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103D CONGRESS
2D SESSION

H. R. 4840

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

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 1994

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

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A BILL

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

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

SECTION 1. SHORT TITLE.

(a) SHORT TITLE.—This Act may be cited as ''The Prescription for Health Act of 1994''.

(b) TABLE OF CONTENTS.—

TITLE I—INSURANCE REFORMS

Subtitle A—Reform of Insured Market for Employers and Individuals

PART 1—GENERAL REFORMS

SEC. 101. ASSURANCE OF RENEWABILITY OF COVERAGE.

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

(1) for nonpayment of premiums,

(2) for fraud or other misrepresentations,

(3) for noncompliance with plan provisions, or

(4) because the insurer is ceasing to provide any health insurance in the State, or, in the case of a health maintenance organization, in a geographic area with respect to employer or individuals, respectively.

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

SEC. 102. LIMITATION ON ANNUAL PREMIUM INCREASES.

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

SEC. 103. ASSURANCE OF CONTINUITY OF COVERAGE.

(a) IN GENERAL.—No insurer shall deny health insurance coverage to any employer or individual, and no sponsor of a group health plan shall deny coverage to an eligible individual, on the basis of health status or preexisting condition, if the employer or individual was covered by health insurance or a group health plan for the same condition by another insurer or group health plan for a period of not less than 12 months within the 15-month period ending with the month in which the application for coverage is made.

(b) PREEXISTING CONDITIONS.—An insurer or sponsor of a group health plan shall waive any period applicable to a preexisting condition under health insurance or a group health plan if the employer or individual was covered by health insurance or a group health plan for the same condition by another insurer or sponsor of a group health plan for a period of not less than 12 months within

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

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

SEC. 104. LIMITATION ON CONTINUATION PREMIUMS.

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

SEC. 105. BASIS FOR VARIATIONS IN PREMIUMS.

Nothing in sections 102 and 104 shall be construed as prohibiting variations in health insurance premiums among employers or individuals based on differences in covered services, age, gender, family composition, geographic area, or group size.

SEC. 106. DISCLOSURE OF RATING PRACTICES.

An insurer shall upon request fully disclose all actuarial assumptions and methods used in establishing its

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

SEC. 107. ENFORCEMENT.

Any insurer or sponsor of a group health plan which fails to comply with the provisions of this part shall be subject to a civil money penalty of $250,000 for each individual for each violation. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under this section in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

SEC. 108. DEFINITIONS.

For purposes of this title:

(1)(A) The term ''health insurance'' means any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract, that is provided by an insurer, other than health insurance described in subparagraph (B).

(B) The term ''health insurance'' does not include any of the following (or any combination thereof):

(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.

(v) Automobile medical-payment insurance.

(vi) Coverage for a specified disease or illness.

(vii) A hospital or fixed indemnity policy (unless the Secretary determines that such a policy provides sufficiently comprehensive coverage of a benefit so that it should be treated as a health benefit plan).

(viii) Credit insurance.

(2) The term ''insurer'' means a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or multiple employer health plan (as defined in section 3(40) of the Employee Retirement Income Security Act of

1974) regulated under State or Federal law for solvency.

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

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

SEC. 109. EFFECTIVE DATE.

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

PART 2—STATE PREEMPTIONS

SEC. 111. PROHIBITION OF STATE BENEFIT MANDATE.

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

SEC. 112. ELIMINATION OF RESTRICTIONS ON GROUP PURCHASE OF INSURANCE.

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

SEC. 113. EFFECTIVE DATE.

This part shall take effect on the date of the enactment of this Act.

Subtitle B—ERISA and Internal Revenue Code Requirements

SEC. 131. CLARIFICATION OF ERISA PREEMPTION.

(a) IN GENERAL.—Section 514(b)(6)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(6)(A)) is amended—

(1) in clause (i), by striking ''in the case'' and inserting ''In the case'', and by striking in subclause (ii) '', and'' and inserting a period; and

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

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

SEC. 132. SOLVENCY REQUIREMENTS FOR SINGLE-EMPLOYER PLANS.

(a) IN GENERAL.—Section 609 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1168) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by inserting after subsection (d) the following new subsection:

''(e) SOLVENCY REQUIREMENTS FOR SINGLE-EMPLOYER PLANS.—

''(1) IN GENERAL.—The Secretary shall prescribe by regulation—

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

''(B) rules for monitoring and enforcing compliance with such standards.

''(2) TREATMENT OF EXCESS OR STOP-LOSS COVERAGE.—In prescribing solvency standards pursuant to paragraph (1), the Secretary shall take into consideration the extent to which a plan's potential liabilities are covered by excess or stop-loss coverage.

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

standards pursuant to paragraph (1), the plan sponsor of each group health plan shall, in accordance with such regulations, take such steps as are necessary to ensure that plan assets held for the purpose of complying with such solvency standards are held in trust under the plan and are available solely for such purpose.''.

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

SEC. 133. CLARIFICATION OF VEBA CONTRIBUTIONS.

Paragraph (1) of section 419A(c) of the Internal Revenue Code of 1986 (relating to qualified asset account; limitation on additions to account) is amended by striking ''and'' at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting '', and'', and by adding at the end the following new subparagraph:

''(C) in the case of an account providing medical benefits, compliance with Federal or State solvency requirements.''

TITLE II—TAX FAIRNESS

SEC. 201. INDIVIDUALS ALLOWED DEDUCTION FROM GROSS INCOME FOR COST OF HEALTH INSURANCE AND CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.

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

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

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

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

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

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

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

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

''(1) the amounts paid during the taxable year for coverage of the taxpayer, his spouse, and dependents (as defined in section 152) under any health plan,

''(2) in the case of a taxpayer who is an eligible individual (as defined in subsection (f)), the amounts paid in cash during the taxable year by or on behalf of such taxpayer to a medical savings account for the benefit of the taxpayer, his spouse, and dependents (as so defined) if such spouse and dependents are eligible individuals, and

''(3) the expenses (other than expenses described in paragraph (1)) paid during the taxable year, not compensated by insurance or otherwise, for medical care of the taxpayer, his spouse, and dependents (as so defined) to the extent such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer.

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

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

is amended by adding at the end the following new subsection:

''(f) DEFINITIONS AND SPECIAL RULES RELATING TO MEDICAL SAVINGS ACCOUNTS.—

''(1) ONLY 1 ACCOUNT PER FAMILY.—Except as provided in regulations prescribed by this Secretary, no deduction shall be allowed under subsection (a)(2) 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)(2) for the taxable year shall not exceed the lesser of—

''(A) the lowest deductible under any catastrophic health plan providing coverage to any beneficiary of the medical savings account, or

''(B)(i) $2,500, or

''(ii) $5,000 if the catastrophic health plan covering the taxpayer provides coverage for more than 1 individual.

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

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

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

''(A) IN GENERAL.—The term 'eligible individual' means any individual who is covered under a catastrophic health plan throughout the calendar year in which or with which the taxable year ends.

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

''(4) CATASTROPHIC HEALTH PLAN.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'catastrophic health plan' means a health plan covering specified expenses incurred by an individual for medical care 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 $1,800 ($3,600 if the catastrophic

health plan covering the taxpayer provides coverage for more than 1 individual) or such higher amounts as may be specified by the plan.

''(B) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year after 1994, each dollar amount in subparagraph (A) 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.

''(5) NO DEDUCTION FOR MEDICAL EXPENSES PAID FROM ACCOUNT.—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 such Code 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 213(a)(2).''

(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 213(a)(2) of the Internal Revenue Code of 1986.''

(2) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end thereof 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 213(a)(2).''

(3) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code 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 213(a)(2).''

(4) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code 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 213(a)(2).''

(e) REFUNDABLE INCOME TAX CREDIT EQUIVALENT TO EXEMPTION FROM FICA TAXES FOR NONEMPLOYMENT-RELATED PURCHASES OF HEALTH PLAN COVERAGE AND CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of such Code (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

''SEC. 35. FICA TAXES ON AMOUNTS USED TO PAY FOR PURCHASE OF HEALTH PLAN COVERAGE AND TO MAKE CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.

''(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to the allocable FICA tax for such year.

''(b) ALLOCABLE FICA TAX.—For purposes of this section, the term 'allocable FICA tax' means, for any taxable year, the sum of—

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

''(2) the sum of the amounts by which the taxes imposed by sections 3101(a) and 3111(a) would have been reduced for such calendar year if the contribution and benefit base (as determined under section 230 of the Social Security Act) for such calendar year were reduced by the aggregate of the amounts described in subsection (c).

''(c) AMOUNTS DESCRIBED.—

''(1) IN GENERAL.—The amounts described in this subsection are—

''(A) the amounts paid for coverage of the taxpayer, his spouse, and dependents (as defined in section 152) under any health plan, and

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

pendents (as so defined) if such spouse and dependents are eligible individuals.

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

''(2) LIMITATIONS.—

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

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

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

(3) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the item relating to section 35 and inserting the following:

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

''Sec. 36. Overpayments of tax.''

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

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

TITLE III—MEDICAL SAVINGS ACCOUNTS

SEC. 301. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 7524. MEDICAL SAVINGS ACCOUNTS.

''(a) MEDICAL SAVINGS ACCOUNTS.—For purposes of this title—

''(1) MEDICAL SAVINGS ACCOUNT.—

''(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 (b)(4), 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 section 213(a)(2) 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 plan (as defined in section 213(f)(4)),

''(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 plan, and

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

''(2) MEDICAL EXPENSES.—The term 'medical expenses' means, with respect to an individual, amounts paid or incurred by such individual for—

''(A) medical care (as defined in section 213), or

''(B) long-term care (as defined in paragraph (3)),

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 are not compensated for by insurance or otherwise.

''(3) LONG-TERM CARE.—

''(A) IN GENERAL.—The term 'long-term care' means diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services which are required by, and provided to, a chronically ill individual, which have as their primary purpose the direct provision of needed assistance with 1 or more activities of daily living (or the alleviation of the conditions necessitating such assistance) that the individual is certified under subparagraph (B) as being unable to perform, and which are provided in a setting other than an acute care unit of a hospital pursuant to a continuing plan of care prescribed by a physician or registered professional nurse. Such term does not include food or lodging provided in an institutional or other setting, or basic living services associated with the maintenance of a household or participation in

community life, such as case management, transportation or legal services, or the performance of home maintenance or household chores.

''(B) CHRONICALLY ILL INDIVIDUAL.—The term 'chronically ill individual' means an individual who is certified by a physician or registered professional nurse as being unable to perform at least 3 activities of daily living without substantial assistance from another individual. For purposes of this paragraph, the term 'activities of daily living' means bathing, dressing, eating, toileting, transferring, and walking.

''(4) 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).

''(b) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) IN GENERAL.—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 unless

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

''(2) 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 section 213(a)(2) 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.

''(3) PENALTY FOR DISTRIBUTIONS NOT USED FOR MEDICAL EXPENSES.—

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

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

''(B) ACCOUNT BALANCE LIMITATION.—If—

''(i) the tax imposed by this chapter is required to be increased under subparagraph (A) by reason of a distribution, and

''(ii) after such distribution, the aggregate balance of all medical savings accounts established for the benefit of the individual, is less than the amount of the deductible under the catastrophic health plan covering such individual,

subparagraph (A) shall be applied by substituting '50 percent' for '10 percent'.

''(4) 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 ac-

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

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

''(A) IN GENERAL.—If during any taxable year—

''(i) there is a payment of a mandatory distribution expense incurred by a beneficiary of a medical savings account, and

''(ii) the person making such payment is not reimbursed for such payment with a distribution from such account before the 60th day after such payment,

the taxpayer's tax imposed by this chapter for such taxable year shall be increased by 100 percent of the excess of the amount of such payment over the amount of reimbursement made before such 60th day.

''(B) MANDATORY DISTRIBUTION EXPENSE.—For purposes of subparagraph (A), the term 'mandatory distribution expense' means any expense incurred which may be counted towards a deductible, or for a

copayment or coinsurance, under the catastrophic health plan covering such beneficiary.

''(c) 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

(b) 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.

''(d) 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 (a).

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.

''(e) 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) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (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 7524(a)),'',

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

(4) by adding at the end thereof 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 7524(a)), the term 'excess contributions' means the amount by which the amount contributed for the taxable year to the account exceeds the amount allowable as a deduction under section 213(a)(2) 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 7524(b)(2) applies shall be treated as an amount not contributed.''

(c) TAX ON PROHIBITED TRANSACTIONS.—Section 4975 of such Code (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

7524(a)) 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 medical savings account by reason of the application of section 7524(b)(2)(A) to such account.'', and

(2) by inserting ''or a medical savings account described in section 7524(a)'' in subsection (e)(1) after ''described in section 408(a)''.

(d) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—Section 6693 of such Code (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 7524(e) 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.''

(e) CLERICAL AMENDMENTS.—

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

''Sec. 7524. Medical savings accounts.''

(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.

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

TITLE IV—MEDICAL MALPRACTICE

SEC. 401. 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. 402. 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. 403. 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. 404. 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. 405. 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. 406. TREATMENT OF COSTS AND ATTORNEY'S FEES.

(a) 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.

(b) 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.

(c) 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 subsection (b) 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—

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

(2) 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

(3) 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.

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

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

(2) reduce the amount to be awarded pursuant to this section, 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 in-

creased the costs of, the final resolution of the matter in controversy.

SEC. 407. 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. 408. 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 submitted 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 de-

gree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

SEC. 409. 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 packaging 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 with-

held 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. 410. EFFECTIVE DATE.

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

TITLE V—ANTITRUST REFORM

SEC. 501. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guidelines on the application of antitrust laws to the activities

of health plans. The guidelines shall be designed to facilitate the development and operation of plans, consistent with the antitrust laws.

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

(c) DEFINITIONS.—In this section—

(1) 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); and

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

curred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract, but does not include—

(A) coverage only for accident, dental, vision, disability, or long term care, medicare supplemental health insurance, or any combination thereof,

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

(C) workers' compensation or similar insurance, or

(D) automobile medical-payment insurance.

SEC. 502. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary of Health and Human Services, shall issue in accordance with this section a certificate of public advantage to each eligible health care collaborative activity 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 ac-

tivity, and the parties to such activity, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such activity 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 collaborative activity if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the activity outweigh the reduction in competition (if any) that is likely to result from the activity, 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 activity 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 the availability of equally efficient, less restrictive alternatives to achieve the benefits that are intended to be achieved by carrying out the activity.

(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 collaborative activity (in the case of an activity in existence as of the time of the application) and implementation plan for the collaborative activity.

(d) ELIGIBLE HEALTH CARE COLLABORATIVE ACTIVITY.—To be an eligible health care collaborative activity for purposes of this section, a health care collaborative activity 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 activity that the activity will not foreclose competition by entering into contracts that prevent health care providers from providing health care in competition with the activity,

(2) an agreement that the activity will submit to the Attorney General annually a report that describes the operations of the activity and information

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

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

(e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—Not later than 90 days after an eligible health care collaborative activity 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 90-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 collaborative activity 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 At-

torney 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 collaborative activity 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 re-

vokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care collaborative activity 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 collaborative activity with respect to which such a certificate is in effect.

(i) DEFINITIONS.—In this section:

(1) The term ''antitrust laws'' has the meaning given it in section 501(c)(1).

(2) The term ''certificate'' means a certificate of public advantage authorized to be issued under subsection (a).

(3) The term ''health care collaborative activity'' 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.

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

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

(6) 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 VI—CONSUMER INFORMATION

SEC. 601. REQUIREMENT FOR DISCLOSURE OF PRICES FOR HEALTH CARE SERVICES.

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

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

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

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

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

(e) EFFECTIVE DATE.—This section shall apply to items and services furnished on or after the date of issuance of final regulations under subsection (d).

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