

Medicare Funding Warning Response Act of 2008

Summary

NOTE: Except as otherwise indicated, references in this summary are to the Social Security Act. Terms used in this summary have the following meanings:

- The "Secretary" means the Secretary of Health and Human Services.
- "Medicare" and "Medicare program" mean the program under title XVIII of the Social Security Act.
- "CMS" means the Centers for Medicare & Medicaid Services.
- "MMA" means The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).
- "Medicare funding warning" has the meaning given such term by section 801(a)(2) of the MMA.
- "Excess general revenue medicare funding" has the meaning given such term by section 801(c) of the MMA (and "excess funding" has the same meaning).

SECTION 1. SHORT TITLE; REFERENCES; PURPOSE OF LEGISLATION.

Subsection (a) provides that the Act may be cited as the "Medicare Funding Warning Response Act of 2008". Subsection (b) provides an explanation of various references used in the Act. Subsection (c) states that the purpose of the Act is to respond to the medicare funding warning currently in effect under section 801(a)(2) of the MMA.

TITLE I—INTRODUCING PRINCIPLES OF VALUE-BASED HEALTH CARE INTO THE MEDICARE PROGRAM

SEC. 101. INTRODUCING PRINCIPLES OF VALUE-BASED HEALTH CARE INTO THE MEDICARE PROGRAM.

Subsection (a) requires the Secretary to develop and implement a system for encouraging nationwide adoption and use of interoperable electronic health records and to make personal health records available to Medicare beneficiaries.

Subsection (b) requires the Secretary to provide price and cost information (including information related to episodes of care) to Medicare beneficiaries to assist them in making choices among providers, plans, and treatment options.

Subsection (c) requires the Secretary to provide quality of care information to Medicare beneficiaries to assist them in making choices among providers, plans, and treatment options. In addition, the Secretary is required to develop a plan for ensuring that by 2013, quality measures are available and reported with respect to at least 50 percent of the care provided under the Medicare program, and to report annually to the Congress on progress with respect to these goals.

Subsection (d) directs the Secretary to:

- Design and implement a system under which a portion of the payment that would otherwise be made to individuals or entities serving Medicare beneficiaries is based on the quality and efficiency of their performance. The Secretary would be required to first implement such system in settings where measures are well-accepted and already collected. The system would also include incentives for reducing unwarranted geographic variation in quality and efficiency.
- Implement incentives for Medicare beneficiaries to use more efficient providers and preventive services known to reduce costs, and assure a transition into the Medicare program for individuals who own health savings accounts.

Subsection (e) requires the Secretary to use and release Medicare data for quality improvement, performance measurement, public reporting, and treatment-related purposes.

Subsection (f) requires the Secretary to ensure that individually identifiable beneficiary health information is appropriately protected.

Subsection (g) authorizes the Secretary to implement any of the systems described in section 101 through regulation, but only if the Secretary provides for public notice and an opportunity for public comment with respect to such regulation.

Subsection (h) provides definitions of the terms "efficiency" and "information on quality of care".

Subsection (i) provides that the Secretary may implement the provisions of subsections (a) through (e) of section 101 and section 102 for a year only to the extent that the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services certifies) that:

- The total amount of payment made under Medicare over the five and ten year periods that begin with January 1 of such year as a result of the implementation of such provisions is less than the amount that would have been made over such periods if such provisions had not been implemented.

- The total amount of payment made under each of Medicaid and SCHIP over those same time periods is no greater than the amount that would have been made if such provisions had not been implemented.

SEC. 102. RELEASE OF PHYSICIAN PERFORMANCE MEASUREMENTS.

Section 102 amends section 1848(k) to add a new paragraph (9), authorizing the Secretary to publicly release physician-specific measurements of the quality or efficiency of physician performance (against a standard endorsed by the Secretary pursuant to a notice in the Federal Register). The Secretary is also authorized to release necessary data to an entity responsible for generating or calculating such measurements. Proposed section 1848(k)(9) provides that the Secretary may make such releases notwithstanding the provisions of the Privacy Act (section 552a of title 5, United States Code).

TITLE II—REDUCING THE EXCESSIVE BURDEN THE LIABILITY SYSTEM PLACES ON THE HEALTH CARE DELIVERY SYSTEM

SEC. 201. SHORT TITLE.

Section 201 provides that title II may be cited as the "Help, Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2008".

SEC. 202. FINDINGS AND PURPOSE.

Section 202 states the findings and purpose of the title.

SEC. 203. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

Section 203 establishes a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers (or should have discovered) the injury, whichever comes first, unless tolled on the basis of fraud, intentional concealment, or the presence of a foreign body in the injured person. This section also provides that lawsuits on behalf of minors under the age of six years must be commenced within three years of the manifestation of the injury or prior to their eighth birthday, whichever provides the longer period, with certain exceptions.

SEC. 204. COMPENSATING PATIENT INJURY.

Section 204 establishes rules concerning patients' ability to recover for certain types of damages. Included in section 204 are provisions:

- Declaring that, with respect to any health care lawsuit, nothing in title II limits the recovery of economic damages.
- Limiting noneconomic damages for the same injury to \$250,000, and prohibiting the jury from being informed of such limit.

- Making each party liable only for the amount of damages directly proportional to such party's percentage of responsibility.

SEC. 205. MAXIMIZING PATIENT RECOVERY.

Section 205 requires court supervision over payment arrangements to protect against conflicts of interest that may reduce the amount of damages awarded that are actually paid to claimants. Section 205 authorizes courts to restrict the payment of attorney contingency fees, and provides that the total of all contingency fees for representing all claimants in a health care lawsuit may not exceed: (1) 40 percent of the first \$50,000 recovered by the claimant(s); (2) 33 1/3 percent of the next \$50,000; (3) 25 percent of the next \$500,000; and (4) 15 percent of any amount recovered in excess of \$600,000.

SEC. 206. ADDITIONAL HEALTH BENEFITS.

Section 206 permits any party to a lawsuit involving injury or wrongful death to introduce evidence of collateral source benefits; and any opposing party to then introduce evidence of any amount paid or contributed to secure the right to such benefits. Under this section, providers of such benefits are prohibited from recovering any amount from the claimant's recovery or from being subrogated to the right of the claimant. The provisions of section 206 do not apply to the Medicare secondary payer provisions of section 1862(b) of the Social Security Act or to the Medicaid third party liability provisions of section 1902(a)(25) of such Act, to specified provisions of the Federal Employees' Compensation Act, or to employee benefit plans subject to Title I of the Employee Retirement Income Security Act.

SEC. 207. PUNITIVE DAMAGES.

Section 207 specifies new guidelines for the awarding of punitive damages. Under this section, punitive damages may be awarded (if otherwise permitted by applicable State or Federal law) against a person in a health care lawsuit only if: (1) the claimant proves by clear and convincing evidence that the person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer; and (2) compensatory damages are awarded. This section also establishes procedural requirements for a claim for punitive damages, and enumerates the factors to be considered for an award of punitive damages, including: the severity of harm caused by the conduct of the party; the duration of the conduct or any concealment of it; the profitability of the conduct; and any criminal penalties imposed. Under section 207, punitive damage awards are limited to the greater of \$250,000 or two times the amount of economic damages awarded, and the jury may not be informed of such limit.

Section 207 also prohibits a punitive damage award in a product liability suit against a manufacturer, distributor, or supplier of a medical product that has been approved by the Food and Drug Administration (FDA) or that is generally recognized among qualified

experts as safe and effective pursuant to conditions established by the FDA. Section 207 provides exceptions if: (1) the trier of fact finds by clear and convincing evidence that the product is substantially out of compliance with applicable labeling or packaging regulations; (2) a person knowingly misrepresented or withheld from the FDA required information that is material and causally related to the harm suffered by the claimant; or (3) an illegal payment is made to an FDA official to secure approval of the medical product. In addition, section 207 prohibits a product liability suit against a medical care provider who prescribes or dispenses such a medical product approved by the FDA.

SEC. 208. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

Section 208 requires the court, at the request of any party, to order that the award of future damages equaling or exceeding \$50,000 be paid by periodic payments.

SEC. 209. DEFINITIONS.

Section 209 provides definitions for terms used in title II.

SEC. 210. EFFECT ON OTHER LAWS.

Section 210 declares that title II does not apply to civil actions brought for a vaccine-related injury or death which is covered under provisions of the Public Health Service Act. In addition, section 210 states that nothing in title II should affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 211. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

Section 211 specifies rules governing the relationship between the provisions of title II and State and Federal laws. Section 211 provides that title II preempts State law to the extent that it prevents the application of any provision of law established by the Act, but does not: (1) preempt State law that provides greater protections for health care providers or organizations or that specifies particular damage limits; or (2) affect any defenses available to a party under any other provision of State or Federal law.

Section 211 also provides that title II supersedes the Federal Tort Claims Act (FTCA) to the extent that the FTCA would provide for (or allow for) a greater amount of damages or contingent fees or a longer period in which a health care lawsuit may be commenced, or would preclude or reduce the applicability of title II's provisions related to periodic payments of future damages. The FTCA is also superseded if (through the application of State law) it conflicts with provisions of title II concerning joint liability, collateral source benefits, subrogation, or liens.

SEC. 212. APPLICABILITY; EFFECTIVE DATE.

Section 212 states that the provisions of title II apply to any health care lawsuit brought in Federal or State court, or subject to alternative dispute resolutions system, that is initiated on or after the date of the enactment of the title, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of the title is governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

TITLE III—INCREASING HIGH-INCOME BENEFICIARY AWARENESS AND RESPONSIBILITY FOR HEALTH CARE COSTS

SEC. 301. INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.

Section 301 amends section 1860D-13(a) of the Social Security Act to add a new paragraph (7) (Reduction in Premium Subsidy Based on Income) to extend the Medicare Part B income-related premium adjustment to the Part D program (with certain differences). Under current law, the Federal government provides a subsidy for the cost of Part D prescription drug coverage. Effective January 1, 2009, proposed section 1860D-13(a)(7) would reduce the Federal subsidy and increase the beneficiary premium for prescription drug coverage for single beneficiaries with incomes greater than \$82,000 and married beneficiaries with incomes greater than \$164,000. Unlike the beneficiary income thresholds that apply with respect to the parallel process for premium adjustments under Part B, the beneficiary income thresholds used for purposes of the Part D premium calculations would hold constant as fixed dollar amounts without any indexing.

Under proposed section 1860D-13(a)(7), the additional payment amount owed by an individual whose Part D premium is subject to adjustment would be collected through withholding from benefit payments in the manner provided under section 1840 of the Social Security Act (and the proposed section establishes a procedure in the event such benefit payments are not sufficient to pay the premium adjustment amount). Proposed section 1860D-13(a)(7) establishes procedures for ensuring that the income-related premium adjustments required by the proposed section will be carried out correctly. The section also includes conforming amendments to title XVIII of the Social Security Act and to the Internal Revenue Code of 1986.