Calendar No. 370

103D CONGRESS
2D SESSION

S. 1807

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.

FEBRUARY 22, 1994

Read the second time and placed on the calendar

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IN THE SENATE OF THE UNITED STATES

JANUARY 27 (legislative day, JANUARY 25), 1994

Mr. GRAMM (for himself, Mr. MCCAIN, Mr. COATS, Mr. BROWN, Mr. COVERDELL, Mrs. HUTCHISON, Mr. BENNETT, Mr. HELMS, Mr. LOTT, Mr. FAIRCLOTH, and Mr. WALLOP) introduced the following bill; which was read the first time

FEBRUARY 22, 1994

Read the second time and placed on the calendar

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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; DEFINITIONS.

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

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

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

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

(2) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term by section 5000(b)(1) of the Internal Revenue Code of 1986, but does not include any type of coverage excluded from the definition of a health insurance plan under paragraph (2).

(3) HEALTH INSURANCE PLAN.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''health insurance plan'' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

(B) EXCEPTION.—Such term does not include any of the following—

(i) coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof,

(ii) medicare supplemental health insurance,

(iii) coverage issued as a supplement to liability insurance,

(iv) worker's compensation or similar insurance, or

(v) automobile medical-payment insurance,

or any combination thereof.

(4) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' includes a health insurance plan that offers to provide health services on a prepaid, at-risk basis primarily through a defined set of providers.

(5) INSURER.—The term ''insurer'' means a licensed insurance company, a prepaid hospital or medical service plan, or a health maintenance organization offering such a plan to an employer, and includes a similar organization regulated under State law for solvency.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(7) STATE.—The term ''State'' means each of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

TITLE I—PORTABLE AND PERMANENT PRIVATE HEALTH INSURANCE

Subtitle A—Portability

SEC. 101. AMENDMENTS TO COBRA.

(a) LOWER COST COVERAGE OPTIONS.—Subparagraph (A) of section 4980B(f)(2) of the Internal Revenue Code of 1986 (relating to continuation coverage requirements of group health plans) is amended to read as follows:

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

''(i) is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred,

''(ii) is so identical, except such coverage is offered with an annual $1,000 deductible, and

''(iii) is so identical, except such coverage is offered with an annual $3,000 deductible.

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

(b) TERMINATION OF COBRA COVERAGE AFTER ELIGIBLE FOR EMPLOYER-BASED COVERAGE FOR 90 DAYS.—Clause (iv) of section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 (relating to period of coverage) is amended—

(1) by striking ''or'' at the end of subclause (I),

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

(3) by inserting after subclause (I) the following new subclause:

''(II) eligible for such employer-based coverage for more than 90 days, or''.

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

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

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

(1) by striking ''or'' at the end of clauses (iv) and (v),

(2) by striking the period at the end of clause (vi) and inserting '', or'', and

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

''(vii) made to an employee who is a qualified beneficiary during the period of continuation coverage under section 4980B(f).''

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

Subtitle B—Permanence

SEC. 111. GENERAL RENEWABILITY REQUIREMENTS.

(a) INSURERS.—

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

(A) for nonpayment of premiums,

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

(C) for noncompliance with plan provisions, or

(D) because the insurer is ceasing to provide any health insurance plan in a State, or, in the case of a health maintenance organization, in a geographic area.

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

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

(1) for nonpayment of premiums,

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

(3) for noncompliance with plan provisions, or

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

(c) EFFECTIVE DATE.—The provisions of this section shall apply to any plan on or after the date of the enactment of this Act.

SEC. 112. INDIVIDUAL HEALTH INSURANCE PLANS.

(a) EXISTING PLANS.—With respect to any individual health insurance plan in effect on the date of the enactment of this Act, the insurer shall offer the insured the option to purchase a new individual health insurance described in subsection (b).

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

SEC. 113. GROUP HEALTH PLANS.

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

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

existing condition of the insured, and may be increased based on the health of such insured, and

(2) the employer or group sponsor of such plan the option to purchase a new group health plan described in subsection (b).

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

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

(2) shall offer any insured of such plan the option to purchase upon leaving the group a new individual health insurance plan, the premium of which shall be rated based on actuarial data, may not be based on any preexisting condition of the insured, and may not be increased based on the health of such insured.

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

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

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

(B) subsection (a)(2) shall not apply, and

(2) the effective date of which with respect to the employer or group sponsor occurs after the date of the enactment of this Act, subsection (b) shall apply through 1 or more insurers contracted with by such plan.

SEC. 114. FAILURE OF HEALTH PLANS TO MEET PORTABILITY AND PERMANENCE REQUIREMENTS.

(a) DEDUCTION FOR INDIVIDUAL HEALTH INSURANCE PLANS.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended—

(1) by striking ''or'' at the end of subparagraph (B), and

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

''(C) for insurance—

''(i) meeting the requirements of section 112 of the Comprehensive Family Health Access and Savings Act, and

''(ii) covering medical care referred to in subparagraphs (A) and (B), or

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

(b) TAX EXCLUSIONS FOR EMPLOYER-PROVIDED HEALTH INSURANCE.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by striking ''an accident or health plan'' and inserting ''an accident or health plan meeting the requirements of section 113 of the Comprehensive Family Health Access and Savings Act''.

(c) BUSINESS EXPENSE DEDUCTION FOR HEALTH INSURANCE.—Section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) GROUP HEALTH PLANS.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section unless such plan meets the requirements of section 113 of the Comprehensive Family Health Access and Savings Act.''

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

inserting ''or group health insurance'' after ''group-term life insurance''.

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

TITLE II—EXPANSION OF HEALTH CARE CHOICES

Subtitle A—Employer-Provided Health Insurance

SEC. 201. TAX TREATMENT OF EMPLOYER-PROVIDED HEALTH INSURANCE.

(a) TAX EXCLUSIONS FOR EMPLOYER-PROVIDED HEALTH INSURANCE.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans), as amended by section 115(b), is amended by striking ''an accident or health plan meeting the requirements of section 113 of the Comprehensive Family Health Access and Savings Act'' and inserting ''a qualified health insurance package (as defined in section 162(o)(2)), which meets the requirements of section 113 of the Comprehensive Family Health Access and Savings Act, to the extent the employer contribution does not exceed the actual cost of such coverage''.

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

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

''(o) GROUP HEALTH PLANS.—

''(1) IN GENERAL.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section unless—

''(A) such plan meets the requirements of section 113 of the Comprehensive Family Health Access and Savings Act,

''(B) such plan is offered through a qualified health insurance package, and

''(C) such employer's contribution per employee—

''(i) for coverage described in subparagraph (B) or (C) of paragraph (2) is not less than such contribution for coverage described in paragraph (2)(A) (determined either on an average cost or actual cost basis as elected by the employer), and

''(ii) for coverage described in paragraph (2)(C) does not exceed such contribution for coverage described in sub-

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

''(2) QUALIFIED HEALTH INSURANCE PACKAGE.—For purposes of paragraph (1), the term 'qualified health insurance package' means an annual option provided to each employee of the employer during a 2-month election period to select 1 of the following health insurance coverages for the following calendar year:

''(A) The health insurance coverage provided by the employer on the date of the enactment of the Comprehensive Family Health Access and Savings Act.

''(B) Coverage in a health maintenance organization, managed care arrangement, or preferred provider organization.

''(C) Medical savings account under section 220.''

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

Subtitle B—Medical Savings Accounts

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

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

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

(2) by inserting after paragraph (15) the following:

''(16) MEDICAL EXPENSES ATTRIBUTABLE TO CATASTROPHIC HEALTH INSURANCE PLAN COVERAGE.—

''(A) IN GENERAL.—The deduction allowed by section 213 to the extent attributable to coverage under a catastrophic health insurance plan (as defined in section 220(c)(2)).

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

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

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

''(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the expenses paid during the taxable year, not compensated by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152) in an amount equal to the sum of—

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

''(2) the excess of such expenses (other than expenses described in paragraph (1)) over 7.5 percent of the adjusted gross income of the taxpayer.''

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

SEC. 212. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

"SEC. 220. MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an eligible individual, there shall be allowed as a deduction the amounts paid in cash during the taxable year by or on behalf of such individual to a medical savings account for the benefit of such individual and (if any) such individual's spouse and dependents if such spouse and dependents are eligible individuals.

''(b) LIMITATIONS.—

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

''(2) DOLLAR LIMITATION.—The amount allowable as a deduction under subsection (a) for the taxable year shall not exceed $3,000, or such higher amounts as may be specified in subparagraph (c)(2)(C).

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

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means any individual who is covered

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

''(B) LIMITATIONS.—Such term does not include an individual who is 65 years of age or older, unless the individual is covered under a catastrophic health insurance plan that is a primary plan (within the meaning of section 1862(b)(2)(A) of the Social Security Act).

''(2) CATASTROPHIC HEALTH INSURANCE PLAN.—

''(A) IN GENERAL.—The term 'catastrophic health insurance plan' means a health plan covering specified expenses incurred by an individual for medical care (as defined in subparagraph (B)) for such individual and the spouse and dependents (as defined in section 152) of such individual only to the extent such expenses covered by the plan for any calendar year exceed $3,000 or such higher amounts as may be specified by the plan.

''(B) MEDICAL CARE.—The term 'medical care' means—

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

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

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

''(C) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year after 1995, the dollar amount in subparagraph (A) and paragraph (b)(2) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for such calendar year.

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

''(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section:

''(1) MEDICAL SAVINGS ACCOUNT DEFINED.—

''(A) IN GENERAL.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the

purpose of paying the medical expenses of the beneficiaries of such trust, but only if the written governing instrument creating the trust meets the following requirements:

''(i) Except in the case of a rollover contribution described in subsection (e)(5), no contribution will be accepted unless it is in cash, and contributions will not be accepted in excess of the amount allowed as a deduction under this section for the taxable year.

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

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

''(iv) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(v) The interest of an individual in the balance in his account is nonforfeitable.

''(vi) Under regulations prescribed by the Secretary, rules similar to the rules of section 401(a)(9) shall apply to the distribution of the entire interest of beneficiaries of such trust.

''(B) TREATMENT OF COMPARABLE ACCOUNTS HELD BY INSURANCE COMPANIES.—For purposes of this section, an account held by an insurance company in the United States shall be treated as a medical savings account (and such company shall be treated as a bank) if—

''(i) such account is part of a health insurance plan that includes a catastrophic health insurance plan (as defined in subsection (c)(2)),

''(ii) such account is exclusively for the purpose of paying the medical expenses of the beneficiaries of such account who are covered under such catastrophic health insurance plan, and

''(iii) the written instrument governing the account meets the requirements of clauses (i), (v), and (vi) of subparagraph (A).

''(2) MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'medical expenses' means, with respect to an individual, amounts paid or incurred by such individual for medical care for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts—

''(i) are not compensated for by insurance or otherwise, and

''(ii) are counted towards a deductible under the terms of such individual's catastrophic health insurance plan.

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

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

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

''(e) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—Except as provided in paragraphs (2), (3), and (5), any amount paid or distributed out of a medical savings account shall be included in the gross income of the individual for whose benefit such account was established.

''(2) EXCEPTION FOR MEDICAL AND LONG TERM CARE EXPENSES.—

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

''(i) the medical expenses of such individual, or

''(ii) except as provided in subparagraph (B), the expenses for long term care services of the type identified in section 1931(e)(3) of the Social Security Act for the individual.

''(B) NONQUALIFIED PAYMENTS OR DISTRIBUTIONS FOR LONG TERM EXPENSES.—Paragraph (1) shall apply to any portion of a payment or distribution for expenses for long

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

''(i) the amount of the deductible under the catastrophic health insurance plan covering the individual, exceeds

''(ii) the aggregate balance of all medical savings accounts established for the benefit of the individual.

For purposes of this paragraph, any payment or distribution for medical expenses shall be considered to have been made before any other payment or distribution.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—Paragraph (1) shall not apply to the distribution of any contribution paid during a taxable year to a medical savings account to the extent that such contribution exceeds the amount allowable as a deduction under subsection (a) if—

''(A) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(B) such distribution is accompanied by the amount of net income attributable to such excess contribution.

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

''(4) PENALTY FOR DISTRIBUTIONS NOT USED FOR MEDICAL EXPENSES WHICH LEAVE AN AMOUNT LESS THAN THE CATASTROPHIC DEDUCTIBLE IN THE ACCOUNT.—

''(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a medical savings account which is includible in gross income under paragraph (1) shall be increased by 10 percent with respect to the penalty portion of such payment or distribution.

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

''(i) the amount of the deductible under the catastrophic health insurance plan covering the individual, exceeds

''(ii) the aggregate balance of all medical savings accounts established for the benefit of the individual.

For purposes of this paragraph, any payment or distribution for medical expenses shall be considered to have been made before any other payment or distribution.

''(5) ROLLOVERS.—Paragraph (1) shall not apply to any amount paid or distributed out of a medical savings account to the individual for whose benefit the account is maintained if the entire amount received (including money and any other property) is paid into another medical savings account for the benefit of such individual not later than the 60th day after the day on which he received the payment or distribution.

''(f) TAX TREATMENT OF ACCOUNTS.—

''(1) EXEMPTION FROM TAX.—Any medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account by reason of paragraph (2) or (3). Notwithstanding the preceding sentence, any such account shall be subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATES IF INDIVIDUAL ENGAGES IN PROHIBITED TRANSACTION.—

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

''(B) ACCOUNT TREATED AS DISTRIBUTING ALL ITS ASSETS.—In any case in which any account ceases to be a medical savings account by reason of subparagraph (A) on the first day of any taxable year, paragraph (1) of subsection (e) shall be applied as if there were a distribution on such first day in an amount equal to the fair market value (on such first day) of all assets in the account (on such first day) and no portion of such distribution were used to pay medical expenses.

''(3) EFFECT OF PLEDGING ACCOUNT AS SECURITY.—If, during any taxable year, the individual for whose benefit a medical savings account was established uses the account or any portion thereof as security for a loan, the portion so used is treated as

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

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

''(1) the assets of such account are held by a bank (as defined in section 408(n)) or another person who demonstrates to the satisfaction of the Secretary that the manner in which he will administer the account will be consistent with the requirements of this section, and

''(2) the custodial account would, except for the fact that it is not a trust, constitute a medical savings account described in subsection (d).

For purposes of this title, in the case of a custodial account treated as a trust by reason of the preceding sentence, the custodian of such account shall be treated as the trustee thereof.

''(h) REPORTS.—The trustee of a medical savings account shall make such reports regarding such account to the Secretary and to the individual for whose benefit the account is maintained with respect to contributions, distributions, and such other matters as the Secretary may require under regulations. The reports required by this subsection shall be filed at such time and in such manner

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

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of the Internal Revenue Code of 1986 (defining adjusted gross income), as amended by section 211, is amended by inserting after paragraph (16) the following new paragraph:

''(17) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) DISTRIBUTIONS FROM MEDICAL SAVINGS ACCOUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUCTION.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses) is amended by adding at the end the following new subsection:

''(g) COORDINATION WITH MEDICAL SAVINGS ACCOUNTS.—The amount otherwise taken into account under subsection (a) as expenses paid for medical care shall be reduced by the amount (if any) of the distributions from any medical savings account of the taxpayer during the taxable year which is not includible in gross income by reason of being used for medical care.''

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

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 of the Internal Revenue Code of 1986 (defining wages) is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(B) Subsection (a) of section 209 of the Social Security Act is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by inserting after paragraph (18) the following new paragraph:

''(19) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220 of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code (defining compensation) is amended by adding at the end the following new paragraph:

''(10) EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—The term 'compensation' shall not include any payment made to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

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

''(17) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code (defining wages) is amended by striking ''or'' at the end of paragraph (19), by

striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding deduction is allowable under section 220.''

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of the Internal Revenue Code of 1986 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''**MEDICAL SAVINGS ACCOUNTS,**'' after ''**ACCOUNTS,**'' in the heading of such section,

(2) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)),'',

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

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

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of a medical savings account (within the meaning of section 220(d)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount excludable from gross income under section 220 for such taxable year. For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(e)(3) applies shall be treated as an amount not contributed.''

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

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

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medi-

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

(2) by inserting ''or a medical savings account described in section 220(d)'' in subsection (e)(1) after ''described in section 408(a)''.

(g) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of the Internal Revenue Code of 1986 (relating to failure to provide reports on individual retirement account or annuities) is amended—

(1) by inserting ''**OR ON MEDICAL SAVINGS ACCOUNTS**'' after ''**ANNUITIES**'' in the heading of such section, and

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

(h) CLERICAL AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.

''Sec. 221. Cross reference.''

(2) The table of sections for chapter 43 of such Code is amended by striking the item relating to section 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 annuities.''

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

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

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.

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

''SEC. 106A. CERTAIN HEALTH INSURANCE COVERAGE COSTS.

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

''(1) the amounts paid by the taxpayer for coverage under a health insurance plan (as defined in section 1(3) of the Comprehensive Family Health Access and Savings Act), plus

''(2) the contributions made by such taxpayer to a medical savings account under section 220,

during the taxable year as do not exceed the national per employee average of employer-provided contributions excluded under section 106 for the preceding taxable year.

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

''(1) IN GENERAL.—Subsection (a) shall not apply to any individual—

''(A) who is eligible to participate in any subsidized health plan maintained by an employer of such individual or the spouse of such individual, or

''(B) who is (or whose spouse is) a member of a subsidized class of employees of an employer.

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

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

''(3) SPECIAL RULES.—

''(A) CONTROLLED GROUPS.—All persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as a single employer for purposes of paragraph (2).

''(B) CLASSES.—Classes of employees shall be determined under regulations prescribed by the Secretary based on such factors as the Secretary determines appropriate to carry out the purposes of this subsection.

''(c) APPLICABLE PERCENTAGE.—

''(1) IN GENERAL.—For purposes of subsection (a), the term 'applicable percentage' means—

''(A) 33 percent for any taxable year beginning in 1996 or, if later, the alternate year,

''(B) 46 percent for any taxable year beginning in 1997 or, if later, the alternate year,

''(C) 60 percent for any taxable year beginning in 1998 or, if later, the alternate year,

''(D) 73 percent for any taxable year beginning in 1999 or, if later, the alternate year,

''(E) 86 percent for any taxable year beginning in 2000 or, if later, the alternate year, and

''(F) 100 percent for taxable years beginning with 2001 or, if later, the alternate year.

''(2) ALTERNATE YEAR.—For purposes of paragraph (1), the term 'alternate year' means any taxable year other than the taxable year described the applicable subparagraph of paragraph (1) as determined under section 1302 of the Comprehensive Family Health Access and Savings Act.

''(d) COORDINATION WITH DEDUCTIONS.—No amount excluded from the gross income of the taxpayer for any taxable year under this section shall be taken into account for purposes of determining the allowable deduction for such year under sections 162(l), 213, and 220.

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

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

(1) SOCIAL SECURITY TAXES.—

(A) Subsection (a) of section 3121 of the Internal Revenue Code of 1986 (defining wages), as amended by section 212(d), is amended by striking ''or'' at the end of paragraph (21), by striking the period at the end of paragraph (22) and inserting ''; or'', and by inserting after paragraph (22) the following new paragraph:

''(23) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding exclusion is allowable under section 106A.''

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

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

payment of such remuneration it is reasonable to believe that a corresponding exclusion is allowable under section 106A of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code (defining compensation), as amended by section 212(d), is amended by adding at the end the following new paragraph:

''(11) EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—The term 'compensation' shall not include any payment made to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding exclusion is allowable under section 106A.''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code (defining wages), as amended by section 212(d), is amended by striking ''or'' at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting ''; or'', and by inserting after paragraph (17) the following new paragraph:

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

payment of such remuneration it is reasonable to believe that a corresponding exclusion is allowable under section 106A.''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code (defining wages), as amended by section 212(d), is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) remuneration paid to or on behalf of an employee if (and to the extent that) at the time of payment of such remuneration it is reasonable to believe that a corresponding exclusion is allowable under section 106A.''

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

''Sec. 106A. Certain health insurance coverage costs.''

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

TITLE IV—SMALL BUSINESS HEALTH INSURANCE POOLS

SEC. 401. PROHIBITION OF RESTRICTIONS ON GROUPS PURCHASING HEALTH INSURANCE.

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

(b) MULTIPLE EMPLOYER HEALTH PLAN.—For purposes of subsection (a), the term ''multiple employer health plan'' means a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974).

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

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

SEC. 403. PROHIBITION OF RESTRICTIONS ON MANAGED CARE.

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

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of a group health plan to negotiate reimbursement rates with providers or to contract selectively with 1 provider or a limited number of providers.

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

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

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

(B) requires that such review be made (i) by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or (ii) by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being reviewed,

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

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

(D) requires payments to providers for the expenses of responding to utilization review requests, or

(E) imposes liability for delays in performing such review.

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

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of the regulatory and legal impediments at the Federal, State, and local levels of government that restrict the ability of small businesses and other organizations to group together voluntarily to allow their employees or members to pool their health insurance purchases.

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

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

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

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

SEC. 501. PREEXISTING CONDITION INSURANCE POOL ALLOTMENT PROGRAM.

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

(1) CATASTROPHIC HEALTH INSURANCE PLAN.—The term ''catastrophic health insurance plan'' has the meaning given such term by section 220(c)(2) of the Internal Revenue Code of 1986 (determined without regard to subparagraph (B)(i)).

(2) PREEXISTING CONDITION.—The term ''preexisting condition'' means, with respect to coverage under a health insurance plan, a condition that has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage (without regard to any waiting period).

(3) PROGRAM ADMINISTRATOR.—The term ''program administrator'' means the entity responsible for the administration of the program established under subsection (e)(2).

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

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

(d) APPLICATION.—To be eligible to receive an allotment for a fiscal year under this section, a State shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may by rule require. Such application shall include an assurance by the State that all administrative costs of the insurance pool program shall be borne by the State from resources other than such allotment.

(e) STATE PROGRAM.—

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

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

(2) ESTABLISHMENT.—The State shall establish an insurance pool program to provide premium assistance to an individual who has a preexisting condition and who is otherwise unable to purchase coverage under an affordable health insurance policy, to enable such individual to obtain such coverage.

(3) BID PROCESS.—

(A) IN GENERAL.—With respect to a program established under paragraph (2), the State shall, for each fiscal year, accept bids from private insurance carriers that desire to administer the program and provide catastrophic health insurance plans to individuals with preexisting conditions under the program. The State may accept such a bid or, after determining that no such bids are acceptable, administer the program itself.

(B) CONSIDERATION OF BIDS.—In considering bids submitted under subparagraph (A), the State, in consultation with private insurance carriers, shall compile a profile of individuals

with preexisting conditions. Such profile shall consider—

(i) the number of individuals who may be eligible for premium assistance under the State program for the fiscal year involved;

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

(iii) the estimated amount of premiums to be paid by such eligible individuals for the fiscal year involved;

(iv) the estimated amount by which the medical service costs will exceed the premiums received for the fiscal year involved;

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

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

(4) PROVISION OF PREMIUM ASSISTANCE.—

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

under this section, an individual shall be determined by the program administrator—

(i) to have a preexisting condition;

(ii) to be charged under a catastrophic health insurance plan, a premium which exceeds 150 percent of the average premium paid for catastrophic health insurance plans (considering residence, age and gender);

(iii) not to have any avoidable health conditions, including medical conditions related to smoking, alcohol abuse, drug abuse, and other activities harmful to health, which are the sole reason for the excess described in clause (ii); and

(iv) not to be described in section 601.

(B) AMOUNT.—An individual determined to be eligible under subparagraph (A) shall receive premium assistance under this section in an amount that equals the amount by which the premium paid by such individual for a catastrophic health insurance plan exceeds the greater of—

(i) 150 percent of the average premium paid for catastrophic health insur-

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

(ii) 7.5 percent of the individual or family adjusted gross income of the individual,

but only to the extent such excess is not attributable to any avoidable health conditions, including medical conditions related to smoking, alcohol abuse, drug abuse, and other activities harmful to health.

(f) PAYMENTS.—

(1) IN GENERAL.—The Secretary shall pay to each State for which an application has been approved under this section for each fiscal year an amount not to exceed its allotment under subsection (c) to be expended by the State in accordance with the terms of the application for the fiscal year for which the allotment is to be made.

(2) METHOD OF PAYMENTS.—The Secretary may make payments to a State in installments, and in advance or, by way of reimbursement, with necessary adjustments due to overpayments or underpayments, as the Secretary may determine appropriate.

(3) STATE SPENDING OF PAYMENTS.—Payments to a State from the allotment under subsection (c) for any fiscal year must be expended by the State in that fiscal year or in the succeeding fiscal year.

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

(h) EFFECTIVE DATE.—

(1) IN GENERAL.—The provisions of this title shall apply with respect to payments made to individuals in calendar years beginning with 1996 or, if later, with the alternate year.

(2) ALTERNATE YEAR.—For purposes of paragraph (1), the term ''alternate year'' means any calendar year other than 1996 as determined under section 1302 of the Comprehensive Family Health Access and Savings Act.

TITLE VI—ENCOURAGE RESPONSIBLE BEHAVIOR BY THE FINANCIALLY CAPABLE

SEC. 601. ONE YEAR WINDOW TO PURCHASE HEALTH INSURANCE COVERAGE.

Any individual with family income exceeding 200 percent of the income official poverty line (as determined

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

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

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

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

SEC. 701. REFUNDABLE CATASTROPHIC HEALTH INSURANCE PLAN CREDIT.

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

''SEC. 34A. CATASTROPHIC HEALTH INSURANCE PLAN PREMIUMS.

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

''(b) QUALIFIED INDIVIDUALS.—For purposes of this section:

''(1) IN GENERAL.—The term 'qualified individual' means the taxpayer, the spouse of the taxpayer, and each dependent of the taxpayer (as defined in section 152) who is enrolled in a catastrophic health insurance plan.

''(2) FEDERALLY COVERED INDIVIDUALS.—The term 'qualified individual' does not include any individual whose medical care is covered under titles XIX and XVIII of the Social Security Act.

''(3) SPECIAL RULE IN THE CASE OF CHILD OF DIVORCED PARENTS, ETC.—Any child to whom section 152(e) applies shall be treated as a dependent of both parents.

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

the provisions of section 6013(d) (relating to determination of status as husband and wife).

''(c) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage for any taxable year is 100 percent reduced (but not below zero percent) by 1 percentage point for each 1 percentage point (or portion thereof) the qualified individual's family income exceeds 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(d) CATASTROPHIC HEALTH INSURANCE PLAN.—For purposes of this section, the term 'catastrophic health insurance plan' means a health plan covering specified expenses incurred by an individual for medical care (as defined in section 220(c)(2)(B)(ii)) for such individual and the spouse and dependents (as so defined) of such individual only to the extent such expenses covered by the plan for any calendar year exceed the greater of—

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

''(2) $3,000.

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

''(1) DETERMINATIONS OF INCOME.—

''(A) IN GENERAL.—The term 'income' means adjusted gross income (as defined in section 62(a))—

''(i) determined without regard to sections 135, 162(l), 911, 931, and 933; and

''(ii) increased by—

''(I) the amount of interest received or accrued which is exempt from tax, plus

''(II) the amount of social security benefits (described in section 86(d)) which is not includible in gross income under section 86.

''(B) FAMILY INCOME.—The term 'family income' means, with respect to a family, the sum of the income for all members of the family, not including the income of a dependent child with respect to which no return is required.

''(C) FAMILY SIZE.—The family size to be applied under this section, with respect to family income, is the number of individuals included in the family for purposes of coverage under a catastrophic health insurance plan.

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

''(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.

''(g) APPLICATION OF SECTION.—

''(1) IN GENERAL.—This section shall apply with respect to—

''(A) any individual with a filing status described in subsection (a), (b), or (d) of section 1 and whose family income is less than 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, in any taxable year beginning with 1997 or, if later, the alternate year,

''(B) any individual with a filing status described in subsection (c) of section 1 and whose family income is less than 100 percent of such income official poverty line, in any taxable year

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

''(C) any individual with a filing status described in subsection (a), (b), or (d) of section 1 and whose family income is equal to or exceeds 100 percent of such income official poverty line, but only to the extent of 33 percent of the credit allowable under this section, in any taxable year beginning with 1999 or, if later, the alternate year, and

''(D) any individual with a filing status described in subsection (a), (b), (c), or (d) of section 1 and whose family income is equal to or exceeds 100 percent of such income official poverty line, in any taxable year beginning with 2000 or, if later, the alternate year.

''(2) ALTERNATE YEAR.—For purposes of paragraph (1), the term 'alternate year' means any taxable year other than the taxable year described the applicable subparagraph of paragraph (1) as determined under section 1302 of the Comprehensive Family Health Access and Savings Act.

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

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

"SEC. 3507A. ADVANCE PAYMENT OF CATASTROPHIC HEALTH INSURANCE PLAN PREMIUMS CREDIT.

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

''(b) CATASTROPHIC HEALTH INSURANCE PLAN ELIGIBILITY CERTIFICATE.—For purposes of this title, a catastrophic health insurance plan eligibility certificate is a statement furnished by an employee to the employer which—

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

''(2) certifies that the employee does not have a catastrophic health insurance plan eligibility certificate in effect for the calendar year with respect to the payment of wages by another employer,

''(3) states whether or not the employee's spouse has a catastrophic health insurance plan eligibility certificate in effect, and

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

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

''(c) CATASTROPHIC HEALTH INSURANCE PLAN ADVANCE AMOUNT.—

''(1) IN GENERAL.—For purposes of this title, the term 'catastrophic health insurance plan advance amount' means, with respect to any payroll period, the amount determined—

''(A) on the basis of the employee's wages from the employer for such period,

''(B) on the basis of the employee's estimated premiums for a catastrophic health insurance plan (as so defined) included in the catastrophic health insurance plan eligibility certificate, and

''(C) in accordance with tables provided by the Secretary.

''(2) ADVANCE AMOUNT TABLES.—The tables referred to in paragraph (1)(C) shall be similar in form to the tables prescribed under section 3402 and, to the maximum extent feasible, shall be coordinated with such tables and the tables prescribed under section 3507(c).

''(d) OTHER RULES.—For purposes of this section, rules similar to the rules of subsections (d) and (e) of section 3507 shall apply.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''

(c) CREDIT AMOUNT NOT ALLOWED AS MEDICAL EXPENSE DEDUCTION.—Section 213 of the Internal Revenue Code of 1986 (relating to medical, dental, etc., expenses), as amended by section 212(c), is amended by adding at the end the following new subsection:

''(h) COORDINATION WITH CATASTROPHIC HEALTH INSURANCE PLAN PREMIUMS CREDIT.—The amount otherwise taken into account under subsection (a) as expenses paid for medical care shall be reduced by the amount (if any) of the amount taken into account under section 34A for the taxable year.''

(d) CLERICAL AMENDMENTS.—

(1) The table of sections for subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 34 the following new item:

''Sec. 34A. Catastrophic health insurance plan premiums.''

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

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

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

No provision of Federal, State, or local law shall apply that prohibits the use of any statutory procedure for the collection of unpaid debts for medical expenses incurred by individuals who are eligible for the credit allowed under section 34A of the Internal Revenue Code of 1986, but who fail to claim such credit.

TITLE VIII—REWARD PREVENTIVE MEDICINE AND HEALTHY LIFESTYLES

SEC. 801. REWARD PREVENTIVE MEDICINE AND HEALTHY LIFESTYLES.

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

tion of premiums or the allowance of incentives with respect to such plans for individuals who pursue 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.

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

''CAP ON FEDERAL PAYMENT MADE FOR MEDICAL ASSISTANCE

''SEC. 1931. (a) ANNUAL FEDERAL CAP.—For purposes of furnishing medical assistance to eligible individuals, the Secretary shall pay to a State for a fiscal year under section 1903 an amount that does not exceed the State total funding amount determined under subsection (b).

''(b) STATE TOTAL FUNDING AMOUNT.—

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

''(A) the State's acute care funding amount for the fiscal year determined under subsection (c); and

''(B) the State's long-term care funding amount for the fiscal year determined under subsection (d).

''(2) ESTIMATIONS OF AND ADJUSTMENTS TO STATE TOTAL FUNDING AMOUNT.—The Secretary shall—

''(A) establish a process for estimating the State total funding amount under this subsection at the beginning of each fiscal year and adjusting such amount during such fiscal year; and

''(B) notify each State of the estimations and adjustments referred to in subparagraph (A).

''(c) STATE ACUTE CARE FUNDING AMOUNT.—

''(1) IN GENERAL.—A State's acute care funding amount for a fiscal year is an amount equal to the product of—

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

''(B) the total number of eligible individuals receiving medical assistance in the form of acute medical services in the State during the fiscal year.

''(2) PER CAPITA ACUTE CARE FUNDING AMOUNT.—

''(A) IN GENERAL.—The Secretary shall calculate for each State a per capita acute care funding amount in accordance with subparagraph (B) for each fiscal year.

''(B) DETERMINATION OF PER CAPITA ACUTE CARE FUNDING AMOUNTS.—

''(i) IN GENERAL.—The per capita acute care funding amount for a State shall be—

''(I) for fiscal year 1995, an amount equal to the base acute care per capita funding amount (as determined under clause (ii)) updated by the estimated change in the medical consumer price index through the midpoint of fiscal year 1995; and

''(II) for fiscal year 1996 and succeeding fiscal years, an amount equal to the amount determined under

this clause for the previous fiscal year updated through the midpoint of the fiscal year by the estimated percentage change in the medical consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this clause in the projected percentage change in the medical consumer price index.

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

''(I) the total amount of Federal funds paid to such State under section 1903 for fiscal year 1993 for furnishing medical assistance in the form of acute medical services to eligible individuals; divided by

''(II) the total number of eligible individuals who received medical assistance in the form of acute medical

services in such State during fiscal year 1993.

''(d) STATE LONG-TERM CARE FUNDING AMOUNT.—

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

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

''(B) the total number of eligible individuals receiving medical assistance in the form of long-term care services in the State during the fiscal year.

''(2) PER CAPITA LONG-TERM CARE FUNDING AMOUNT.—

''(A) IN GENERAL.—The Secretary shall calculate for each State a per capita long-term care funding amount in accordance with subparagraph (B) for each fiscal year.

''(B) DETERMINATION OF PER CAPITA LONG-TERM CARE FUNDING AMOUNTS.—

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

''(I) for fiscal year 1995, an amount equal to the base long-term care per capita funding amount (as determined under clause (ii)) updated by the estimated change in the medical consumer price index through the midpoint of fiscal year 1995; and

''(II) for fiscal year 1996 and succeeding fiscal years, an amount equal to the amount determined under this clause for the previous fiscal year updated through the midpoint of the fiscal year by the estimated percentage change in the medical consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this clause in the projected percentage change in the medical consumer price index.

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

a State is an amount equal to the quotient of—

''(I) the total amount of Federal funds paid to such State under section 1903 for fiscal year 1993 for furnishing medical assistance in the form of long-term care services to eligible individuals; divided by

''(II) the total number of eligible individuals who received medical assistance in the form of long-term care medical services in such State during fiscal year 1993.

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

''(1) ACUTE MEDICAL SERVICES.—The term 'acute medical services' means all of the care and services furnished to individuals eligible under a State plan under this title other than long-term care services.

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is a member of any group of individuals described in section 1902(a)(10) that is eligible to receive medical assistance under the State plan under this title.

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

''(A) Nursing facility services (as defined in section 1905(f)).

''(B) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

''(C) Personal care services (as described in section 1905(a)(24)).

''(D) Private duty nursing services (as referred to in section 1905(a)(8)).

''(E) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

''(F) Home and community care furnished to functionally disabled elderly individuals under section 1929.

''(G) Community supported living arrangements services under section 1930.

''(H) Case-management services (as described in section 1915(g)(2)).

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

''(J) Hospice care.

''(4) MEDICAL CONSUMER PRICE INDEX.—The term 'medical consumer price index' means the consumer price index for medical services as determined by the Bureau of Labor Statistics.''

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

(1) by striking ''and'' at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting ''; and''; and

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

''(63) provide that the State will continue to make eligible for medical assistance under section 1902(a)(10) any class or category of individuals eligible for medical assistance under such section during fiscal year 1993.''

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

SEC. 902. WAIVERS FOR FURNISHING MEDICAL ASSISTANCE UNDER THE MEDICAID PROGRAM.

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

is amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

''WAIVERS FOR FURNISHING MEDICAL ASSISTANCE UNDER THE MEDICAID PROGRAM

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

''(b) APPLICATION FOR WAIVERS.—

''(1) IN GENERAL.—In order to receive a waiver under subsection (a), a State shall submit an application to the Secretary at such time and containing such information as the Secretary determines appropriate.

''(2) APPROVAL OF APPLICATION.—

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

''(B) ADDITIONAL REVIEW.—Within 60 days after a State resubmits any application under this subsection, the Secretary shall review and approve such application or provide the State with a summary of which items included on the list provided to the State under subparagraph (A) remain unsatisfied. A State may resubmit an application under this subparagraph as many times as necessary to gain approval.

''(c) DURATION OF WAIVERS.—Except as provided in subsection (d), any waiver under this section shall be granted for a period of 5 years, and renewed for subsequent 5-year periods, unless the Secretary determines that the State has failed to furnish medical assistance in accordance with the terms of the waiver and any provisions of this title with respect to which the Secretary has not granted a waiver.

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

''(e) REPORTS.—The State shall evaluate the programs operated under a waiver granted under this section

and submit reports to the Secretary at such times and containing such information as the Secretary shall require.''

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

Subtitle B—Medicare

SEC. 951. INDIVIDUAL ELECTION FOR TYPE OF COVERAGE.

(a) ELECTION FOR NEW ELIGIBLES.—

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

''INDIVIDUAL ELECTION FOR TYPE OF COVERAGE

''SEC. 1805. (a) An individual may enroll with a private health care arrangement under section 1893 or an eligible organization under section 1876 only if such individual has elected to enroll with such an arrangement or organization within 1 year after the date that the individual—

''(1) becomes entitled to benefits under part A of this title, or

''(2) foregoes a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer (or the employer or former employer of the individual's spouse) where such plan was the individual's primary insurer.

''(b) If an individual makes an election under subsection (a), such individual shall be entitled to payment under this title only if such individual remains enrolled with an arrangement or organization described in such subsection.''

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to individuals who become entitled to benefits under part A of title XVIII of the Social Security Act on or after October 1, 1994.

(b) ELECTION FOR CURRENT ELIGIBLES.—

(1) ENROLLMENT WITH A PRIVATE HEALTH CARE ARRANGEMENT OR ELIGIBLE ORGANIZATION.—

(A) IN GENERAL.—If an individual is entitled to benefits under part A of title XVIII of the Social Security Act on or before September 30, 1994, such individual may elect to enroll with a private health care arrangement under section 1893 of such Act or an eligible organization under section 1876 of such Act only if such election is made on or before March 31, 1995.

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

ual shall be entitled to payment under title XVIII of the Social Security Act only if such individual remains enrolled with an arrangement or organization described in such subparagraph.

(2) DECISION TO RETURN TO FEE FOR SERVICE PLAN.—If an individual is enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) on or before September 30, 1994, such individual may terminate the individual's enrollment with such organization on or before March 31, 1995, without being subject to the payment limitation described in paragraph (1)(B).

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

SEC. 952. HEALTH CARE COVERAGE UNDER A PRIVATE HEALTH CARE ARRANGEMENT.

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

''PAYMENTS TO PRIVATE HEALTH CARE ARRANGEMENTS

''SEC. 1893. (a) PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall make payment as specified in subsection (c) for each individual who is enrolled with a private health care arrangement.

''(2) SOLE PAYMENTS.—Payments to an individual under this section shall be in lieu of the amounts that would otherwise be payable pursuant to sections 1814(b) and 1833(a).

''(b) CERTIFICATION.—

''(1) IN GENERAL.—An individual who is enrolled with a private health care arrangement shall certify to the Secretary, by not later than December 15 of each year, the individual's enrollment for the coming calendar year. Such certification shall indicate the individual's annual premium amount.

''(2) FAILURE TO CERTIFY.—For purposes of determining payment under subsection (c), an individual who fails to provide the certification described in paragraph (1) shall be deemed to be enrolled with the private health care arrangement at the same premium for which the Secretary last received a certification.

''(c) PAYMENT AMOUNT SPECIFIED.—

''(1) PRIVATE HEALTH CARE ARRANGEMENT.—

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

''(i) the individual's annual premium amount, or

''(ii) the per capita amount specified under paragraph (2).

''(B) RETURN OF PAYMENT.—In the event of the death of an individual, the private health care arrangement certified by the individual under subsection (b)(1) shall reimburse the Secretary for a prorated portion of the amount received under subparagraph (A), less any amount expended by the private health care arrangement for the health care expenses for such individual. Such amount (if any) shall be deposited in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the same proportion as such payment was paid by each trust fund under subsection (e).

''(2) PER CAPITA AMOUNT.—

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

''(B) DETERMINATION OF PER CAPITA RATE OF PAYMENT.—The per capita amount for each group of individuals (based on residency, age, and gender) is equal to—

''(i) the total estimated government expenditures for all benefits under parts A and B of this title in the coming calendar year for such group (excluding any premiums, deductibles, and copayments paid by individuals for benefits under part B), divided by

''(ii) the total estimated number of individuals in such group expected to be entitled to benefits under part A and enrolled in part B in the coming calendar year.

''(3) ADDITIONAL AMOUNTS FOR CERTAIN INDIVIDUALS.—

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

''(i) the per capita amount under paragraph (2), over

''(ii) the annual premium for the individual's private health care arrangement

(or in the case of a private health care arrangement that is a catastrophic health insurance plan, the annual premium for such plan and the annual deductible amount for such plan).

''(B) LONG TERM CARE PLAN.—The Secretary shall pay annually to an individual who has received payment under subparagraph (A) and is enrolled with a long term care plan, an additional payment equal to the amount received by such individual under subparagraph (A).

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

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

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

''(3) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' has the meaning given to such term by section 220(d)(1) of the Internal Revenue Code of 1986.

''(4) PRIVATE HEALTH CARE ARRANGEMENT.—The term 'private health care arrangement' means—

''(A) any arrangement which offers at least the health care services described in section 1876(b)(2)(A), or

''(B) a catastrophic health insurance plan in connection with a medical savings account.

''(e) SOURCE OF PAYMENT.—The payment to an individual under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The proportion of the payment to be paid by each trust fund shall be determined each year by the Secretary based on the relative proportion of government expenditures that benefits from each fund contribute to the per capita amount determined under subsection (b)(2)(B).''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payments made on or after October 1, 1994.

TITLE X—ENHANCED EFFICIENCY THROUGH PAPERWORK REDUCTION

SEC. 1001. FEDERAL PAPERWORK REDUCTION AND EFFICIENCY REQUIREMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to in this title as the ''Secretary'') shall, in consultation with the Director of the Office of Management and Budget, the Secretary of Veterans Affairs, the Secretary of Defense, the Director of Personnel Management, and other appropriate Federal officials, adopt standards to reduce the administrative and paperwork burdens of all Federal health care programs by—

(1) 50 percent within the 2-year period following the date of the enactment of this Act, and

(2) an additional 50 percent reduction from the balance specified in (1) over a subsequent 3-year period,

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

(b) INITIAL REDUCTION.—In order to achieve a paperwork reduction described in subsection (a)(1), the Secretary, shall adopt standards for Federal health care programs relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health insurance plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

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

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

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

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

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

(d) DEFINITION.—For purposes of this section, the term ''Federal health care program'' means all Federal programs related to health care, including programs described in—

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

(2) the Public Health Service Act,

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

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

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

(6) the Indian Health Care Improvement Act.

SEC. 1002. STATE PAPERWORK REDUCTION AND EFFICIENCY REQUIREMENTS.

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

during the 5-year period following the date of the enactment of this Act.

(b) ENFORCEMENT.—

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

(2) FINAL COMPLIANCE.—If at the end of the 5-year period following the date of the enactment of this Act the Secretary determines that a State has not achieved the reductions required under subsection (a), the Secretary shall reduce Federal payments for health care programs administered by such State by 10 percent. For each year that such State fails to comply with the requirements of subsection (a), Federal payments for health care programs administered by the State shall be reduced by an additional 10 percent.

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

under paragraph (2) may appeal to the Secretary for a 1-year waiver of such reduction. In granting such a waiver, the Secretary shall make a determination of the good faith effort of such State to comply with the requirements of subsection (a), taking into account the technical, practical, and financial capabilities of the State in meeting such requirements.

SEC. 1003. STANDARDIZED FORMS COMMISSION.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall establish a Standardized Forms Commission (hereafter referred to in this section as the ''Commission'') which shall make recommendations on the standardization of paper and electronic claims processing so as to reduce the paperwork burden associated with, and enhance the efficiency and productivity of, such claims processing.

(2) MEMBERSHIP.—

(A) IN GENERAL.—The Commission shall be composed of at least 12 but not more than 20 representatives of private health care providers and private insurers.

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

(3) REPORT ON FINDINGS AND RECOMMENDATIONS.—Not later than 24 months after the date of the enactment of this Act, the Chair of the Commission shall report to the Secretary on the findings and recommendations of the Commission.

(4) PROHIBITION OF COMPENSATION.—Members of the Commission shall serve without pay except for reimbursement for travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon request of the Chair, the head of any Federal department or agency shall detail any of the personnel of that department or agency to the Commission to assist it in carrying out its duties under this section.

(6) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section.

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

Commission to carry out its responsibilities under this section.

(b) LEGISLATIVE PROPOSAL.—

(1) IN GENERAL.—

(A) DEVELOPMENT OF IMPLEMENTING BILL.—Not later than 3 months after the Commission has submitted its findings and recommendations to the Secretary, the Secretary shall take such recommendations and submit them to Congress in the form of an implementing bill which contains the provisions necessary or appropriate to implement the recommendations by either repealing or amending existing laws or providing new statutory authority.

(B) CONSIDERATION OF IMPLEMENTING BILL.—The implementing bill described in subparagraph (A) shall be considered by Congress under the procedures for consideration described in paragraph (2).

(2) CONGRESSIONAL CONSIDERATION.—

(A) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This paragraph is enacted by Congress—

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

the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementing bill described in paragraph (1)(A), and supersedes other rules only to the extent that such rules are inconsistent therewith; and

(ii) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

(B) INTRODUCTION AND REFERRAL.—On the day on which the implementing bill described in paragraph (1)(A) is transmitted to the House of Representatives and the Senate, such bill shall be introduced (by request) in the House of Representatives by the Majority Leader of the House, for himself and the Minority Leader of the House, or by Members of the House designated by the Majority Leader and Minority Leader of the House and shall be introduced (by request) in the Senate by the Ma-

jority Leader of the Senate, for himself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate. If either House is not in session on the day on which the implementing bill is transmitted, the bill shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter on which the House is in session. The implementing bill introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(C) AMENDMENTS PROHIBITED.—No amendment to an implementing bill shall be in order in either the House of Representatives or the Senate and no motion to suspend the application of this paragraph shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this paragraph by unanimous consent.

(D) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

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

tees of either House to which an implementing bill has been referred have not reported it at the close of the 45th day after its introduction, such committee or committees shall be automatically discharged from further consideration of the implementing bill and it shall be placed on the appropriate calendar. A vote on final passage of the implementing bill shall be taken in each House on or before the close of the 45th day after the implementing bill is reported by the committees or committee of that House to which it was referred, or after such committee or committees have been discharged from further consideration of the implementing bill. If prior to the passage by 1 House of an implementing bill of that House, that House receives the same implementing bill from the other House then—

(I) the procedure in that House shall be the same as if no implementing bill had been received from the other House; but

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

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

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

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

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

(i) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of an implementing bill shall be highly privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

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

(iii) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives with respect to the consideration of an implementing bill, and motions to proceed to the consideration of other business, shall be decided without debate.

(iv) APPEALS.—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to an implementing bill shall be decided without debate.

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

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

(F) FLOOR CONSIDERATION IN THE SENATE.—

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

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

(iii) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any de-

batable motion or appeal in connection with an implementing bill shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the implementing bill, except that in the event the manager of the implementing bill is in favor of any such motion or appeal, the time in opposition thereto, shall be controlled by the Minority Leader or his designee. Such leaders, or either of them, may, from time under their control on the passage of an implementing bill, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(iv) OTHER MOTIONS.—A motion in the Senate to further limit debate is not debatable. A motion to recommit an implementing bill is not in order.

(c) FAILURE TO COMPLY WITH RECOMMENDATIONS ENACTED.—A health care provider or health care insurer that fails to comply with any recommendations of the Commission that are enacted in accordance with subsection (b) and that are applicable to such provider or insurer shall be ineligible for payments of claims submitted

under any provision of the Social Security Act or the Public Health Service Act.

TITLE XI—MEANINGFUL MEDICAL LIABILITY REFORM

SEC. 1101. APPLICABILITY AND PREEMPTION.

(a) APPLICABILITY.—This title shall apply with respect to any medical malpractice liability claim and to any medical malpractice liability action brought in any State or Federal court, except that this title shall not apply to a claim or action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the claim or action.

(b) PREEMPTION.—

(1) IN GENERAL.—The provisions of this title shall preempt any State or local law to the extent such law is inconsistent with the limitations contained in such provisions. The provisions of this title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title, places greater limitations on the amount of attorneys' fees and expenses that can be collected, or otherwise imposes greater restrictions than those provided in this title.

(2) NEGOTIATED LIABILITY.—The provisions of this title shall preempt any Federal, State or local law to the extent that such law prohibits a health care provider and a purchaser of health care from voluntarily entering into a contractual agreement in which the provider offers reduced fees for medical services in exchange for a prearranged limit on the amount of any award in a medical malpractice liability action resulting from the provision of such services or a limit on the cause of action that may be maintained with respect to such services.

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

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

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

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

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

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

SEC. 1102. STATUTE OF LIMITATIONS.

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

(b) EXCEPTION FOR CERTAIN MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, no medical malpractice liability action shall be initiated after the expiration of the 2-year

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

SEC. 1103. SCOPE OF LIABILITY.

(a) IN GENERAL.—With respect to economic and noneconomic damages, the liability of each defendant in a medical malpractice liability action shall be several only and may not be joint. Such a defendant shall be liable only for the amount of economic or noneconomic damages allocated to the defendant in direct proportion to such defendant's percentage of fault or responsibility for the injury suffered by the claimant.

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

SEC. 1104. DISCOVERY; FAILURE TO MAKE OR COOPERATE IN DISCOVERY.

(a) IN GENERAL.—All requests for discovery pursuant to a medical malpractice liability action shall identify the relevant portion of the complaint, answer or other pleading to which responses to the discovery requests are expected to relate.

(b) FEES AND EXPENSES.—With respect to any motion for an order compelling discovery that is made pursuant to a medical malpractice liability action, the court shall award the prevailing party reasonable fees and other expenses incurred by that party in bringing or defending against the motion, including reasonable attorney fees, unless the court finds that the position of the unsuccessful party was substantially justified or that special circumstances make such an award unjust.

SEC. 1105. LIMITATION ON NONECONOMIC DAMAGES.

The total amount of noneconomic damages that may be awarded to a claimant and the members of the claimant's family for losses resulting from the injury which is the subject of a medical malpractice liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to such injury.

SEC. 1106. TREATMENT OF PAYMENTS FOR FUTURE ECONOMIC LOSSES.

(a) PROHIBITING SINGLE LUMP-SUM PAYMENT.—In any medical malpractice liability action in which the damages awarded for any economic losses to be incurred after the date on which the judgment is entered exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on projections of the amount of damages expected to be incurred by the claimant at appropriate intervals, as determined by the court.

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

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

under which a party may obtain relief from a final judgment.

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

(a) COSTS AND FEES, GENERALLY.—

(1) COURT DISCRETION.—A court in a medical malpractice liability action may, as a condition of the initiation of such an action, require an undertaking for the payment of the costs associated with such action, including reasonable attorneys' fees.

(2) PAYMENT OF COSTS.—If a judgment in a medical malpractice liability action is rendered against a party to such action, upon a motion by the prevailing party to such action, the court shall require the party against whom the judgment was rendered to pay to such prevailing party the costs and fees incurred by such prevailing party under the action, including reasonable attorneys' fees and other expenses. The court may waive the application of this paragraph if the court finds that the position maintained by the party against whom such judgment was rendered under such action was substantially justified or that special circumstances make such an award unjust.

(3) APPLICATION FOR RECOVERY OF COSTS.—A party to a medical malpractice liability action who

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

(A) a certification that the submitting party is a prevailing party and is eligible to receive costs and fees under paragraph (2);

(B) a description of the amount of costs and fees sought, including an itemized statement from any attorney or expert witness representing or appearing on behalf of such party stating the actual time expended and the rate at which fees and other expenses were computed; and

(C) a description of the reasons why the position of the party against whom the judgment was rendered was not substantially justified.

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

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

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

(B) reduce the amount to be awarded pursuant to this subsection, or deny an award, to the extent that the prevailing party, during the course of the proceedings, engaged in conduct which unnecessarily and unreasonably lengthened the time for, or increased the costs of, the final resolution of the matter in controversy.

(b) ATTORNEY'S FEES.—

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

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

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

(2) RECORDS.—

(A) IN GENERAL.—With respect to a medical malpractice liability action, in order to receive an award of attorneys' fees as provided for in this title, the attorney of record of a party to such action shall have maintained accurate, complete records of hours worked on the action regardless of the fee arrangement entered into by the attorney with such party, including records of other attorneys, legal staff, expert witnesses and others who worked on the action on behalf of such attorney.

(B) CALCULATION.—The court shall determine the amount of reasonable attorneys' fees and expenses that shall be awarded in a medical malpractice liability action under this title on the basis of an hourly rate or as a percentage of the total damages awarded under such action for economic and noneconomic losses. Such amount shall be indexed to account for inflation. The amount of attorneys' fees and expenses as determined by the court may not ex-

ceed an amount that would be considered reasonable based on the following:

(i) The time, labor, and skill necessary to properly perform the legal services required by the action.

(ii) The novelty and difficultly of the questions involved in the action.

(iii) The likelihood, if apparent to the client, that the acceptance of employment with respect to the client's action will preclude other employment by the attorney.

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

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

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

(vii) The nature and length of the professional relationship between the attorney and the client.

(viii) The experience, reputation, and ability of the attorney performing the services in connection with the action.

SEC. 1108. CONTRIBUTION AND INDEMNIFICATION.

(a) RECOVERY.—With respect to a medical malpractice liability action, each nonsettling party may recover contribution and indemnification from any other such nonsettling party who, if joined in the original action, would have been liable for such damages.

(b) RELEASE, DISMISSAL, SETTLEMENT.—A party who is released or dismissed (with or without prejudice) from, or who, in good faith prior to a verdict or judgment, settles a medical malpractice liability action shall, upon the execution of the release, dismissal or settlement agreement, be discharged from all claims for contribution or indemnification brought by nonsettling or other settling parties to such action. Any party to such action who asserts a lack of good faith shall have the burden of proof concerning such good faith issue.

SEC. 1109. COLLATERAL SOURCES.

(a) IN GENERAL.—The total amount of damages received by a claimant in a medical malpractice liability action shall be reduced, in accordance with subsection (b), by any other payment that has been made, or that will be made, to such claimant to compensate such claimant for an injury that was part of such action, including payments—

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

(2) under Federal, State, or private health insurance programs;

(3) under private disability insurance programs;

(4) under employer wage continuation programs; and

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

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

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

(2) the amount paid by such claimant (or by the spouse, parent, or legal guardian of such claimant) to secure the payments described in paragraph (1).

SEC. 1110. DAMAGES RELATING TO MEDICAL PRODUCT LIABILITY CLAIMS.

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

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

(A) was subject to approval under section 505, or premarket approval under section 515, of the Federal Food, Drug, and Cosmetic Act by the Food and Drug Administration with respect to—

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

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

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

(2) the drug or device is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

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

(1) withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device that is required to be sub-

mitted under the Federal Food, Drug, and Cosmetic Act or section 352 of the Public Health Service Act and that is material and relevant to the action involved; or

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

(c) DEFINITION.—As used in this section, the term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

SEC. 1111. CLASS ACTIONS.

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

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

(b) PROHIBITION OF CONFLICTS OF INTEREST.—In any medical malpractice liability action that is certified as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure, if a party is represented by any attorney who has a beneficial interest in the subject of the litigation, the court shall make a determination of whether such interest constitutes a conflict of interest sufficient to disqualify the attorney from representing the party.

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

SEC. 1112. DEFINITIONS.

(1) CLAIMANT.—The term ''claimant'' means any person who alleges a medical malpractice liability claim, and any person on whose behalf such a claim is alleged, including the decedent in the case

of an action brought through or on behalf of an estate.

(2) COMMERCIAL LOSS.—The term ''commercial loss'' means loss, including damage to the product itself, which is not harm described in subparagraph (A) or (B) of paragraph (5), and which is of a kind for which there is a remedy under applicable contract or commercial law.

(3) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

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

(5) HARM.—The term ''harm'' means—

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

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

(C) the physical damage caused by a medical product to property other than the medical product itself.

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

(6) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(7) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice liability action or a medical malpractice liability claim.

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means a civil action brought in a State or Federal court against a health care provider or health care professional in which the plaintiff alleges a medical malpractice liability claim, but does not include any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

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

(10) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term ''medical product'' means, with respect to the allegation of a claimant, a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or device which is the subject of the claimant's allegation or the adequacy of the packag-

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

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(11) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, emotional distress, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, injury to

reputation, humiliation, and other noneconomic injury.

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

SEC. 1113. SEVERABILITY.

If any provision of this title or the application of any provision to any person or circumstance is held invalid, the remainder of this title and the application of such provisions to any other person or circumstance shall not be affected by such invalidation.

SEC. 1114. EFFECTIVE DATE.

This title shall apply to all medical malpractice liability actions commenced on or after the date of enactment of this Act.

TITLE XII—ANTITRUST REFORMS

SEC. 1201. ESTABLISHMENT OF LIMITED EXEMPTION PROGRAM FOR HEALTH CARE JOINT VENTURES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this Act, the Attorney General, after consultation with the Secretary of Health and Human Services and the Interagency

Advisory Committee on Competition, Antitrust Policy, and Health Care, shall promulgate specific guidelines under which a health care joint venture may submit an application requesting that the Attorney General provide the entities participating in the joint venture with an exemption under which (notwithstanding any other provision of law)—

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

(B) the conduct of the entity in making or performing a contract to carry out the joint venture shall not be deemed illegal per se under the antitrust laws but shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including (but not limited to) effects on competition in properly defined, relevant research, development, product, process, and service markets (taking into consideration worldwide capacity to the extent that it may be appropriate in the circumstances).

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

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

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

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

(2) The nature, objectives, and planned activities of the joint venture.

(3) Assurances that the entities participating in the joint venture shall notify the Attorney General of any changes in the information described in paragraphs (1) and (2) during the period for which the exemption is in effect.

(c) REVOCATION OF EXEMPTION.—

(1) IN GENERAL.—The Attorney General, after consultation with the Secretary, may revoke an exemption provided to a health care joint venture under this section if, at any time during which the exemption is in effect, the Attorney General finds that the joint venture no longer meets the applicable requirements for approval under subsection (b), except that the Attorney General may not revoke such an exemption if the failure of the health care joint venture to meet such requirements is merely technical in nature.

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

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

(e) REQUIREMENTS RELATING TO NOTICE AND PUBLICATION OF EXEMPTIONS AND RELATED INFORMATION.—

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

(A) IN GENERAL.—With respect to each exemption for a health care joint venture provided under subsection (a), the Attorney General (acting jointly with the Secretary) shall—

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

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

(iii) after submitting the notice to such entities (but not later than 30 days after approving the application for the exemption for the joint venture), publish the notice in the Federal Register.

(B) EFFECT OF PUBLICATION.—An exemption provided by the Attorney General under subsection (a) shall take effect as of the date of the publication in the Federal Register of the notice with respect to the exemption pursuant to subparagraph (A).

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

(A) IN GENERAL.—All information and documentary material submitted as part of an application of a health care joint venture for an exemption under subsection (a), together with any other information obtained by the Attorney General, the Secretary, or the Advisory Committee in the course of any investigation, administrative proceeding, or case with respect to a potential violation of the antitrust laws by the joint venture with respect to which the exemption applies, shall be exempt from disclosure under section 552 of title 5, United States Code, and shall not be made publicly available by any agency of the United States to which such section applies, except as relevant to a law enforcement investigation or in a judicial or ad-

ministrative proceeding in which such information and material is subject to any protective order.

(B) EXCEPTION FOR INFORMATION INCLUDED IN FEDERAL REGISTER NOTICE.—Subparagraph (A) shall not apply with respect to information contained in a notice published in the Federal Register pursuant to paragraph (1).

(3) USE OF INFORMATION TO SUPPORT OR ANSWER CLAIMS UNDER ANTITRUST LAWS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the fact of disclosure of conduct under an application for an exemption under subsection (a) and the fact of publication of a notice in the Federal Register under paragraph (1) shall be admissible into evidence in any judicial or administrative proceeding for the sole purpose of establishing that a person is entitled to the protections provided by an exemption granted under subsection (a).

(B) EFFECT OF REJECTED APPLICATION.—If the Attorney General denies, in whole or in part, an application for an exemption under subsection (a), or revokes an exemption

under such section, neither the negative determination nor the statement of reasons therefor shall be admissible into evidence in any administrative or judicial proceeding for the purpose of supporting or answering any claim under the antitrust laws.

SEC. 1202. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

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

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

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

(A) the benefits that are likely to result from carrying out the venture outweigh the reduction in competition (if any) that is likely to result from the venture, and

(B) such reduction in competition is reasonably necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the venture is likely —

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

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs,

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

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

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care joint venture and the entities responsible for making payments to such providers to negotiate societally optimal payment and service arrangements,

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

(iii) the availability of equally efficient, less restrictive alternatives to achieve

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

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care joint venture (in the case of a venture in existence as of the time of the application) and implementation plan for the joint venture.

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

(1) an agreement by the parties to the venture that the venture will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the venture,

(2) an agreement that the venture will submit to the Attorney General annually a report that describes the operations of the venture and information regarding the impact of the venture on health care and on competition in health care, and

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

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 30 days after an eligible health care joint venture submits to the Attorney General an application that complies with the rules in effect under subsection (c) and with subsection (d), the Attorney General shall issue or deny the issuance of such certificate. If, before the expiration of such 30-day period, the Attorney General fails to issue or deny the issuance of such certificate, the Attorney General shall be deemed to have issued such certificate.

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

(g) WRITTEN REASONS; JUDICIAL REVIEW.—

(1) DENIAL AND REVOCATION OF CERTIFICATES.—If the Attorney General denies an application for a certificate or revokes a certificate, the Attorney General shall include in the notice of denial or revocation a statement of the reasons relied upon for the denial or revocation of such certificate.

(2) JUDICIAL REVIEW.—

(A) AFTER ADMINISTRATIVE PROCEEDING.—(i) If the Attorney General denies an application submitted or revokes a certificate issued under this section after an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

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

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care joint venture involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

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

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

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

SEC. 1203. INTERAGENCY ADVISORY COMMITTEE ON COMPETITION, ANTITRUST POLICY, AND HEALTH CARE.

(a) ESTABLISHMENT.—There is hereby established the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care. The Advisory Committee shall be composed of—

(1) the Secretary of Health and Human Services (or the designee of the Secretary);

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

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

(4) a representative of the Federal Trade Commission.

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

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

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

gram established under section 1201(a) or certificates under section 1202 in reducing the costs of and expanding access to the health care services that are the subject of such ventures; and

(3) to make such recommendations to Congress not later than 2 years after the date of the enactment of this Act (and at such subsequent periods as the Advisory Committee considers appropriate) regarding modifications to the program established under section 1201(a) or to section 1202 as the Advisory Committee considers appropriate, including modifications relating to the costs to health care providers of obtaining an exemption for a joint venture under such program.

SEC. 1204. DEFINITIONS.

For purposes of this title:

(1) The term ''Advisory Committee'' means the Interagency Advisory Committee on Competition, Antitrust Policy, and Health Care established under section 1203.

(2) The term ''antitrust laws''—

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

(15 U.S.C. 45) to the extent such section applies to unfair methods of competition; and

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

(3) The term ''certificate'' means a certificate of public advantage authorized to be issued under section 1202(a).

(4) The term ''health care joint venture'' means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision of health care services and that involves substantial integration or financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(5) The term ''health care services'' includes services related to the delivery or administration of health care services.

(6) The term ''liable'' means liable for any civil or criminal violation of the antitrust laws.

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

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

TITLE XIII—EXPENDITURE TARGETS FOR THE MEDICAID AND MEDICARE PROGRAMS

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

(a) DETERMINATION OF EXCESS EXPENDITURES.—

(1) IN GENERAL.—Not later than 30 days after the end of each fiscal year beginning with fiscal year 1995, the Director of the Office of Management and Budget (hereafter referred to in this title as the ''Director''), in consultation with the Secretary, shall determine the amount of medicaid excess expenditures and medicare excess expenditures for such fiscal year.

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

(A) MEDICAID EXCESS EXPENDITURES.—The term ''medicaid excess expenditures'' for a fiscal year means the amount by which the Federal expenditures under the medicaid program for such fiscal year exceed the target expendi-

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

(B) MEDICARE EXCESS EXPENDITURES.—The term ''medicare excess expenditures'' for a fiscal year means the amount by which the expenditures under the medicare program for such fiscal year exceed the target expenditure for such program as determined under subsection (b)(2) for such fiscal year.

(C) MEDICAID PROGRAM.—The term ''medicaid program'' means the program under title XIX of the Social Security Act.

(D) MEDICARE PROGRAM.—The term ''medicare program'' means the program under title XVIII of the Social Security Act.

(b) TARGET EXPENDITURES.—

(1) MEDICAID PROGRAM.—

(A) IN GENERAL.—The target expenditure determined under this paragraph for the medicaid program for a fiscal year shall be an amount equal to the applicable percentage of the total Federal expenditures under the medicaid program for the previous fiscal year.

(B) MEDICAID APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the medicaid applicable percentage is—

(i) 106.8 percent for the determination with respect to fiscal year 1995;

(ii) 106.9 percent for the determination with respect to fiscal year 1996; and

(iii) 107 percent for the determination with respect to fiscal year 1997 and succeeding fiscal years.

(2) MEDICARE PROGRAM.—

(A) IN GENERAL.—The target expenditure determined under this paragraph for the medicare program for a fiscal year shall be an amount equal to the applicable percentage of the total expenditures under the medicare program for the previous fiscal year.

(B) MEDICARE APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the medicare applicable percentage is—

(i) 109.4 percent for the determination with respect to fiscal year 1995;

(ii) 108.9 percent for the determination with respect to fiscal year 1996;

(iii) 108.5 percent for the determination with respect to fiscal year 1997; and

(iv) 108 percent for the determination with respect to fiscal year 1998 and succeeding fiscal years.

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

(a) IN GENERAL.—If the Director determines that there are medicaid or medicare excess expenditures for a fiscal year under section 1301, any category of health insurance benefit described in subsection (b) that is effective in the taxable or calendar year (whichever is applicable) beginning after such fiscal year may be delayed until the following year. This subsection shall be applied only to so many of the categories of health insurance benefits described in subsection (b) in the order in which such categories are listed such that the savings resulting from such delay at least equal the costs of the medicaid and medicare excess expenditures.

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

(1) The tax credit under section 34A of the Internal Revenue Code of 1986 applicable to individ-

uals described in subparagraphs (C) and (D) of section 34A(g)(1).

(2) The tax credit under section 34A of the Internal Revenue Code of 1986 applicable to individuals described in subparagraph (B) of section 34A(g)(1).

(3) The tax credit under section 34A of the Internal Revenue Code of 1986 applicable to individuals described in subparagraph (A) of section 34A(g)(1).

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

(5) Assistance to individuals with preexisting conditions in purchasing health insurance under section 501.

S 1807 PCS——2

S 1807 PCS——3

S 1807 PCS——4

S 1807 PCS——5

S 1807 PCS——6

S 1807 PCS——7

S 1807 PCS——8

S 1807 PCS——9