110th Congress, 2d Session – – – – – – – – – – – – – – House Document 110–96

PROPOSED LEGISLATION: MEDICARE FUNDING WARNING RESPONSE ACT OF 2008

COMMUNICATION

FROM

THE SECRETARY, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

TRANSMITTING

A DRAFT OF PROPOSED LEGISLATION ENTITLED THE "MEDICARE FUNDING WARNING RESPONSE ACT OF 2008"

FEBRUARY 21, 2008.—Referred jointly to the Committees on Energy and Commerce, Ways and Means, and the Judiciary and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

69–011 WASHINGTON : 2008

THE SECRETARY OF HEALTH
AND HUMAN SERVICES,
Washington, DC, February 15, 2008.

Hon. NANCY PELOSI,
Speaker of the House of Representatives,
Washington, DC.

DEAR SPEAKER PELOSI: Under the Medicare Prescription Drug, Improvement, and Modernization Act (Public Law 108–173), a Medicare funding warning is triggered whenever the Trustees determine, for two consecutive years, that more than 45 percent of total Medicare spending will be derived from general revenues within the current or following six years. In April 2007, the Trustees issued the first such warning. The President has assigned me the task of submitting proposed legislation to respond to this Medicare funding warning, and I am accordingly submitting the enclosed bill.

The Medicare program is on an unsustainable path, driven by two principal factors: projected growth in its per-capita costs, and increases in the beneficiary population as a result of population aging. Excess cost growth will not be brought under control until there is comprehensive reform changing Medicare's underlying structure. The funding warning is merely one near-term signal illuminating a small piece of a much larger problem. That problem is an unsustainable design in which government controls too many aspects of health care. In traditional fee-for-service Medicare, the government decides what treatments are provided and what the price should be. Until this system is modernized to offer greater choice and price accountability to individual consumers, the program's finances will remain on a path to insolvency.

In the meantime, we urge the Congress to pass the Medicare savings submitted with the President's fiscal year 2009 Budget. Enactment of these savings would improve Medicare's long-term outlook—reducing the 75-year unfunded obligation by nearly one-third. It would also respond to the 2007 funding warning and maintain quality of care in a fiscally responsible way.

The enclosed proposal that I am submitting in response to the funding warning takes a three-step approach to strengthening Medicare. In developing these proposed reforms, we have been guided by the highly successful experience of the Part D program, which made a prescription drug benefit available to 44 million beneficiaries. By empowering individual consumers, projected Part D costs have decreased by $244 billion relative to original estimates for the 2004–2013 time period. Market-based principles must be further applied to Medicare to allow it to operate more efficiently, as it must for the long-term.

Title I of our proposal provides the Secretary of Health and Human Services the authority and responsibility to introduce prin-

ciples of value-based health care in the Medicare program, consistent with the President's Executive Order 13410 of August 22, 2006. This title directs the Secretary to develop and implement proposals that reduce Medicare spending by increasing provider efficiency and encouraging beneficiaries to be wise health-care consumers. The specific elements included in the legislation are:

- Improved health information technology, including electronic medical records;
- Transparency of pricing information;
- Transparency of quality information; and
- Incentives for providers to deliver, and beneficiaries to choose, high-quality, low-cost health care.

Title II of the proposed legislation would implement the President's medical liability reform agenda. To address the rising cost of health care, we must have a rational medical liability system. Our courts are littered with junk lawsuits. The current medical liability system encourages defensive medicine, which raises the costs of Medicare, Medicaid, Veterans Affairs, and other Federal health-care programs by an estimated $28 billion per year (and national health care costs by $60–$100 billion). The medical liability crisis has resulted in 1,500 counties in the United States that do not have an obstetrician-gynecologist. This legislation would take the first steps to addressing this growing crisis.

Finally, Title III of the proposed legislation would provide for income-relating the Part D premium. This provision was contained in the President's most recent two Budgets and would save over $900 million in 2013 and nearly $3.2 billion over five years.

This legislative package, particularly if enacted in concert with the President's Budget, would take the first step of responding to the funding warning in the Trustees' 2007 report. Perhaps more importantly, it would begin to address the long-term challenge and lay the foundation for the comprehensive Medicare reforms that are necessary to strengthen and improve the program for future generations. Accordingly, we urge the Congress to promptly pass the proposed legislation.

The Office of Management and Budget advises that the transmittal of this legislation is in accord with the President's program.

Sincerely,

MICHAEL O. LEAVITT.

Enclosure.

A BILL

To respond to a medicare funding warning.

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

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

(a) SHORT TITLE.—This Act may be cited as the "Medicare Funding Warning Response Act of 2008".

(b) REFERENCES.—In this Act:

(1) Except where otherwise specifically provided, references in this Act shall be considered to be made to the Social Security Act, or to a section or other provision thereof.

(2) The term "Secretary" shall be deemed a reference to the Secretary of Health and Human Services.

(3) The terms "Medicare" and "Medicare program" mean the program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) shall be referred to as the "MMA".

(5) The term "excess general revenue medicare funding" has the meaning given such term by section 801(c) of the MMA.

(6) The term "Trustees Report" means the annual report submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i(b)(2) and 1395t(b)(2), respectively).

(c) PURPOSE.—It is the purpose of this Act 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.

(a) ELECTRONIC HEALTH RECORDS.—The Secretary shall develop and implement a system for encouraging nationwide adoption and use of interoperable electronic health records and to make available personal health records for Medicare beneficiaries.

(b) PRICING TRANSPARENCY.—The Secretary shall make publicly available information on prices and payments under the Medicare program for treatments (including episodes of care), items, and services to assist Medicare beneficiaries in making choices among providers, plans, and treatment options.

(c) QUALITY TRANSPARENCY.—The Secretary shall make publicly available information on the quality of care provided to Medicare beneficiaries to assist them in making choices among providers, plans, and treatments. To ensure the continued development and evolution of quality measures, the Secretary shall develop and implement a plan for ensuring that, by the year 2013, quality measures are available and reported with respect to at least 50 percent of the care provided under the Medicare program (determined according to the amount of payment made under such program for items and services with respect to which such measures are available). The Secretary shall report to the Committees on Ways and Means and Energy and Commerce in the House of Representatives and the Committee on Finance in the Senate annually on the progress of the goal specified in the preceding sentence.

(d) INCENTIVES FOR VALUE.—

(1) INCENTIVES FOR PROVIDERS AND SUPPLIERS.—

(A) IN GENERAL.—The Secretary shall design and implement a system for use in the Medicare program under which a portion of the payments that would otherwise be made under such program to some or all classes of individuals and entities furnishing items or services to beneficiaries of such program would be based on the quality and efficiency of their performance.

(B) IMPLEMENTATION.—The Secretary shall first implement such system in settings where measures are well-accepted and already collected, including hospitals, physicians' offices, home health agencies, skilled nursing facilities, and renal dialysis facilities. The initial focus of such efforts shall be on quality, but the Secretary shall add measures of efficiency as they are identified. The system shall also include incentives for reducing unwarranted geographic variations in quality and efficiency.

(C) SECRETARY'S AUTHORITY.—The Secretary may implement the system described in this paragraph without regard to any provision of title XVIII of the Social Security Act that would, in the absence of subparagraphs (A) and (B), apply with respect to payment to an individual or entity furnishing items or services for which payment may be made under the Medicare program.

(2) BENEFICIARY INCENTIVES.—

(A) IN GENERAL.—The Secretary shall implement incentives for Medicare beneficiaries to use more efficient providers and preventive services known to reduce costs.

(B) ACCESS TO HEALTH SAVINGS ACCOUNTS.—The Secretary shall assure

a transition into the Medicare program for individuals who are not yet enrolled in such program who own health savings accounts, and shall provide for the availability of high deductible health plan options in the Medicare program.

(e) BROADLY TRANSFORMING THE PRIVATE HEALTH CARE MARKETPLACE.—The Secretary shall use and release Medicare data for quality improvement, performance measurement, public reporting, and treatment-related purposes. In implementing the preceding sentence, the Secretary shall apply risk adjustment techniques where appropriate and shall determine the circumstances under which it is appropriate to release such data.

(f) PROTECTING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—In implementing this title, the Secretary shall ensure that individually identifiable beneficiary health information is protected (in accordance with the regulations adopted under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and such other laws and regulations as may apply).

(g) REGULATIONS.—The Secretary may implement a system described in this section by regulation, but only if such regulation is issued after public notice and an opportunity for public comment.

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

(1) The term "efficiency" means the delivery of health care in a manner that reduces the costs of providing care for Medicare beneficiaries while maintaining or improving the quality of such care.

(2) The term "information on quality of care" means such measures of—

(A) the use of clinical processes and structures known to improve care,

(B) health outcomes, and

(C) patient perceptions of their care,

as the Secretary may select with preference given to those measures that have been recognized through a consensus-based process.

(i) SAVINGS REQUIREMENT.—

(1) IN GENERAL.—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—

(A) the total amount of payment made under title XVIII of the Social Security Act over the five and ten year periods that begin with January 1 of such year as a result of the implementation of such subsections (a) through (e) and section 102 is less than the amount that would have been made over such periods if such implementation had not occurred; and

(B) the total amount of payment made under each of titles XIX and XXI of such Act over such periods as a result of such implementation is no greater than the amount that would have been made under each such title over such periods if such implementation had not occurred.

(2) AVAILABILITY OF APPROPRIATIONS.—The Secretary shall carry out the provisions of this section subject to the availability of appropriations and to the extent permitted consistent with paragraph (1).

SEC. 102. RELEASE OF PHYSICIAN PERFORMANCE MEASUREMENTS.

Section 1848(k) (42 U.S.C. 1395w-4(k)) is amended by adding at the end the following new paragraph:

"(9) RELEASE OF QUALITY MEASUREMENTS.—

"(A) IN GENERAL.—Notwithstanding section 552a of title 5, United States Code, the Secretary may—

"(i) release to the public physician-specific measurements of the quality or efficiency of physician performance against a standard (reflecting measurements that have been recognized through a consensus-based process) that has been endorsed by the Secretary; and

"(ii) release, to an entity that will generate or calculate such measurements, data that the entity may use to perform such task.

"(B) ENDORSEMENT OF STANDARDS.—The Secretary may make an endorsement under subparagraph (A) by publication of a notice in the Federal Register.".

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

SEC. 201. SHORT TITLE.

This title may be cited as the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2008".

SEC. 202. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and

compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this title to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of "defensive medicine" and lower the cost of health care

liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 203. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud

or collusion in the failure to bring an action on behalf of the injured minor.

SEC. 204. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this title shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of noneconomic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be informed about the maximum award for noneconomic damages. An award for noneconomic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to

such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 205. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

(1) 40 percent of the first $50,000 recovered by the claimant(s).

(2) 33 1/3 percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).

(4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SEC. 206. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act, or to section 8131 or section 8132 of title 5, United States Code. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act, or to section 8131 or section 8132 of title 5, United States Code, or to a collateral source provider that is an employee benefit plan under section 3(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(3)).

SEC. 207. PUNITIVE DAMAGES.

(a) IN GENERAL.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such 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. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded

with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

(c) NO PUNITIVE DAMAGES FOR PRODUCTS THAT COMPLY WITH FDA STANDARDS.—

(1) IN GENERAL.—

(A) No punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product, based on a claim that such product caused the claimant's harm where—

(i)(I) such medical product was subject to premarket approval, clearance, or licensure by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and

(II) such medical product was so approved, cleared, or licensed; or

(ii) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug

Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

(B) RULE OF CONSTRUCTION.—Subparagraph (A) may not be construed as establishing the obligation of the Food and Drug Administration to demonstrate affirmatively that a manufacturer, distributor, or supplier referred to in such subparagraph meets any of the conditions described in such subparagraph.

(2) LIABILITY OF HEALTH CARE PROVIDERS.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a medical product approved, licensed, or cleared by the Food and Drug Administration shall not be named as a party to a product liability lawsuit involving such product and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or seller of such product. Nothing in this paragraph prevents a court from consolidating cases involving health care providers and cases involving products liability claims against the manufacturer, distributor, or product seller of such medical product.

(3) PACKAGING.—In a health care lawsuit for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the trier of fact by clear and convincing evidence to be substantially

out of compliance with such regulations.

(4) EXCEPTION.—Paragraph (1) shall not apply in any health care lawsuit in which—

(A) a person, before or after premarket approval, clearance, or licensure of such medical product, knowingly misrepresented to or withheld from the Food and Drug Administration information that is required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and is causally related to the harm which the claimant allegedly suffered; or

(B) a person made an illegal payment to an official of the Food and Drug Administration for the purpose of either securing or maintaining approval, clearance, or licensure of such medical product.

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

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this Act.

SEC. 209. DEFINITIONS.

In this title:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term "alternative dispute resolution system" or "ADR" means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term "claimant" means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term "collateral source benefits" means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law (except the Federal Employees' Compensation Act (5 U.S.C. 8101 et seq.);

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental,

or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term "compensatory damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. The term "compensatory damages" includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term "contingent fee" includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term "economic damages" means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE LAWSUIT.—The term "health care lawsuit" means any health

care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services or any medical product affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include a claim brought by the United States Government or a relator under the False Claims Act (31 U.S.C. 3729 et seq.) or a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) HEALTH CARE LIABILITY ACTION.—The term "health care liability action" means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The term "health care liability claim" means a demand by any person, whether or not pursuant to ADR, against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer,

promoter, or seller of a medical product, including, but not limited to, third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) HEALTH CARE ORGANIZATION.—The term "health care organization" means any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) HEALTH CARE PROVIDER.—The term "health care provider" means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(12) HEALTH CARE GOODS OR SERVICES.—The term "health care goods or services" means any goods or services provided by a health care organization, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) MALICIOUS INTENT TO INJURE.—The term "malicious intent to injure" means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) MEDICAL PRODUCT.—The term "medical product" means a drug, device, or biological product intended for humans, and the terms "drug", "device", and "biological

product" have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(15) NONECONOMIC DAMAGES.—The term "noneconomic damages" means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) PUNITIVE DAMAGES.—The term "punitive damages" means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider, health care organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages are neither economic nor noneconomic damages.

(17) RECOVERY.—The term "recovery" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 210. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—

(1) To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this title does not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this title in conflict with a rule of law of such title XXI shall not apply to such action.

(2) If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this title or otherwise applicable law (as determined under this title) will apply to such aspect of such action.

(b) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this title shall be deemed to 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.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides or allows for a greater amount of damages or contingent fees, or a

longer period in which a health care lawsuit may be commenced, than provided in this title;

(2) precludes or reduces the applicability or scope of periodic payment of future damages as provided in this title; or

(3) through application of State law, conflicts with provisions of this title concerning joint liability, collateral source benefits, subrogation, or liens.

(b) PROTECTION OF STATES' RIGHTS AND OTHER LAWS.—

(1) Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This title shall not preempt or supersede any State or Federal law that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this title or create a cause of action.

(c) STATE FLEXIBILITY.—No provision of this title shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this title) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 204(a); or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

SEC. 212. APPLICABILITY; EFFECTIVE DATE.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this title, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this title shall be 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.

(a) INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.—

(1) IN GENERAL.—Section 1860D-13(a) (42 U.S.C. 1395w-113(a)) is amended by adding at the end the following new paragraph:

"(7) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

"(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under subparagraph (B) for the calendar year, the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2008 shall be reduced (and the monthly beneficiary premium shall be increased) by the monthly adjustment amount specified in subparagraph (C).

"(B) THRESHOLD AMOUNT.—For purposes of this paragraph, the threshold amount is—

"(i) except as provided in clause (ii), $82,000, and

"(ii) in the case of a joint return, twice the amount applicable under clause (i) for the calendar year.

"(C) MONTHLY ADJUSTMENT AMOUNT.—

"(i) IN GENERAL.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

"(I) the quotient obtained by dividing—

"(aa) the applicable percentage specified in the table in clause (ii) for the individual for the calendar year reduced by 25.5 percent; by

"(bb) 25.5 percent; and

"(II) the base beneficiary premium (as computed under paragraph (2)).

"(ii) APPLICABLE PERCENTAGE.—

"(I) IN GENERAL.—

''If the modified adjusted gross income is:	**The applicable percentage is:**
More than $82,000 but not more than $102,000	35 percent
More than $102,000 but not more than $153,000	50 percent
More than $153,000 but not more than $205,000	65 percent
More than $205,000	80 percent.

"(II) JOINT RETURNS.—In the case of a joint return, subclause (I) shall be applied by substituting dollar amounts which are twice the dollar amounts otherwise applicable under subclause (I) for the calendar year.

"(III) MARRIED INDIVIDUALS FILING SEPARATE RETURNS.—In the case of an individual who—

"(aa) is married as of the close of the taxable year (within

the meaning of section 7703 of the Internal Revenue Code of 1986) but does not file a joint return for such year, and

"(bb) does not live apart from such individual's spouse at all times during the taxable year,

subclause (I) shall be applied by reducing each of the dollar amounts otherwise applicable under such subclause for the calendar year by the threshold amount for such year applicable to an unmarried individual.

"(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall have the authority to make initial and reconsideration determinations necessary to carry out the income-related reduction in premium subsidy under this paragraph.

"(E) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

"(F) JOINT RETURN DEFINED.—For purposes of this paragraph, the term 'joint return' has the meaning given to such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

"(G) PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.—

"(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2008, the Secretary shall disclose to the Commissioner of Social Security the amount of the base

beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

"(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2008, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year:

"(I) The monthly adjustment amount specified in subparagraph (C).

"(II) Any other information the Commissioner of Social Security determines necessary to carry out the income-related reduction in premium subsidy under this paragraph.

"(H) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (C) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.".

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D-13(c) (42 U.S.C. 1395w-113(c)) is amended—

(A) in paragraph (1), by striking "(2) and (3)" and inserting "(2), (3), and (4)"; and

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

"(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

"(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from benefit payments in the manner provided under section 1840.

"(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.".

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Part D of title XVIII (42 U.S.C. 1395w-101 et seq.) is amended—

(A) in section 1860D-13(a)(1)—

(i) by redesignating subparagraph (F) as subparagraph (G);

(ii) in subparagraph (G), as redesignated by subparagraph (A), by striking "(D) and (E)" and inserting "(D), (E), and (F)"; and

(iii) by inserting after subparagraph (E) the following new subparagraph:

"(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7)."; and

(B) in section 1860D-15(a)(1)(B), by striking "paragraph (1)(B)" and inserting "paragraphs (1)(B) and (1)(F)".

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by striking "PART B PREMIUM SUBSIDY ADJUSTMENT" and inserting "PARTS B AND D PREMIUM SUBSIDY ADJUSTMENTS";

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting "or 1860D-13(a)(7)" after "1839(i)"; and

(ii) in clause (vii), by inserting after "subsection (i) of such section" the following: "or under section 1860D-13(a)(7) of such Act"; and

(C) in subparagraph (B)—

(i) by inserting "or such section 1860D-13(a)(7)" before the period at the end;

(ii) as amended by clause (i), by adding at the end the following new sentence: "Such return information may be disclosed to officers and employees of the Departments of Health and Human Services and Justice, to the extent necessary, and solely for their use, in any administrative or judicial proceeding ensuing from an adjustment to any such premium."; and

(D) by adding at the end the following new subparagraph:

"(C) TIMING OF DISCLOSURE.—Return information shall be disclosed to officers, employees, and contractors of the Social Security Administration under subparagraph (A):

"(i) for taxpayers currently entitled to benefits under title II of the Social Security Act, or as qualified railroad retirement beneficiaries within the meaning of section 7(d) of the Railroad Retirement Act of 1974, within 4 months preceding the month in which the taxpayer first becomes entitled to benefits under part A or is eligible to enroll in part B or part D of title XVIII of the Social Security Act; and

"(ii) for taxpayers not currently receiving benefits under title II of the Social Security Act, or as qualified railroad retirement beneficiaries within the meaning of section 7(d) of the Railroad Retirement Act of 1974, or who have participated in Medicare qualified government employment as defined in section 210(p) of the Social Security Act, after the taxpayer applies for a benefit under part A or part B and is eligible to enroll in part D of title XVIII of the Social Security Act.".

(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary, in consultation with the Commissioner of Social Security may implement this section, and the amendments made by this section, by program instruction or otherwise.

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.