

104TH CONGRESS
1ST SESSION

S. 121

To guarantee individuals and families continued choice and control over their doctors and hospitals, to ensure that health coverage is permanent and portable, to provide equal tax treatment for all health insurance consumers, to control medical cost inflation through medical savings accounts, to reform medical liability litigation, to reduce paperwork, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 4, 1995

Mr. GRAMM introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Family Health Care Preservation Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—PORTABLE AND PERMANENT PRIVATE HEALTH
INSURANCE

Subtitle A—Portability

Sec. 101. Amendments to COBRA.

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

Subtitle B—Permanence

Sec. 111. General renewability requirements.

Sec. 112. Individual health insurance plans.

Sec. 113. Group health plans.

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

Sec. 115. Definitions.

TITLE II—AFFORDABLE HEALTH INSURANCE COVERAGE

Sec. 200. Amendment of 1986 Code.

Subtitle A—Equitable Tax Treatment of Individuals Providing Own Health
Care

Sec. 201. Deduction for individuals and self-employed individuals providing own
health insurance.

Subtitle B—Medical Savings Accounts

Sec. 211. Medical savings accounts.

TITLE III—ENHANCED EFFICIENCY THROUGH PAPERWORK
REDUCTION

Sec. 301. Federal paperwork reduction and efficiency requirements.

Sec. 302. State paperwork reduction and efficiency requirements.

TITLE IV—MEANINGFUL MEDICAL LIABILITY REFORM

Sec. 401. Applicability and preemption.

Sec. 402. Statute of limitations.

Sec. 403. Scope of liability.

Sec. 404. Discovery; failure to make or cooperate in discovery.

Sec. 405. Limitation on noneconomic damages.

Sec. 406. Treatment of payments for future economic losses.

- Sec. 407. Treatment of costs and attorney's fees.
- Sec. 408. Contribution and indemnification.
- Sec. 409. Collateral sources.
- Sec. 410. Damages relating to medical product liability claims.
- Sec. 411. Class actions.
- Sec. 412. Definitions.
- Sec. 413. Severability.
- Sec. 414. Effective date.

1 **TITLE I—PORTABLE AND PER-**
 2 **MANENT PRIVATE HEALTH**
 3 **INSURANCE**

4 **Subtitle A—Portability**

5 **SEC. 101. AMENDMENTS TO COBRA.**

6 (a) LOWER COST COVERAGE OPTIONS.—Subpara-
 7 graph (A) of section 4980B(f)(2) of the Internal Revenue
 8 Code of 1986 (relating to continuation coverage require-
 9 ments of group health plans) is amended to read as fol-
 10 lows:

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

14 “(i) is identical to the coverage pro-
 15 vided under the plan to similarly situated
 16 beneficiaries under the plan with respect to
 17 whom a qualifying event has not occurred,

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

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

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

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

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

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

18 (3) by inserting after subclause (I) the follow-
19 ing new subclause:

20 “(II) eligible for such employer-
21 based coverage for more than 90 days,
22 or”.

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

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

3 (a) IN GENERAL.—Subparagraph (A) of section
4 72(t)(2) of the Internal Revenue Code of 1986 (relating
5 to additional tax not to apply to certain distributions) is
6 amended—

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

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

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

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

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

20 **Subtitle B—Permanence**

21 **SEC. 111. GENERAL RENEWABILITY REQUIREMENTS.**

22 (a) INSURERS.—

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

1 (A) for nonpayment of premiums,

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

4 (C) for noncompliance with plan provi-
5 sions, or

6 (D) because the insurer is ceasing to pro-
7 vide any health insurance plan in a State, or,
8 in the case of a health maintenance organiza-
9 tion, in a geographic area.

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

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

18 (1) for nonpayment of premiums,

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

21 (3) for noncompliance with plan provisions, or

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

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

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

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

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

15 **SEC. 113. GROUP HEALTH PLANS.**

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

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

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

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

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

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

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

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

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

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

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

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

14 “(o) GROUP HEALTH PLANS.—The expenses paid or
15 incurred by an employer for a group health plan shall not
16 be allowed as a deduction under this section unless such
17 plan meets the requirements of section 113 of the Family
18 Health Care Preservation Act.”

19 (d) PAYROLL TAX EXCLUSION FOR EMPLOYER-PRO-
20 VIDED HEALTH INSURANCE.—Section 209(a)(2) of the
21 Social Security Act (42 U.S.C. 409(a)(2)) is amended by
22 inserting “or group health insurance” after “group-term
23 life insurance”.

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

4 **SEC. 115. DEFINITIONS.**

5 For purposes of this subtitle:

6 (1) EMPLOYER.—The term “employer” shall
7 have the meaning applicable under section 3(5) of
8 the Employee Retirement Income Security Act of
9 1974 (29 U.S.C. 1002(5)).

10 (2) GROUP HEALTH PLAN.—The term “group
11 health plan” has the meaning given such term by
12 section 5000(b)(1) of the Internal Revenue Code of
13 1986, but does not include any type of coverage ex-
14 cluded from the definition of a health insurance plan
15 under paragraph (2).

16 (3) HEALTH INSURANCE PLAN.—

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

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

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

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

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

24 (6) STATE.—The term “State” means each of
25 the several States of the United States, the District

1 of Columbia, the Commonwealth of Puerto Rico, the
 2 United States Virgin Islands, Guam, American
 3 Samoa, and the Commonwealth of the Northern
 4 Mariana Islands.

5 **TITLE II—AFFORDABLE HEALTH**
 6 **INSURANCE COVERAGE**

7 **SEC. 200. AMENDMENT OF 1986 CODE.**

8 Except as otherwise expressly provided, whenever in
 9 this subtitle an amendment or repeal is expressed in terms
 10 of an amendment to, or repeal of, a section or other provi-
 11 sion, the reference shall be considered to be made to a
 12 section or other provision of the Internal Revenue Code
 13 of 1986.

14 **Subtitle A—Equitable Tax Treat-**
 15 **ment of Individuals Providing**
 16 **Own Health Care**

17 **SEC. 201. DEDUCTION FOR INDIVIDUALS AND SELF-EM-**
 18 **PLOYED INDIVIDUALS PROVIDING OWN**
 19 **HEALTH INSURANCE.**

20 (a) GENERAL RULE.—Section 213 (relating to medi-
 21 cal, dental, etc. expenses) is amended by adding at the
 22 end the following new subsection:

23 “(f) HEALTH INSURANCE COSTS OF INDIVIDUALS.—

24 “(1) IN GENERAL.—The adjusted gross income
 25 limitation under subsection (a) shall not apply to

1 amounts paid by an individual during the taxable
2 year for qualified health insurance costs (and such
3 amounts shall not be taken into account in deter-
4 mining whether such limitation applies to other
5 amounts).

6 “(2) QUALIFIED HEALTH INSURANCE COSTS.—
7 For purposes of this subsection—

8 “(A) IN GENERAL.—The term ‘qualified
9 health insurance costs’ means amounts paid for
10 insurance described in subparagraphs (C) and
11 (D) of subsection (d)(1) for the taxpayer, the
12 taxpayer’s spouse, or any dependent (as defined
13 in section 152).

14 “(B) LIMITATIONS.—For purposes of sub-
15 paragraph (A)—

16 “(i) NO DEDUCTION FOR EMPLOYER-
17 SUBSIDIZED HEALTH COSTS.—Qualified
18 health insurance costs shall not include
19 any amount paid for insurance coverage of
20 an individual for any month if the individ-
21 ual is eligible to participate for such month
22 in an employer-subsidized health plan
23 maintained by any employer of the tax-
24 payer, the taxpayer’s spouse, or any de-
25 pendent.

1 “(ii) PHASE-IN.—In the case of tax-
 2 able years beginning after 1993 and before
 3 2001, only the following percentages of the
 4 qualified health insurance costs shall be
 5 taken into account:

“If the taxable year begins in:	The applicable percentage is:
1994, 1995 or 1996	25 percent
1997 or 1998	50 percent
1999 or 2000	75 percent.

6 “(3) DEDUCTION NOT ALLOWED FOR SELF-EM-
 7 PLOYMENT TAX PURPOSES.—The deduction allow-
 8 able by reason of this subsection shall not be taken
 9 into account in determining an individual’s net earn-
 10 ings from self-employment (within the meaning of
 11 section 1402(a)) for purposes of chapter 2.”

12 (b) DEDUCTION ALLOWED AGAINST GROSS IN-
 13 COME.—Section 62(a) (defining adjusted gross income) is
 14 amended by inserting after paragraph (15) the following
 15 new paragraph:

16 “(16) DEDUCTION FOR HEALTH INSURANCE
 17 PREMIUMS.—The deduction allowed under section
 18 213(a) for amounts described in section 213(f).”

19 (c) EFFECTIVE DATE.—The amendments made by
 20 this section shall apply to taxable years beginning after
 21 December 31, 1993.

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

3 **SEC. 211. MEDICAL SAVINGS ACCOUNTS.**

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

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

10 “(a) DEDUCTION ALLOWED.—In the case of an eligi-
11 ble individual, there shall be allowed as a deduction the
12 amounts paid in cash during the taxable year by or on
13 behalf of such individual to a medical savings account for
14 the benefit of such individual and (if any) such individual’s
15 spouse and dependents if such spouse and dependents are
16 eligible individuals.

17 “(b) LIMITATIONS.—

18 “(1) ONLY ONE ACCOUNT PER FAMILY.—Ex-
19 cept as provided in regulations prescribed by the
20 Secretary, no deduction shall be allowed under sub-
21 section (a) for amounts paid to any medical savings
22 account for the benefit of an individual, such indi-
23 vidual’s spouse, or any dependent of such individual
24 or spouse if such individual, spouse, or dependent is
25 a beneficiary of any other medical savings account.

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

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

7 “(1) ELIGIBLE INDIVIDUAL.—

8 “(A) IN GENERAL.—The term ‘eligible in-
9 dividual’ means any individual who is covered
10 under a catastrophic health insurance plan
11 throughout the calendar year in which or with
12 which the taxable year ends.

13 “(B) LIMITATIONS.—Such term does not
14 include an individual who is 65 years of age or
15 older, unless the individual is covered under a
16 catastrophic health insurance plan that is a pri-
17 mary plan (within the meaning of section
18 1862(b)(2)(A) of the Social Security Act).

19 “(2) CATASTROPHIC HEALTH INSURANCE
20 PLAN.—

21 “(A) IN GENERAL.—The term ‘cata-
22 strophic health insurance plan’ means a health
23 plan covering specified expenses incurred by an
24 individual for medical care (as defined in sub-
25 paragraph (B)) for such individual and the

1 spouse and dependents (as defined in section
2 152) of such individual only to the extent such
3 expenses covered by the plan for any calendar
4 year exceed \$3,000 or such higher amounts as
5 may be specified by the plan.

6 “(B) MEDICAL CARE.—The term ‘medical
7 care’ means medical care as defined in section
8 213(d) (without regard to non-emergency trans-
9 portation under paragraph (1)(B) and amounts
10 described in paragraph (2)).

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

16 “(i) such dollar amount, multiplied by

17 “(ii) the cost-of-living adjustment de-
18 termined under section 1(f)(3) for such
19 calendar year.

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

23 “(d) MEDICAL SAVINGS ACCOUNT.—For purposes of
24 this section:

25 “(1) MEDICAL SAVINGS ACCOUNT DEFINED.—

1 “(A) IN GENERAL.—The term ‘medical
2 savings account’ means a trust created or orga-
3 nized in the United States exclusively for the
4 purpose of paying the medical expenses of the
5 beneficiaries of such trust, but only if the writ-
6 ten governing instrument creating the trust
7 meets the following requirements:

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

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

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

24 “(iv) The assets of the trust will not
25 be commingled with other property except

1 in a common trust fund or common invest-
2 ment fund.

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

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

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

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

22 “(ii) such account is exclusively for
23 the purpose of paying the medical expenses
24 of the beneficiaries of such account who

1 are covered under such catastrophic health
2 insurance plan, and

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

7 “(2) MEDICAL EXPENSES.—

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

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

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

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

24 “(3) TIME WHEN CONTRIBUTIONS DEEMED
25 MADE.—A contribution shall be deemed to be made

1 on the last day of the preceding taxable year if the
2 contribution is made on account of such taxable year
3 and is made not later than the time prescribed by
4 law for filing the return for such taxable year (not
5 including extensions thereof).

6 “(e) TAX TREATMENT OF DISTRIBUTIONS.—

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

12 “(2) EXCEPTION FOR MEDICAL AND LONG-
13 TERM CARE EXPENSES.—

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

17 “(i) the medical expenses of such indi-
18 vidual, or

19 “(ii) except as provided in subpara-
20 graph (B), the expenses for
21 long-term care services of the type identi-
22 fied in section 1931(e)(3) of the Social Se-
23 curity Act for the individual.

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

1 Paragraph (1) shall apply to any portion of a
2 payment or distribution for expenses for long-
3 term care services equal to the amount by
4 which, after such payment or distribution—

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

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

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

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

22 “(A) such distribution is received by the
23 individual on or before the last day prescribed
24 by law (including extensions of time) for filing

1 such individual's return for such taxable year,
2 and

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

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

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

13 “(A) IN GENERAL.—The tax imposed by
14 this chapter for any taxable year in which there
15 is a payment or distribution from a medical
16 savings account which is includible in gross in-
17 come under paragraph (1) shall be increased by
18 10 percent with respect to the penalty portion
19 of such payment or distribution.

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

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

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

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

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

20 “(f) TAX TREATMENT OF ACCOUNTS.—

21 “(1) EXEMPTION FROM TAX.—Any medical sav-
22 ings account is exempt from taxation under this sub-
23 title unless such account has ceased to be a medical
24 savings account by reason of paragraph (2) or (3).

1 Notwithstanding the preceding sentence, any such
2 account shall be subject to the taxes imposed by sec-
3 tion 511 (relating to imposition of tax on unrelated
4 business income of charitable, et cetera organiza-
5 tions).

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

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

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

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

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

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

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

19 For purposes of this title, in the case of a custodial ac-
20 count treated as a trust by reason of the preceding sen-
21 tence, the custodian of such account shall be treated as
22 the trustee thereof.

23 “(h) REPORTS.—The trustee of a medical savings ac-
24 count shall make such reports regarding such account to
25 the Secretary and to the individual for whose benefit the

1 account is maintained with respect to contributions, dis-
2 tributions, and such other matters as the Secretary may
3 require under regulations. The reports required by this
4 subsection shall be filed at such time and in such manner
5 and furnished to such individuals at such time and in such
6 manner as may be required by those regulations.”

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

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

15 (c) DISTRIBUTIONS FROM MEDICAL SAVINGS AC-
16 COUNTS NOT ALLOWED AS MEDICAL EXPENSE DEDUC-
17 TION.—Section 213 of the Internal Revenue Code of 1986
18 (relating to medical, dental, et cetera, expenses) is amend-
19 ed by adding at the end the following new subsection:

20 “(g) COORDINATION WITH MEDICAL SAVINGS AC-
21 COUNTS.—The amount otherwise taken into account
22 under subsection (a) as expenses paid for medical care
23 shall be reduced by the amount (if any) of the distribu-
24 tions from any medical savings account of the taxpayer

1 during the taxable year which is not includible in gross
2 income by reason of being used for medical care.”

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

6 (1) SOCIAL SECURITY TAXES.—

7 (A) Subsection (a) of section 3121 of the
8 Internal Revenue Code of 1986 (defining
9 wages) is amended by striking “or” at the end
10 of paragraph (20), by striking the period at the
11 end of paragraph (21) and inserting “; or”, and
12 by inserting after paragraph (21) the following
13 new paragraph:

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

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

1 “(19) remuneration paid to or on behalf of an
2 employee if (and to the extent that) at the time of
3 payment of such remuneration it is reasonable to be-
4 lieve that a corresponding deduction is allowable
5 under section 220 of the Internal Revenue Code of
6 1986.”

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

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

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

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

1 payment of such remuneration it is reasonable to be-
2 lieve that a corresponding deduction is allowable
3 under section 220.”

4 (4) WITHHOLDING TAX.—Subsection (a) of sec-
5 tion 3401 of such Code (defining wages) is amended
6 by striking “or” at the end of paragraph (19), by
7 striking the period at the end of paragraph (20) and
8 inserting “; or”, and by inserting after paragraph
9 (20) the following new paragraph:

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

15 (e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
16 of the Internal Revenue Code of 1986 (relating to tax on
17 excess contributions to individual retirement accounts, cer-
18 tain section 403(b) contracts, and certain individual re-
19 tirement annuities) is
20 amended—

21 (1) by inserting “medical savings accounts,”
22 after “accounts,” in the heading of such section,

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

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

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

5 (4) by adding at the end the following new sub-
6 section:

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

18 (f) TAX ON PROHIBITED TRANSACTIONS.—Section
19 4975 of the Internal Revenue Code of 1986 (relating to
20 prohibited transactions) is amended—

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

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

1 220(d)) is established shall be exempt from the tax
2 imposed by this section with respect to any trans-
3 action concerning such account (which would other-
4 wise be taxable under this section) if, with respect
5 to such transaction, the account ceases to be a medi-
6 cal savings account by reason of the application of
7 section 220(f)(2)(A) to such account.”, and

8 (2) by inserting “or a medical savings account
9 described in section 220(d)” in subsection (e)(1)
10 after “described in section 408(a)”.

11 (g) FAILURE TO PROVIDE REPORTS ON MEDICAL
12 SAVINGS ACCOUNTS.—Section 6693 of the Internal Reve-
13 nue Code of 1986 (relating to failure to provide reports
14 on individual retirement account or annuities) is amend-
15 ed—

16 (1) by inserting “or on medical savings ac-
17 counts” after “annuities” in the heading of such sec-
18 tion, and

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

1 (h) CLERICAL AMENDMENTS.—

2 (1) The table of sections for part VII of sub-
3 chapter B of chapter 1 of the Internal Revenue Code
4 of 1986 is amended by striking the last item and in-
5 serting the following:

“Sec. 220. Medical savings accounts.
“Sec. 221. Cross reference.”

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

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

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

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

16 **TITLE III—ENHANCED EFFI-**
17 **CIENCY THROUGH PAPER-**
18 **WORK REDUCTION**

19 **SEC. 301. FEDERAL PAPERWORK REDUCTION AND EFFI-**
20 **CIENCY REQUIREMENTS.**

21 (a) IN GENERAL.—The Secretary of Health and
22 Human Services (hereafter referred to in this title as the

1 “Secretary”) shall, in consultation with the Director of the
2 Office of Management and Budget, the Secretary of Veter-
3 ans Affairs, the Secretary of Defense, the Director of Per-
4 sonnel Management, and other appropriate Federal offi-
5 cials, adopt standards to reduce the administrative and
6 paperwork burdens of all Federal health care programs
7 by—

8 (1) 50 percent within the 2-year period follow-
9 ing the date of the enactment of this Act, and

10 (2) an additional 50 percent reduction from the
11 balance specified in (1) over a subsequent 3-year pe-
12 riod,

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

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

19 (1) Data elements for use in paper and elec-
20 tronic claims processing under health insurance
21 plans (as defined in section 115(3)), as well as for
22 use in utilization review and management of care
23 (including data fields, formats, and medical nomen-
24 clature, and including plan benefit and insurance in-
25 formation).

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

5 (3) Uniform electronic transmission of the data
6 elements (for purposes of billing and utilization re-
7 view).

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

17 (c) SUBSEQUENT REDUCTION.—In order to achieve
18 a further paperwork reduction described in subsection
19 (a)(2), the Secretary shall modify by regulation the stand-
20 ards adopted under subsection (b). The modification of the
21 standards may include any other provisions necessary to
22 meet the goals for reduction in the paperwork burden of
23 Federal health care programs.

24 (d) DEFINITION.—For purposes of this section, the
25 term “Federal health care program” means all Federal

1 programs related to health care, including programs de-
2 scribed in—

3 (1) title XVIII or XIX of the Social Security

4 Act,

5 (2) the Public Health Service Act,

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

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

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

9 or

10 (6) the Indian Health Care Improvement Act.

11 **SEC. 302. STATE PAPERWORK REDUCTION AND EFFI-**
12 **CIENCY REQUIREMENTS.**

13 (a) IN GENERAL.—In order to be eligible for Federal
14 funds in connection with any State-administered health
15 care program, each State shall standardize the processing
16 of paper and electronic claims to reduce the administrative
17 and paperwork burdens on such programs by 75 percent
18 during the 5-year period following the date of the enact-
19 ment of this Act.

20 (b) ENFORCEMENT.—

21 (1) INTERIM EVALUATION.—If at the end of the
22 4-year period following the date of the enactment of
23 this Act the Secretary determines that a State has
24 not achieved substantial progress toward the reduc-
25 tions required under subsection (a), the Secretary

1 shall notify such State regarding the proportion of
2 required reductions achieved and the further reduc-
3 tion necessary to achieve compliance with subsection
4 (a).

5 (2) FINAL COMPLIANCE.—If at the end of the
6 5-year period following the date of the enactment of
7 this Act the Secretary determines that a State has
8 not achieved the reductions required under sub-
9 section (a), the Secretary shall reduce Federal pay-
10 ments for health care programs administered by
11 such State by 10 percent. For each year that such
12 State fails to comply with the requirements of sub-
13 section (a), Federal payments for health care pro-
14 grams administered by the State shall be reduced by
15 an additional 10 percent.

16 (3) WAIVERS OF PAYMENT REDUCTIONS.—Any
17 State subject to a reduction in Federal payments
18 under paragraph (2) may appeal to the Secretary for
19 a 1-year waiver of such reduction. In granting such
20 a waiver, the Secretary shall make a determination
21 of the good faith effort of such State to comply with
22 the requirements of subsection (a), taking into ac-
23 count the technical, practical, and financial capabili-
24 ties of the State in meeting such requirements.

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

7 **TITLE IV—MEANINGFUL**
8 **MEDICAL LIABILITY REFORM**

9 **SEC. 401. APPLICABILITY AND PREEMPTION.**

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

17 (b) PREEMPTION.—

18 (1) IN GENERAL.—The provisions of this title
19 shall preempt any State or local law to the extent
20 such law is inconsistent with the limitations con-
21 tained in such provisions. The provisions of this title
22 shall not preempt any State law that provides for
23 defenses or places limitations on a person’s liability
24 in addition to those contained in this title, places
25 greater limitations on the amount of attorneys’ fees

1 and expenses that can be collected, or otherwise im-
2 poses greater restrictions than those provided in this
3 title.

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

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

18 (1) waive or affect any defense of sovereign im-
19 munity asserted by any State under any provision of
20 law;

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

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

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

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

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

15 **SEC. 402. STATUTE OF LIMITATIONS.**

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

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

12 **SEC. 403. SCOPE OF LIABILITY.**

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

21 (b) DETERMINATION OF PERCENTAGE OF LIABIL-
22 ITY.—The trier of fact in a medical malpractice liability
23 action shall determine the extent of each defendant's fault
24 or responsibility for the economic or noneconomic damages

1 suffered by the claimant, and shall assign a percentage
2 of responsibility for such injury to each such defendant.

3 **SEC. 404. DISCOVERY; FAILURE TO MAKE OR COOPERATE**
4 **IN DISCOVERY.**

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

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

19 **SEC. 405. LIMITATION ON NONECONOMIC DAMAGES.**

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

1 against whom the action is brought or the number of ac-
2 tions brought with respect to such injury.

3 **SEC. 406. TREATMENT OF PAYMENTS FOR FUTURE ECO-**
4 **NOMIC LOSSES.**

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

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

23 (c) REQUIREMENT OF PERIODIC PAYMENT AS FINAL
24 ORDER.—A judgment of a court awarding periodic pay-
25 ments under this section may not be reopened at any time

1 to contest, amend, or modify the schedule or amount of
2 the payments in the absence of fraud or any other basis
3 under which a party may obtain relief from a final judg-
4 ment.

5 **SEC. 407. TREATMENT OF COSTS AND ATTORNEY'S FEES.**

6 (a) COSTS AND FEES, GENERALLY.—

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

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

1 (3) APPLICATION FOR RECOVERY OF COSTS.—

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

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

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

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

23 In determining whether or not the position of the
24 nonprevailing party was substantially justified the

1 court shall consider only the record presented in the
2 action maintained for the costs and fees.

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

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

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

17 (b) ATTORNEY'S FEES.—

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

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

3 (B) 15 percent of any amount in excess of
4 \$150,000 recovered.

5 (2) RECORDS.—

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

17 (B) CALCULATION.—The court shall deter-
18 mine the amount of reasonable attorneys' fees
19 and expenses that shall be awarded in a medical
20 malpractice liability action under this title on
21 the basis of an hourly rate or as a percentage
22 of the total damages awarded under such action
23 for economic and noneconomic losses. Such
24 amount shall be indexed to account for infla-
25 tion. The amount of attorneys' fees and ex-

1 penses as determined by the court may not ex-
2 ceed an amount that would be considered rea-
3 sonable based on the following:

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

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

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

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

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

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

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

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

1 **SEC. 408. CONTRIBUTION AND INDEMNIFICATION.**

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

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

17 **SEC. 409. COLLATERAL SOURCES.**

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

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

1 (A) was subject to approval under section
2 505, or premarket approval under section 515,
3 of the Federal Food, Drug, and Cosmetic Act
4 (21 U.S.C. 355 and 360e) by the Food and
5 Drug Administration with respect to—

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

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

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

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

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

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

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

1 mitted under the Federal Food, Drug, and Cosmetic
2 Act or section 352 of the Public Health Service Act
3 (42 U.S.C. 263) and that is material and relevant
4 to the action involved; or

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

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

16 **SEC. 411. CLASS ACTIONS.**

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

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

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

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

21 **SEC. 412. DEFINITIONS.**

22 For purposes of this title:

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

1 claim is alleged, including the decedent in the case
2 of an action brought through or on behalf of an es-
3 tate.

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

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

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

20 (5) HARM.—The term “harm” means—

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

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

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

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

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

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

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

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

7 (10) MEDICAL PRODUCT.—

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

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

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

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

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

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

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

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

7 (13) SECRETARY.—The term “Secretary”
8 means the Secretary of Health and Human Services.

9 (14) STATE.—The term “State” means each of
10 the several States of the United States, the District
11 of Columbia, the Commonwealth of Puerto Rico, the
12 United States Virgin Islands, Guam, American
13 Samoa, and the Commonwealth of the Northern
14 Mariana Islands.

15 **SEC. 413. SEVERABILITY.**

16 If any provision of this title or the application of any
17 provision to any person or circumstance is held invalid,
18 the remainder of this title and the application of such pro-
19 visions to any other person or circumstance shall not be
20 affected by such invalidation.

21 **SEC. 414. EFFECTIVE DATE.**

22 This title shall apply to all medical malpractice liabil-
23 ity actions commenced on or after the date of enactment
24 of this Act.

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S 121 IS—2

S 121 IS—3

S 121 IS—4

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