT.—No individual shall be liable for
14 payment for a health care item or service for which a dis-
15 closure is required under subsection (a), if the disclosure
16 has not been substantially made in accordance with such
17 subsection.

18 (d) DEADLINE FOR ISSUANCE OF REGULATIONS.—
19 Not later than one year after the date of the enactment
20 of this Act, the Secretary of Health and Human Services
21 shall issue final regulations carrying out the requirements
22 of this section.

1 (e) EFFECTIVE DATE.—This section shall apply to
2 items and services furnished on or after the date of issu-
3 ance of final regulations under subsection (d).

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