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The President's Proposed Legislative Response to the Medicare Funding Warning

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Summary

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) amended the Social Security Act, requiring the Medicare Board of Trustees to examine and make a determination if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years, creating a seven-year window. An affirmative determination in two consecutive annual reports is considered to be a Medicare funding warning in the year in which the second report is made. Because such a determination was issued in both the 2006 and 2007 Medicare Trustee's reports, resulting in the issuance of a warning, the President must propose and Congress is to consider legislation that would lower the ratio to the 45% level.

The President submitted legislation to the Congress designed to lower general revenue spending to the 45% level on February 15, 2008, which was introduced in the House of Representatives (H.R. 5480) and the Senate (S. 2662) on February 25, 2008. The President's bill is divided into three titles, covering (1) value based health care, (2) tort reform, and (3) income-relating premiums for prescription drug coverage under Part D of Medicare. Title I would require the Secretary of Health and Human Services to establish a system for encouraging the nationwide adoption and use of interoperable electronic health records and would provide price, cost, and quality information to Medicare beneficiaries to assist them in making choices among provider, plan, and treatment options. It would also modify Medicare physician quality reporting requirements to permit the Secretary to release to the public physician-specific measurements of the quality or efficiency of physician performance. Title II would preempt state law regarding some aspects of medical malpractice liability and liability for defective medical products, including drugs. It would not, however, preempt any state law "that imposes greater procedural or substantive protections for health care providers and health care organizations from liability" (§ 211(b)(2)). Title III is identical to a proposal included in the President's 2009 budget which would require that individuals whose income is above a certain income threshold pay a higher percentage of their Part D prescription drug premiums.

This report summarizes the provisions of the President's bill. It also discusses some potential issues that may arise in determining whether or not this bill, or any other bills introduced in Congress will be scored as successfully lowering general revenue spending below the 45% level.

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Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) amended the Social Security Act, requiring the Medicare Board of Trustees to examine and make a determination if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years, for a total of seven years. An affirmative determination in two consecutive annual reports is considered to be a Medicare funding warning in the year in which the second report is made. Because such a determination was issued in both the 2006 and 2007 Medicare Trustee's reports, resulting in the issuance of a warning, the President is required to submit a legislative proposal to Congress, and Congress is to consider legislation, that would lower the ratio to the 45% level. These requirements are found in §1817(b)(2) and §1841(b)(2) of the Social Security Act and §1105 of title 31, United States Code, (as amended by §801-§804 of P.L. 108-173, MMA).

President Bush was required to submit legislation to Congress responding to the warning within the 15-day period, beginning on the date of the budget submission to Congress this year.[1] The President's bill was submitted on February 15, 2008, and introduced in the House of Representatives (H.R. 5480) and the Senate (S. 2662) on February 25, 2008. This report summarizes the legislative proposal submitted by the President as required.[2]

The President's proposed bill is divided into three titles, covering (1) value based health care, (2) tort reform, and (3) income-relating premiums for prescription drug coverage under Part D of Medicare. Title I would require the Secretary of Health and Human Services (Secretary) to establish a system for encouraging the nationwide adoption and use of interoperable electronic health records and would provide price, cost, and quality information to Medicare beneficiaries to assist them in making choices among provider, plan, and treatment options. It would also modify Medicare physician quality reporting requirements to permit the Secretary to release to the public physician-specific measurements of the quality or efficiency of physician performance. Title II is virtually identical to H.R. 5, 109th Congress, and H.R. 5, 108th Congress, both of which the House passed (in 2005 and 2003,

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[1] This year, the President released the budget on February 4, 2008, and the legislation had to be submitted to Congress by February 19, 2008.

[2] For more details on the trigger mechanism, see CRS Report RS22796, *Medicare Trigger*, by Hinda Chaikind and Christopher M. Davis.

respectively).[3] Title II would preempt state law regarding some aspects of medical malpractice liability and liability for defective medical products, including drugs. It would not, however, preempt any state law "that imposes greater procedural or substantive protections for health care providers and health care organizations from liability" (§ 211(b)(2)). Title III is identical to a proposal included in the President's 2009 budget. It would require that individuals whose income is above a certain threshold pay a higher percentage of their Part D prescription drug premiums. The income thresholds begin at $82,000 for an individual and $164,000 for a couple. The thresholds would not be indexed, so that they would not increase each year.[4] The savings estimate for this income-testing proposal in the President's budget is $3.180 billion for fiscal years 2009-2013.

Issues in Certifying Whether the President's Bill Lowers Spending Below the Trigger Level

Before examining the specific components of the President's proposed legislation, it is important to consider the more general question of how Congress would be able to certify whether or not this bill, or any others that are subsequently introduced, would successfully lower general revenue funding below the 45% level. There are some potential issues that should be taken into consideration.

As required by statute, the official determination of a Medicare fund warning was issued by the Medicare Board of Trustees. The Centers for Medicare and Medicaid Services' Office of the Actuary is responsible for providing the estimates of Medicare spending and revenues used to determine whether a funding warning is required. Their estimates were included as part of the 2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds, issued on April 23, 2007. In this report, the actuaries estimated that the general revenue funding would first exceed 45% in 2013, within the critical seven-year period. In their 2006 report, they had also estimated that general revenues would exceed 45% during the critical seven-year period. Having made this determination in two consecutive years, a Medicare fund warning was issued. Similarly, the 2008 Annual Report of the Board of Trustees included an estimate that general revenue funding would exceed 45% in 2014, which is inside the new critical seven-year period. The actuaries indicated that this estimate creates a new warning, based on the estimates of excess general revenues for 2007 and 2008. As a result, the President will be required to submit a legislative proposal in response

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[3] Title II differs from H.R. 5 in that it would make its provision modifying the collateral source rule (see below) inapplicable to 5 U.S.C. § 8132 or to a collateral source provider that is an employee benefit plan under 29 U.S.C. § 1002(3).

[4] Part B of Medicare currently requires that higher income beneficiaries pay a larger share of premiums, however the income limits are indexed. The President's 2009 budget included a proposal that would eliminate the indexing for Part B premiums, similar to that proposed for Part D.

to the warning within 15 days of the President's FY2010 budget, which will be released in early February 2009.[5]

The MMA specified that the Chairman of the House Committee on the Budget is responsible for certifying whether any Medicare funding legislation (or any subsequent amendments to it) eliminates the excess general revenue Medicare funding. The statutes do not specify how this certification is to be made. The rules for the Senate only require certification by the Chairman of the Senate Committee on the Budget for enacted legislation, as an exception to the discharge process.[6]

In general, for bills reported out of committees in either the House or the Senate, the Congressional Budget office (CBO) is statutorily required to provide a cost estimate. The Congressional Budget and Impoundment Control Act of 1974 (P.L. 93-344) requires that whenever a committee of either House reports a bill or committee amendment to its House, it must accompany that bill with a statement (or the committee shall make available such a statement in the case of an approved committee amendment which is not reported to its House), a projection by the Congressional Budget Office of how such measure will affect the levels of such budget authority, budget outlays, revenues, or tax expenditures under existing law for such fiscal year (or fiscal years) and each of the four ensuing fiscal years.

The CBO also makes its own independent estimates of Medicare spending and receipts. Each March, the CBO issues an estimate of baseline spending, an estimate of federal spending and receipts under existing policies. In its March 2007 baseline, the CBO estimated that general revenue funding would first exceed 45% in 2014, which was not within the critical seven-year period. Thus, based on its 2007 estimates, Medicare was already below the trigger level during the prescribed seven-year window, even before savings of the President's proposed legislation or any other bills introduced to lower general revenue spending were included. In its March 2008 baseline, the CBO estimated that general revenue funding would exceed 45% within the new critical seven-year period, in 2013.

On March 12, 2008, CBO released its cost estimates of H.R. 5480 and S. 2662, the House and Senate bills reflecting the President's legislative response to the general fund warning. CBO estimated that the legislative proposal would reduce general revenue funding as a percentage of total outlays to 45% in 2013, compared with 45.1% under its most recent 2008 current law baseline estimates. In 2014, under both its current law baseline estimates and its estimates including the savings

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[5] This requirement may be waived if, before the deadline for the Presidential response (1) Congress enacts legislation to eliminate excess general revenue Medicare funding for the new seven-fiscal year reporting period, and (2) if within 30 days after enactment, the Board of Trustees of the Medicare Trust Funds certifies that the legislation eliminates the funding warning.

[6] The discharge process in the Senate could otherwise occur if the Committee on Finance has not reported a bill reflecting any required Medicare funding legislation by June 30. Then any Senator may move to discharge that committee from a single Medicare funding measure.

from the President's legislative proposal, CBO estimated that general revenues as a percentage of total outlays would exceed the 45% level.

The MMA requires the Medicare Board of Trustees to issue the Medicare funding warning, but does not include a specific provision that would alter CBO's role in the congressional process. Whether the CBO or the Centers for Medicare and Medicaid Services' Office of the Actuary will be responsible for providing the Budget committees with an estimate of the potential savings for the President's legislation, or any other bill introduced to lower general revenue funding, may make a large difference.

Another consideration is the effect on general revenue spending of any potential increase in payments to Medicare. What effect might legislation that increases Medicare spending have on the trigger, if such legislation is enacted after the Board of Trustees issues a warning? As an example, Congress has shown interest in ensuring that Medicare's payments to physicians do not decrease. The current update formula for Medicare physician payments mandates a 0.5% increase in the physician fee schedule for the six-month period from January 1, 2008, through June 30, 2008. Payments for the remaining six months of 2008 and afterwards will be computed as if the modification to the conversion factor for the first six months of 2008 had never applied. Absent new legislation, Medicare payments to physicians will decrease beginning July 1, 2008. However, if Congress passes legislation designed to alleviate this problem, it could result in an increase in Medicare spending unless the costs of increasing physician payments were offset by other legislation affecting the Medicare program. If Congress enacts legislation to increase physician payments and the costs are not offset within Medicare, then the increased spending would further increase general revenue spending for the Medicare program.

Title I. Introducing Principles of Value-Based Health Care into the Medicare Program

Section 101. Introducing Principles of Value-Based Health Care into the Medicare Program

Current Law. Proponents of value-based purchasing in health care emphasize the focus of each decision maker, such as an insurer, employer, or patient, on assessing differences in perceived value — whether it be in efficiency, quality, cost, or some other measure — when choosing among options. The value assessment can be specific to each decision maker, and proponents of the concept prefer the positive connotation of maximizing value, typically emphasizing quality when making health care purchasing decisions. Value-based purchasing approaches emphasize the collection and analysis of data on quality, the dissemination of quality information to providers and beneficiaries, and the selective rewarding of identified high-quality achievers through contracts, partnerships, or incentives. (See, for example, the testimony of Robert Berenson, M.D., before the Subcommittee on Health of the House Committee on Ways and Means, September 29, 2005.) Many health care industry leaders and policy makers have urged the federal government, through publicly funded health care programs such as Medicare, Medicaid, and SCHIP, to pay

health care providers different amounts based on variation in the quality of their services. Proponents of these pay-for-performance systems in health care assert that such programs could help improve the quality of care while also helping to control the rate of growth in health care costs.

Congress has passed legislation to provide the groundwork for implementing value-based payments to providers, including hospitals, physicians, and skilled nursing homes. Section 501(b) of the MMA provided an incentive for an eligible hospital to submit quality data for ten quality measures known as the "starter set" in order to avoid a 0.4 percentage point reduction in its annual payment update from the Centers for Medicare and Medicaid Services (CMS) for FY2005, 2006, and 2007. Section 5001(a) of the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) required hospitals to report additional quality measures to receive the full market basket increase to their payment rates.[7] Payment rates were reduced by 2 percentage points for any hospital that did not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

The DRA required CMS to develop and implement a method for hospital value-based purchasing in 2009. The value-based purchasing system must be budget-neutral while creating incentives for high-quality hospitals and minimum benchmarks for low-quality hospitals. The Tax Relief and Health Care Act of 2006 (P.L. 109-432, TRHCA) requires hospital outpatient departments to submit data on quality measures in order to avert a 2 percentage point reduction in their annual payments starting in 2009.

In August 2006, the President issued an executive order titled "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs."[8] Also referred to as the Health Care Transparency Initiative or the Value-Based Health Care Initiative, this order aims to promote value-based purchasing principles in health care through a number of activities, including transparency in pricing and quality measures as well as encouraging pay-for-performance systems.

President's Proposal. The Secretary would develop and implement a system for encouraging the nationwide adoption and use of interoperable electronic health records and would make the personal health records of Medicare beneficiaries available through this system. The Secretary would make publicly available (1) 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, and (2) 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

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[7] Inpatient services provided by acute care hospitals are reimbursed based on the inpatient prospective payment system (IPPS). Medicare's IPPS payments are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket index.

[8] For more information about the President's initiative, see [http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html]

development and evolution of quality measures, the Secretary would develop and implement a plan for ensuring that, by the year 2013, quality measures are available and reported with respect to at least 50% 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 would 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 these goals.

To accomplish these objectives, the President's proposal would put in place incentives for providers and suppliers, as well as for beneficiaries. For providers and suppliers, the Secretary would 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.

The Secretary would first implement such a 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 would be on quality, but the Secretary would add measures of efficiency as they are identified. The system would also include incentives for reducing unwarranted geographic variations in quality and efficiency. The provision would also clarify that the Secretary would have the authority to implement the system described above.

For Medicare beneficiaries, the Secretary would provide incentives"to use more efficient providers and preventive services known to reduce costs." The Secretary would assure a transition into the Medicare program for individuals who own health savings accounts and would also provide for the availability of high-deductible health plan options in the Medicare program.

The Secretary would use and release Medicare data for quality improvement, performance measurement, public reporting, and treatment-related purposes, with the goal of "broadly transforming the private health care marketplace." The Secretary would apply risk adjustment techniques where appropriate and would determine the circumstances under which it is appropriate to release such data. The Secretary would ensure that individually identifiable beneficiary health information is protected (in accordance with the regulations adopted under the Health Insurance Portability and Accountability Act of 1996 and such other laws and regulations as may apply). The Secretary could implement a system described in this section by regulation, but only if such regulation were issued after public notice and an opportunity for public comment.

These proposals could be implemented only if they achieve savings for the Medicare, Medicaid, and SCHIP programs. Specifically, the Chief Actuary of CMS would be required to certify that (1) the total amount of payments made under the Medicare program over the 5- and 10-year periods, beginning January 1 of the year in which the above proposals are implemented, is less than the amount that would have been made if such implementation had not occurred, and that (2) the total

amount of Medicaid and SCHIP payments over such periods as a result of such implementation is no greater than the amount that would have been made had such implementation not occurred. The Secretary would carry out the provisions of this section subject to the availability of appropriations and to the extent permitted consistent with the savings requirement described in this paragraph.

Section 102. Release of Physician Performance Measurements

Current Law. Section 101 of Title I of the Tax Relief and Health Care Act of 2006 (TRHCA) authorized the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative (PQRI). The PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals who successfully reported PQRI quality measures on claims for dates of service from July 1 through December 31, 2007, could have earned an incentive, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services furnished July 1 through December 31, 2007.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Extension Act, P.L. 110-173) authorized the continuation of the Physician Quality Reporting Initiative (PQRI) for 2008. The financial incentive for eligible professionals who successfully report the designated set of quality measures during 2008 is 1.5% of total allowed charges for covered services payable under the Physician Fee Schedule. Financial incentives earned for 2008 reporting will be paid in mid-2009 from the Federal Supplementary Medical Insurance (Part B) Trust Fund. The 1.5% financial incentive and its funding source for 2008 are the same as for 2007.

President's Proposal. The proposal would modify the existing physician quality reporting program under Medicare to permit the Secretary to (1) 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 (2) release, to an entity that will generate or calculate such measurements, data that the entity may use to perform such task. The Secretary would be able to make an endorsement of such standards 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

Introduction: Preemption of State Laws

Medical malpractice suits are governed by state law, but, because they affect interstate commerce, the U.S. Constitution would permit Congress to regulate them and to preempt state laws that regulate them. Title II of the Medicare Funding Warning Response Act of 2008, which is titled the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2008, would impose federal standards on some aspects of medical malpractice suits, but would leave other aspects to continue

to be governed by state law. Actually, Title II would apply to all "health care liability claims," which it defines to include not only medical malpractice suits, but product liability suits that allege injuries resulting from defective medical products.

This section summarizes the main provisions of Title II, and does so not in the order of the sections of Title II, but in the order of the following subjects that Title II addresses: (1) cap on noneconomic damages, (2) standard for and cap on punitive damages, (3) limiting joint and several liability, (4) modifying the collateral source rule, (5) limiting lawyers' contingent fees, (6) creating a federal statute of limitations, and (7) periodic payment of future damages. Another CRS report, without making reference to any particular legislation, discusses these same subjects in the same order, explaining the legal concepts each involves (in greater depth than the present report does) and offering pros and cons of each.[9]

Even with respect to those aspects of medical malpractice suits on which Title II would impose federal standards, Title II would not preempt every state law. As noted above, it would not preempt any state 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 act or create a cause of action" (§ 211(b)(2)).[10] Title II would also not preempt "any State law (whether effective before, on, or after the date of enactment of this act) 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 act ..." (§ 211(c)). Thus, under Title II, caps on damages would be the one aspect of liability law that states could make more favorable to plaintiffs than Title II would.[11]

(1) Cap on Noneconomic Damages

Section 204(b) would impose a $250,000 cap on noneconomic damages in any health care lawsuit, "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." As noted above, this cap would apply only in states that have no cap before enactment of Title II and that do not enact one subsequently.[12]

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[9] CRS Report RL31692, *Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages*, by Henry Cohen.

[10] This provision does not mention sellers of medical products, which leaves it uncertain whether Title II would preempt state laws that impose greater protections for sellers of medical products.

[11] This provision raises the question whether a state that wishes to have no cap may enact a cap that is so high — say, $1 billion — that it is effectively no cap, and thereby not be subject to Title II's cap.

[12] Section 204(c) provides that, for purposes of applying the $250,000 cap, "future noneconomic damages shall not be discounted to present value." Thus even if an award was is excess of the $250,000 cap and the present value of an annuity for the award would be below the $250,000 cap, the award would still be limited to the cap itself, at $250,000. It would not be reduced to the present value.

Economic damages refer to monetary losses that result from an injury, such as medical expenses, lost wages, and rehabilitation costs; Title II would not cap economic damages. Noneconomic damages consist primarily of damages for pain and suffering. Both economic and noneconomic damages are compensatory damages, as opposed to punitive damages.

(2) Standard for and Cap on Punitive Damages

Section 207(a) provides that punitive damages may be awarded if otherwise permitted by state law, if the claimant proves "by clear and convincing evidence" that the defendant "acted with malicious intent to injure the claimant, or ... deliberately failed to avoid unnecessary injury that [the defendant] knew the claimant was substantially certain to suffer." Title II would thus preempt state law regarding the burden of proof and standard for awarding punitive damages, except in states that provide greater protection for defendants.[13]

Section 207(b)(2) would also impose a cap on punitive damages of $250,000 or two times the amount of *economic* (not of all compensatory) damages awarded, whichever is greater. As with Title II's cap on noneconomic damages, the cap on punitive damages would apply only in states that have no cap before enactment of Title II and that do not enact one subsequently.

Section 207(c)(1)) would provide that "[n]o 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," if the product has been approved by the Food and Drug Administration or is generally recognized as safe and effective under FDA regulations. This prohibition of punitive damages would not apply, however, if a person (1) "knowingly misrepresented to or withheld from the Food and Drug Administration information that is required to be submitted ... that is causally related to the harm which the claimant allegedly suffered," or (2) 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." FDA regulations require that, even after a drug is approved, drug companies report to the FDA new information they obtain about adverse drug experiences.[14] Therefore, a company that fails to do so could, under Title II, apparently be subject to punitive damages, state law permitting.

On February 20, 2008, the Supreme Court limited the potential import of prohibiting punitive damages with respect to products that have been approved by the FDA. It held that federal law — the Medical Device Amendments of 1976, 21 U.S.C. § 360k — bars state tort claims (not just punitive damages claims) regarding

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[13] Regarding the burden of proof for punitive damages, those states that impose the lesser burden of "preponderance of the evidence" on plaintiffs would be preempted. See CRS Report RL31721, *Punitive Damages in Medical Malpractice Actions: Burden of Proof and Standards for Awards in the Fifty States*, by Henry Cohen and Tara Alexandra Rainson.

[14] 21 C.F.R. § 314.80(b),(c), § 314.81(b)(2).

medical devices that receive premarket approval from the FDA and comply with federal requirements.[15]

(3) Limiting Joint and Several Liability

Section 204(d)) would eliminate joint and several liability in health care liability claims. Joint and several liability is the common-law rule that, if more than one defendant is found liable for a plaintiff's injuries, then each defendant may be held 100% liable. With joint and several liability, the plaintiff may not recover more than once, but may recover all his or her damages from fewer than all liable defendants, with any defendant who pays more than its share of the damages entitled to seek contribution from other liable defendants.

The main argument for eliminating joint and several liability is that it allows a plaintiff to recover his entire damage award from a "deep pocket" defendant who was only minimally liable. The main argument for retaining joint and several liability is that it is preferable for a wrongdoer to pay more than its share of the damages than for an injured plaintiff to recover less than the full compensation to which he is entitled.

(4) Modifying the Collateral Source Rule

The collateral source rule is the common-law rule that allows an injured party to recover damages from the defendant even if he is also entitled to receive them from a third party (a "collateral source"), such as a health insurance company, an employer, or the government. To abolish the collateral source rule would be to require courts to reduce damages by amounts a plaintiff receives or is entitled to receive from collateral sources.

Often a collateral source, such as a health insurer or the government, has a right of subrogation against the tortfeasor (the person responsible for the injury). This means that the collateral source takes over the injured party's right to sue the tortfeasor, for up to the amount the collateral source owes or has paid the injured party. Although the collateral source rule may enable the plaintiff to recover from both his insurer and the defendant, the plaintiff, if there is subrogation, must reimburse his insurer the amount it paid him. If the collateral source rule were eliminated, then the defendant would not have to pay the portion of damages covered by a collateral source, and the collateral source would apparently not be able through subrogation to recover the amount it paid the plaintiff. In the medical malpractice context, therefore, eliminating the collateral source rule would benefit liability insurers at the expense of health insurers and other collateral sources.

Section 206 would provide that, in any health care lawsuit, any party (usually the defendant) may introduce evidence of collateral source benefits, and the opposing party (usually the plaintiff) may introduce evidence of amounts paid to secure those benefits (e.g., health insurance premiums). Title II does not state that collateral

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[15] Riegel v. Medtronic, Inc., No. 06-179 (U.S. February 20, 2008).

source benefits, minus amounts paid to secure such benefits, would have to be deducted from damage awards.

Section 206 would also eliminate the right of subrogation. In cases in which collateral source benefits are deducted from damage awards, the plaintiff would not recover any money from the defendant against which the collateral source would have a right of subrogation, even if section 206 did not eliminate the right of subrogation. In cases in which collateral source benefits are not deducted, the plaintiff could apparently recover from both the defendant and the collateral source.

(5) Limiting Lawyers' Contingent Fees

A contingent fee is one in which a lawyer, instead of charging an hourly fee for his services, agrees, in exchange for representing a plaintiff in a tort suit, to accept a percentage of the recovery if the plaintiff wins or settles, but to receive nothing if the plaintiff loses. Payment is thus contingent upon there being a recovery. Plaintiffs agree to this arrangement in order to afford representation without having to pay anything out-of-pocket. Lawyers agree to it, despite the risk of not being compensated, because the percentage they receive if they win or settle — usually from 33⅓% to 40% — generally amounts to more than an hourly fee would.

Section 205 would impose a cap with a sliding scale in medical malpractice cases: 40% of the first $50,000 the plaintiff recovered, 33⅓% of the next $50,000, 25% of the next $500,000, and 15% of any additional amount.

(6) Creating a Federal Statute of Limitations

The statute of limitations — the period within which a lawsuit must be filed — for medical malpractice suits under state law is typically two or three years, starting on the date of injury. Sometimes, however, the symptoms of an injury do not appear immediately, or even for years after, malpractice occurs. Many states therefore have adopted a "discovery" rule, under which the statute of limitations starts to run only when the plaintiff discovers, or in the exercise of reasonable diligence should have discovered, his injury — or, sometimes, his injury and its cause.

Section 203 provides:

> The time for the commencement of a health care lawsuit shall be three years after the date of manifestation of injury or one 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 three years after the date of manifestation of injury unless tolled [i.e., the three years does not start to run] 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.

This provision, rather than imposing a time limitation that begins on the date of injury or on the date of discovery of the injury, would cut off the right to sue upon the earlier of two different periods — three years and one year — that begin,

respectively, on the date of manifestation of injury and discovery of the injury. Title II defines neither term, but, in its report on the 108th Congress's version of this bill, the House Committee on Energy and Commerce explained the former term: "The term 'manifestation of injury' means the injury has become reasonably evident. Thus, if someone unknowingly receives tainted blood, 'manifestation of injury' is not the date of receiving the blood. Instead, it is the date on which adverse symptoms become reasonably evident."[16]

The discovery of the injury, then, would apparently occur on the date that the patient learns that his blood is tainted, which date may not occur until after "manifestation of injury." Suppose that medical tests reveal the tainted blood one year after the plaintiff experienced his first symptoms. There would still be two years to run on the three-year manifestation period, but the plaintiff would apparently have to sue within one year of discovering that his blood is tainted — even if it takes more than one year to learn that his blood is tainted as a result of a transfusion. A patient could also apparently discover his injury, perhaps through a routine medical test, before symptoms become manifest, and, again, the one-year discovery period would apparently apply.

It is not clear whether this provision is, strictly speaking, a statute of limitations. (Title II does not call it that.) A statute of limitations is typically an affirmative defense, which means that the defendant must raise it; if the defendant fails to raise it, then the plaintiff may sue regardless of how much time has passed.[17] Section 203, by contrast, could be interpreted to place the burden of proof on the plaintiff to show that his injury occurred within the time period allowed.

(7) Periodic Payment of Future Damages

Traditionally, damages are paid in a lump sum, even if they are for future medical care or future lost wages. In recent years, however, "attorneys for both parties in damages actions have occasionally foregone lump-sum settlements in favor of structured settlements, which give the plaintiff a steady series of payments over a period of time through the purchase of an annuity or through self-funding by an institutional defendant."[18]

Section 208 provides:

> 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

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[16] H.Rept. 108-32, Part 2 (March 11, 2003) at 28.

[17] See, e.g., Federal Rule of Civil Procedure 8(c).

[18] Annotation, *Propriety and Effect of "Structured Settlements" Whereby Damages are Paid in Installments Over a Period of Time, and Attorneys' Fees Arrangements in Relation Thereto*, 31 ALR4th 95, 96.

promulgated by the National Conference of Commissioners on Uniform State Law.

Though this provision states that an award of future damages shall not be reduced to present value to determine whether it equals or exceeds the $50,000 minimum necessary for a party to require the court to order periodic payments, it does not state whether the amount of the award of future damages would be converted to present value. Not to require such conversion "could be a very major change, significantly reducing awards, if it is intended to allow a defendant to pay, for example, a $1 million award over a 10-year period at $100,000 a year. On the other hand, if it requires the jury award to be converted into present value terms — an annuity with a present value of $1 million — the reform doesn't mean that much; as a practical matter, the defendant would be paying the same amount as before."[19] The defendant, that is, would have to spend $1 million for an annuity that, as it earned interest over the years of its distribution, would yield the plaintiff more than $1 million. Had the defendant paid the plaintiff a lump sum of $1 million, then the plaintiff could have purchased that same annuity.

Title III. Increasing High-Income Beneficiary Awareness and Responsibility for Health Care Costs

Background

Section 301 of the President's bill includes statutory language for a proposal to income- related premiums for drug plans under Medicare Part D. The proposal itself was included in both the President's FY2008 and FY2009 Budgets. The proposal builds on the current law provision which income-relates premiums for Medicare Part B.

Part B Premiums.[20] Medicare Part B is financed through a combination of beneficiary premiums and federal general revenues. In general, beneficiary premiums equal 25% of estimated program costs for the aged. (The disabled pay the same premium as the aged.) Federal general revenues account for the remaining 75%. The basic 2008 premium is $96.40.

Income-Related Part B Premium. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L.108-173) provided that higher-income enrollees pay a higher percentage of Part B costs beginning in 2007. The increase was to be phased in over five years; however, the Deficit Reduction Act of 2005 (P.L.109-171) reduced the phase-in period to three years. In 2008, they pay total premiums ranging from 31.7% to 61.7% of the value of Part B. When fully

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[19] Victor Schwartz, *Doctors' Delight, Attorneys' Dilemma*, Legal Times, Health-Care Law Supplement (February 28, 1994) at 30.

[20] For further information on Part B Premiums, see CRS Report RL32582, *Medicare: Part B Premiums*, by Jennifer O'Sullivan.

phased in during 2009, higher income individuals will pay total premiums ranging from 35% to 80% of the value of Part B.

The income calculation is based on modified adjusted gross income. In general, the taxable year to be used is that beginning in the second calendar year preceding the year involved. Thus, 2006 income is used to calculate the 2008 premium amount. In 2008, singles with incomes over $82,000 and couples with incomes over $164,000 pay higher amounts. Under current law, the income levels are increased each year by the increase in the consumer price index for urban consumers (CPI-U), rounded to the nearest $1,000.

Table 1. Percentage of Part B Premium Costs Paid by High-Income Beneficiaries

Modified AGI Income Category[a]			
Single	**Couple**	**2008**	**2009**
$82,001-$102,000	$164,001-$204,000	31.7%	35%
$102,001-$153,000	$204,001-$306,000	41.7%	50%
$153,001-$205,000	$306,001-$410,000	51.7%	65%
more than $205,000	more than $410,000	61.7%	80%

a. The income levels shown are those used for the 2008 calculation; the amounts are increased each year by the increase in the CPI-U, rounded to the nearest $1,000.

Part D Premiums

Current Law. In 2006, Medicare Part D began providing coverage for outpatient prescription drugs for Medicare beneficiaries. Coverage is provided through private prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. The program relies on these private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies covering the bulk of the risk are provided to encourage participation. Unlike other Medicare services, the benefits can only be obtained through private plans. Further, while all plans have to meet certain minimum requirements, there are significant differences among them in terms of benefit design, drugs included on plan formularies (i.e., list of covered drugs) and cost-sharing applicable for particular drugs.

Medicare Part D is financed through a combination of beneficiary premiums and federal general revenues. In addition, certain transfers are made from the states. Beneficiaries pay different premiums depending on the plan they have selected. On average, beneficiary premiums account for 25.5% of expected total Part D costs for basic coverage. Except for persons entitled to low-income subsidies, all persons selecting a particular Part D plan pay the same monthly premium amount.

Section 301. The President's proposal would establish income-related premiums for Part D. Under the proposal, the income thresholds would be the same

as those established for income-relating Part B premiums, as shown in **Table 2**. Further, the income thresholds would not be updated in future years.[21]

Calculation of Increased Premium. The bill specifies how the increased premium would be calculated. The calculation is linked to the "base beneficiary premium." This is a national figure based on a specified percentage of the national average monthly bid amount for Part D basic coverage. The percentage is roughly 25.5% of the value of coverage nationwide (after removal of reinsurance payments).[22] The 2008 base beneficiary premium is $27.93.

The calculation is designed so that higher-income beneficiaries would pay roughly the same proportion of the value of coverage nationwide for basic Part D coverage as they will pay for the nationwide value of Part B beginning in 2009. **Table 2** shows the estimated additional amounts that these beneficiaries would pay in 2009 based on the 2008 base beneficiary premium; the actual calculation would be based on the 2009 base beneficiary premium.

The add-on amount (also referred to as the subsidy reduction) would be the same regardless of the particular plan selected by the beneficiary. The total amount that a beneficiary would pay in Part D premiums would be the add-on amount (which would be the same nationwide) plus the premium for the particular plan selected (which would vary by plan). Note that when both members of a couple are enrolled in Part D, both would pay the applicable increase.

Table 2. Estimated Beneficiary Part D Monthly Adjustment Amounts, 2009

(based on 2008 base beneficiary premium)

Modified Adjusted Gross Income (AGI)		Additional Premium
Single	**Couple**	
$82,000 or less	$164,000 or less	-0-
$82,001-$102,000	$164,001-$204,000	$10.41
$102,001-$153,000	$204,001-$306,000	$26.83
$153,001-$205,000	$306,001-$410,000	$43.26
more than $205,000	more than $410,000	$59.69

The definition of modified adjusted gross income would be the same as that used for Part B. The income levels would not be adjusted for inflation.

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[21] The President's Budget included a proposal that would also eliminate the current annual CPI-U adjustments for Part B premiums. Consequently, each year the number of beneficiaries subject to the higher premiums would increase. The budget included estimated savings of $110 million in FY2009 and $2.57 billion over the five-year budget period, for this Part B proposal.

[22] See CRS Report RL34280, *Medicare Part D Prescription Drug Benefit: A Primer*, by Jennifer O'Sullivan.

Administrative Provisions. The proposal includes a number of procedural provisions. By September 15 of each year, beginning with 2008, the Secretary of the Department of Health and Human Services (HHS) would disclose to the Commissioner of Social Security the amount of the base beneficiary premium. By October 15, the Secretary would disclose to the Commissioner the monthly adjustment amount and any other information the Secretary determined necessary to carry out the income-related reduction in the premium subsidy.

The monthly adjustment amount would be collected through a reduction in the beneficiary's social security check. If the individual's monthly benefit payments were insufficient, provision would be made to allow other agencies to collect the necessary amounts. (This would likely affect some federal retirees and retirees from the Railroad Retirement Board.) This is the way Part B premiums, including the increased premiums for higher income enrollees, are currently collected. It should be noted that beneficiaries would still have the option of paying the basic Part D premium directly to the plan; alternatively, they could elect to have both amounts deducted from their social security checks.

The provision would also make conforming amendments to the Internal Revenue Code. It would extend to Part D the application of the current provisions relating to disclosure of return information necessary to carry out the Part B premium adjustments. It would add a provision providing that return information (used for both the Part B and Part D adjustments) could be disclosed to officers and employees of HHS and the Department of Justice, to the extent necessary, and solely for their use in any administrative or judicial preceding ensuing from a premium adjustment. Further, the provision would specify the timing for disclosure of return information to officers, employees, and contractors for the Social Security Administration. For persons currently entitled to social security or railroad retirement benefits, the disclosure would have to be made within the four months prior to when the taxpayer first becomes entitled to Part A or eligible to enroll in Parts B or D. For other persons, the disclosure would be made after the taxpayer applied for benefits under Part A or B and was eligible to enroll in Part D.

Potential Impact. The savings estimate for this proposal in the President's Budget are $350 million in FY2009 and $3.18 billion over the five-year budget period (FY2009-FY2013). The Budget did not include an estimate of the number of beneficiaries who would be affected by higher premiums. At the time the 2008 Part B premiums were announced in October 2007, CMS estimated that about 5% of beneficiaries would be affected by the income-related premium increase in 2008. It is thought that a slightly lower percentage would be affected by the Part D proposal; this is because some high-income Medicare beneficiaries have alternative sources of prescription drug coverage (such as through a former employer) and therefore do not enroll in Part D.

The additional Part D premium amount would be recalculated each year based on the new base beneficiary premium amount; over time, this amount is likely to increase. The income categories would not, however, be updated. Consequently, each year the number of beneficiaries subject to the higher Part D premiums would likely increase.