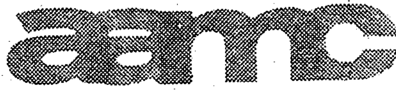

association of american medical colleges

AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

ADMINISTRATIVE BOARD

WEDNESDAY, APRIL 9, 1986

6:00 PM - 10:00 PM

HAMILTON ROOM

THURSDAY, APRIL 10, 1986

8:00 AM - 12 NOON

GRANT ROOM

WASHINGTON HILTON HOTEL
WASHINGTON, DC

one dupont circle, n.w./washington, d.c. 20036

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FUTURE MEETINGS

CAS Administrative Board Meetings

June 18-19, 1986	Washington Hilton Hotel
September 10-11, 1986	Washington Hilton Hotel

CAS Spring Meeting

March 19-20, 1987	Washington, D.C.

AAMC Annual Meetings

October 25-30, 1986	New Orleans, Louisiana	(CAS meets Oct. 26-27)
November 7-12, 1987	Washington, D.C.	(CAS meets Nov. 8-9)

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COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

April 9, 1986

7:00 p.m. Grant Room	CAS Administrative Board Reception
8:00 p.m. Hamilton Room	CAS Dinner

April 10, 1986

8:00 a.m. - 12 noon Grant Room	CAS Administrative Board Meeting
12 Noon - 1:00 p.m. Hemisphere Room	Joint Administrative Boards Luncheon
1:00 p.m. - 3:30 p.m. Military Room	Executive Council Business Meeting

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AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

April 9-10, 1986

I. Report of the Chairman

II. ACTION ITEMS

A. Approval of the Minutes of the January 22-23, 1986 Meeting of the CAS Administrative Board Y1
B. Membership Application: American Association of Pathologists Y9
C. Report of the Committee on Financing GME B19
D. Report of the Ad Hoc Committee on Federal Research Policy B102
E. Finance Committee Interim Report .... mailing
F. Proposed Medicare Regulations on Payments for Medical Education B171
G. Revision of the General Requirements Section of the Essential of Accredited Residencies B18
H. Changes in GME Training Requirements B166
I. Tax Report Update B169
J. Interpreting the AAMC Policy in the Treatment of Irregularities in Medical School Admissions B164

III. DISCUSSION ITEMS

A. Current Proposals on Reimbursement of Indirect Costs B189
B. Medical Malpractice Insurance Legislation Y11
C. 1986 CAS Fall Meeting Program Y24

IV. INFORMATION ITEMS

A. Graduate Medical Education Committee Y25
B. CAS Nominating Committee Y27

B = Blue Agenda Book
Y = Yellow Agenda Book

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MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 22-23, 1986
Washington Hilton Hotel
Washington, D.C.

PRESENT:

Board Members	Staff
David H. Cohen, Chairman	David Baime*
Joe D. Coulter	Melissa Brown*
William F. Ganong	Christine T. Burris
Gary W. Hunninghake	John A. D. Cooper*
Ernst R. Jaffe	Carolyn Demorest
A. Everette James, Jr.	Joseph A. Keyes, Jr.*
Gordon I. Kaye	David B. Moore
Douglas E. Kelly	James Schofield*
Jack L. Kostyo	John F. Sherman*
Frank G. Moody	Elizabeth M. Short
Virginia V. Weldon	August G. Swanson*
	Kathleen Turner*

Guests

Richard Janeway*
Edward J. Stemmler*

* Present for part of meeting

I. The CAS Administrative Board met at 4:30 p.m. Wednesday, January 22, 1986, for an informal discussion of several issues related to representation in the Council of Academic Societies. Dr. Cohen noted that this discussion was prompted, in part, by the continued proliferation of societies seeking membership in the Council and by a growing number of complaints with respect to the representation of societies on the Administrative Board. He said that there were three main questions to be addressed: should the criteria for Council membership be changed, how should member societies be represented within the Council, and how should the members of the Administrative Board be selected?

The general consensus among Board members was that the CAS should be broadly representative of the faculty at academic medical centers; therefore, the criteria for membership should remain relatively open. Two possible dangers were identified with open admission: development of a duplicate constituency and inclusion of non-academic groups. A duplicate representation was thought to be problematic only in terms of the governance of the Council, but because the Council rarely, if ever, takes formal votes on issues, this was not seen as a prohibitive problem. The Board was unable to determine a crisp *a priori* definition of an academic society for use as an admission criterion; therefore, it was decided that the Board would continue to deal with the question of whether a society is "academic" on a case-by-case basis at the time of the society's application for membership.

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With respect to the representation of the individual member societies within the Council, it was felt that the current public affairs and legislative issues facing faculty are inseparable from other academic issues. The Board therefore recommended discontinuation of the office of Public Affairs Representative (PAR). It was decided that each society would continue to have two representatives; however, the Board recommended that the Rules and Regulations should be amended to leave the length of the term for CAS representatives to the discretion of the individual societies. Guidelines would be provided to the societies suggesting that at least one representative have a term sufficient to develop expertise with the issues of importance to the Council and the Association.

It was agreed that the most important consideration in selecting members for the Administrative Board should be the quality of the individuals. As a result, the Board recommended that the current custom of maintaining a 6:6 ratio of basic scientists to clinicians be replaced with a more flexible system with a minimum of 4 basic scientists and 4 clinicians on the Board. This would facilitate the selection of the best possible representative for service on the Board. The Board also recommended an explicit information campaign related to the representation on the Board, and suggested that the CAS Nominating Committee solicit recommendations from the society representatives for nominees for the Board prior to the Committee's conference call in May.

The meeting was adjourned at 6:20 p.m., at which time the CAS Board joined the COD and COTH Boards for a reception and dinner to honor Carolyne K. Davis, Ph.D., former administrator of the Health Care Financing Administration.

II. BUSINESS MEETING

A. ACTION ITEMS

1. Approval of Minutes

   The minutes of the September 11-12, 1985 meeting of the CAS Administrative Board were approved as submitted.

2. Appointment of the 1986 CAS Nominating Committee

   The CAS Administrative Board appointed the following individuals to the CAS Nominating Committee:

   Chair: Frank G. Moody, M.D., Society of Surgical Chairmen
   Basic Scientists:
   David H. Cohen, Ph.D., Soceity for Neuroscience
   Rolla Hill, M.D., Association of Pathology Chairmen
   Mary Lou Pardue, Ph.D., American Society for Cell Biology
   Clinical Scientists:
   Jerry Wiener, M.D., American Association of Chairmen of Departments of Psychiatry
   Nicholas Zervas, M.D., American Association of Neurological Surgeons
   Jo Anne Brasel, M.D., Endocrine Society

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Alternates for Basic Scientists:
Leonard Share, Ph.D., Association of Chairmen of Departments of Physiology
John Basmajian, Ph.D., American Association of Anatomists
Alternates for Clinical Scientists:
C. Philip Larson, Jr., M.D., Association of University Anesthetists
Jerome Goldstein, M.D., Society of University Otolaryngologists-Head and Neck Surgeons
Edwin Cadman, M.D., American Federation for Clinical Research

Dr. Moody, as chairman of the CAS Nominating Committee, will represent the CAS on the AAMC Nominating Committee.

3. Dr. Cohen welcomed the new members of the CAS Administrative Board -- Joe D. Coulter, Ph.D., Society for Neuroscience, Gary Hunninghake, M.D., American Federation for Clinical Research; Gordon Kaye, Ph.D., Association of Anatomy Chairmen; and Ernst Jaffe, M.D., American Society of Hematology.

4. Membership Application

Drs. Kostyo and Yatsu recommended that the Association for Surgical Education be admitted to membership in the Council.

ACTION: The CAS Administrative Board voted to approve the application of the Association for Surgical Education for membership in the CAS and to forward this application to the Executive Council.

5. Request by the American College of Legal Medicine to Reapply for Membership in the Council of Academic Societies

After thorough discussion at several Administrative Board meetings, the original application of the ACLM was rejected in a letter dated 9/27/82 to the president of the ACLM, on the grounds of both insufficient faculty representation among the membership and the society's emphasis on medical practice issues rather than medical education. In December 1985 the ACLM announced by letter its intention to reapply for membership, based primarily on a typographical error in another society's application.

In discussion of the ACLM request, the Administrative Board emphasized that the primary requirements for membership in the Council of Academic Societies, namely an emphasis on medical education and research, particularly as they occur within the academic medical center, had not changed. In view of this primary requirement, the Administrative Board agreed that a reapplication by the ACLM would probably be refused on the same grounds as the initial application. It was agreed that a letter discouraging but not refusing reapplication should be sent to the ACLM.

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ACTION: The CAS Administrative Board voted to send a letter to the American College of Legal Medicine discouraging their reapplication to the CAS on the grounds that the society fails to meet the membership criteria of medical education in medical schools.

6. LCME Involvement in the Accreditation of Foreign Medical Schools

Joe Keyes from the AAMC staff reviewed the discussion by the COD Administrative Board on this issue. The COD requested that the recommendation be stated in a more positive manner, recognizing the serious nature of the issue and suggesting that the Association work with the AMA and other organizations in finding solutions to the problem. The COD also recommended that the Association remain silent on whether the LCME should accept responsibility for the accreditation of foreign medical schools. Mr. Keyes noted that the COD Board was in general agreement on the issue of refusing the LCME permission to accredit foreign medical schools for both legal and financial reasons.

James Schofield, who serves as executive secretary for the LCME, expressed his concern with the effect of state licensure laws on the curricula in medical schools. He predicted that the pressure on the individual state licensure boards to deal with the problem of foreign medical graduates will result in the passage of more restrictions, which will, in turn, place more demands on the curriculum. Dr. Schofield is not as concerned with whether the LCME becomes involved in the inspection of foreign medical schools. He did suggest, however, that if nothing happens on this issue, the federal government might become involved in inspecting foreign medical schools. This inspection might be then extended to domestic medical schools.

Mr. Keyes explained the four specific positions that the Board had been requested to reaffirm. The first was opposition to the use of Medicare funds to pay for the graduate medical education expenses of foreign medical graduates. The second was support for an amendment to the Higher Education Renewal Act that would require a foreign medical school to enroll at least 75 percent of its student body from the citizenry of the country where the school is located for its students to be eligible for guaranteed student loans. The third position was support for an examination of clinical competence for foreign medical graduates to enter into accredited graduate medical education programs. The fourth position was to support a requirement that foreign medical graduates must pass both parts of the FMGEMS examination at the same administration.

ACTION: The CAS Administrative Board voted unanimously to reaffirm the four positions recommended by staff. The Board also voted unanimously to approve the COD's request for a recommendation, phrased in general terms, that this issue be discussed with the AMA and other agencies.

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7. Tax Reform Act

John A. D. Cooper, M.D., Ph.D., president of the AAMC, John Sherman, Ph.D., vice president of the AAMC, Virginia Weldon, M.D., chairman of the AAMC, and Richard Janeway, M.D., immediate past chairman of the AAMC, visited the CAS Board to discuss various proposed policy positions with regard to the Tax Reform Act of 1985 (H.R. 3838). Dr. Sherman explained that this legislation contains three components of major interest to the Association: access to capital under tax-exempt bonds, taxation of scholarships, and retirement benefits.

With regard to tax-exempt bonds, the Board agreed that the AAMC should lobby to have all 501(c)(3) organizations excluded from all restrictions on the use of tax-exempt bonds. As a fallback position, the Board agreed that the AAMC should lobby for a modified version of the bill that would eliminate a proposed cap on the amount of bonds each state can issue per year, but would permit other restrictions.

The Board also agreed that it is appropriate for the Association to take the lead in opposing the enactment of taxation on scholarships and fellowships. The Board also agreed that the staff recommended positions on retirement benefits were appropriate and should be approved.

ACTION: The CAS Administrative Board voted unanimously to approve the staff recommended positions on this bill.

8. Deficit Reduction

Dr. Sherman explained the three general policies recommended by staff to deal with developments surrounding attempts to reduce the federal budget deficit. The CAS Board discussed whether the Association should take a lead in advocating "whatever tax increases are needed to operate and manage important national programs efficiently and economically."

ACTION: The CAS Administrative Board voted unanimously to endorse the Association's leadership in advocating revenue enhancement.

The Board discussed the current situation with regard to Medicare Part A, particularly that as a result of a recent tax increase, current receipts exceed disbursements, and that this program has been subjected to substantial reductions in expenditures over the last 5 years.

ACTION: The CAS Administrative Board voted unanimously to endorse the Association's support for an amendment of the Gramm-Rudman-Hollings law to protect Medicare Part A from further reductions in outlays.

The Board also discussed the extensive proosals to modify the Medicare legislation contained within the fiscal 1986 budget reconciliation package.

ACTION: The CAS Administrative Board voted unanimously to endorse the positions recommended by staff related to the Medicare legislation.

9. Report of the Steering Committee on the Evaluation of Medical Information Science in Medical Education

Dr. Jack Myers, chairman of the Steering Committee, reviewed the background on medical informatics, which concerns the organization and management of information in support of medical research, education, and patient care. Dr. Myers explained the Steering Committee's two fundamental recommendations: that medical informatics should become an integral part of the medical school curriculum and that it have a definable locus within the medical school. How this is accomplished would be left to the individual institutions. He noted that the Steering Committee also recommended a series of coordinated actions involving the Association, the National Library of Medicine, and the NIH.

The CAS Board discussed at length the recommendation that medical informatics become an integral part of the curriculum. Concern was expressed that this recommendation might be interpreted as calling for coursework on informatics, rather than focusing on the use of computers in the educational process.

Dr. Cohen expressed the Board's appreciation to Kat Turner for her work on this project. The Board commended the report in general for providing substantial information on medical informatics.

ACTION: By a vote of 6-4, the CAS Administrative Board approved the recommendation that the Executive Council accept the report and distribute it. The Board further instructed the CAS representatives to the Executive Council to express the Board's reservations with the wording of the recommendation that informatics become an integral part of the medical curriculum.

10. Malpractice Insurance Legislation

Nancy Seline from the AAMC staff, described the background for the current malpractice insurance legislation (S. 1804 and H.R. 3865) that would establish a federal incentive grant program for states that reform their laws governing malpractice insurance. This law would encourage states to modify tort laws to limit the size of the legal fees associated with these cases and to limit the size of the non-economic damages awarded in these cases. She noted that these two factors are often cited as the primary causes for the dramatic increase in malpractice insurance cost.

The CAS Board discussed the role that the Association should play in relation to the AMA, which was the force behind the introduction of this legislation. It is uncertain how far this legislation will move, but HHS Secretary Bowen has identified

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malpractice as a major issue. The Board generally agreed that the Association should support the AMA, but should reserve the right to speak out on issues that are of particular interest to the academic medical centers, such as the use of trainees, the acuity of illness of patients seen in these institutions, the experimental nature of some of the treatments provided, and the dependence on the revenue going beyond practice to the entire medical center to support items of societal benefit.

ACTION: The CAS Administrative Board voted unanimously that the Association position itself in support of the AMA with regard to the malpractice insurance legislation, but that we should reserve the right to speak out on issues that are of particular concern to academic medical centers. The Board also requested more information on this issue to help identify the unique vulnerabilities of academic medicine.

11. Ad Hoc Committee on Graduate Medical Education

In September 1985, the Executive Council authorized the appointment of an ad hoc committee charged to consider the problems created by the residency selection process. During discussion of this issue at the Officers' Retreat in December, it was generally agreed that the transition problems cannot be isolated from overall graduate medical education issues. Thus, it was recommended that the ad hoc committee should review the Association's past positions relative to graduate medical education and recommend both short term and long range strategies to improve graduate medical education and achieve a rational continuum between medical school and residency training.

The CAS Board discussed the concern raised by the COD that this broader charge might sidestep some of the initial questions raised in regard to the fourth year of medical school and the transition to residency training. The Board also discussed the COD's recommendation that the charge to the committee should be more specific and that the committee should address the issue of the fourth year first.

ACTION: The CAS Administrative Board voted unanimously to approve the recommendation for an ad hoc committee on graduate medical education, and that this committee should address the problems associated with the fourth year and the transition to residency training.

12. Coordinated Medical Student Loan Program

Staff presented a proposal for an alternative loan program for medical students. The Association would enter into a contract with a national lending institution, which will be selected on the basis of competitive bidding, and the Higher Education Assistance Foundation (HEAF), which will act as loan guarantor for most of the specific loan programs used by medical students.

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The program offers both financial and administrative advantages for students. The principal advantage would be to streamline the application process. Students would use a single application process for four federal loan programs, including GSL and HEAL. This program would guarantee access to loans for all medical students, and also would provide consolidation and flexible repayment and interest options.

The Association's involvement would be limited to the application process itself. HEAF would use the AAMC data base to verify student's position in medical school. The AAMC would ge additional information on student indebtedness. The financial aid officers at the medical schools and the student representatives approve of this proposal. Staff would like to implement it for 1986.

ACTION: The CAS Administrative Board voted unanimously to recommend that the Executive Council authorize staff to proceed with the development of the Coordinated Medical Student Loan program.

B. Information Items

1. Incorporation of ACCME

The CAS Board discussed the advisability of incorporating the ACCME for the purpose of limiting the potential liability of the parent or sponsor institutions. This discussion was stimulated by a recent suit against the ACCME. It has become evident that the parent bodies could be sued for accreditation decisions in which the parent bodies are not involved because the parent bodies do establish the standards for accreditation. It would appear that the liability of the sponsoring organizations may be limited in almost direct proportion to the degree of autonomy that results from the incorporation. For example, if the sponsoring organizations retain the authority to appoint members of the governing board or to approve changes in accreditation standards, they also would retain the liability with respect to challenges based on those standards.

The Board agreed that the objective of isolating the parent organizations from financial liability is sufficiently important to warrant relinquishing some control. The Board also agreed that any action in this matter should not be viewed as a precedent for the LCME or other organizations with which the Association may wish to maintain a sponsor or parent relationship.

2. 1986 CAS Spring Meeting

The CAS Board reviewed plans for the Spring Meeting, which will include discussions of faculty practice and federal biomedical research policy during Wednesday's plenary session.

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MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Mr. David Moore

NAME OF SOCIETY: American Association of Pathologists, Inc.

MAILING ADDRESS: 9650 Rockville Pike
Bethesda, MD 20814

PURPOSE: The purpose of the Association is the advancement and dissemination of knowledge of disease by scientific and educational means.

MEMBERSHIP CRITERIA: Any American investigator who has contributed meritorious work in pathology is eligible for active membership.

NUMBER OF MEMBERS: 2500

NUMBER OF FACULTY MEMBERS: Approximately 90 percent.

DATE ORGANIZED: Founded December 1900; reincorporated July 1, 1976

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

Adopted 1976
Revised 1979 1. Constitution & Bylaws

April 21-26, 1985 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

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QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

   ___X___ YES ________ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

   501(c)(3)

3. If request for exemption has been made, what is its current status?

   _x_ a. Approved by IRS

   ___ b. Denied by IRS

   ___ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

D. Pitt
(Completed by - please sign)

February 10, 1986
(Date)

MALPRACTICE INSURANCE LEGISLATION

The high cost of malpractice insurance has become a major issue for hospitals and practicing physicians. Some physicians have stopped or restricted their practice to limit malpractice liability. Hospitals and physician groups have employed various strategies to reduce the cost of insurance, including the creation of their own insurance companies or insurance pools. Still, the expense for this insurance is rising rapidly. One reason cited for the increase in premium expense is the size of the awards granted. Another is the frequency with which suits are filed because it is a lucrative business for attorneys.

Hatch Bill (S. 1804)

To curb the cost of malpractice insurance, Senator Hatch (R-UT) and Congressman Lent (R-NY) have introduced a bill (S. 1804 in the Senate, H.R. 3865 in the House) that would establish a federal incentive grant program for states that reformed their laws governing malpractice insurance to:

- allow installment payments of awards in excess of $100,000;
- require that the award to an individual be offset by any other payments made to compensate for the injury, including disability insurance and private health insurance payments;
- prohibit awards for non-economic damages, such as pain and inconvenience, from exceeding $250,000;
- establish a fee schedule for attorneys that would allow attorneys to collect -

  no more than 40 percent of the award if the settlement or award is $50,000 or less;

  $20,000 plus a third of the amount awarded over $50,000 if the settlement or award is more than $50,000 but less than $100,000;

  $36,667 plus 25 percent of the amount awarded in excess of $100,000 if the award or settlement is more than $100,000 but less than $200,000; and

  $61,667 plus 10 percent of the amount awarded in excess of $200,000 if the award or settlement is more than $200,000.
- allocate an amount equal to the licensing or certification fees of each type of health care professional to the state agency responsible for the conduct of disciplinary action for such health professionals;
- require each health care provider to have a risk management program;

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- require each professional liability insuror in the state to make available to licensing boards data on settlement, judgments, and arbitration awards and to establish risk management programs that must be attended once every three years by any professional seeking malpractice insurance; and

- authorize state agencies to enter into agreements with professional societies to review malpractice actions or complaints against a health care professional.

Qualifying states would be eligible for a development grant of $250,000 to plan and implement these necessary legislative reforms. Once the reforms are in place, the state would be eligible for incentive grants of $2,000,000 that could be used to study professional liability programs or to augment state health programs.

The AMA has been the force behind the introduction of this bill and has asked if the AAMC wishes to join in its efforts to muster support for the legislation. The cost of malpractice insurance is a major concern for academic medical centers, especially if it forces physicians to limit the cases seen or treatments performed. Such limits could mean that residents being trained in some specialties or subspecialties may not be exposed to the full scope of patients normally treated by practitioners in that field. Additionally, teaching hospital emergency rooms could become the treatment sources for patients who are difficult to treat and, therefore, more likely candidates for malpractice claims. Thus, it is important for the AAMC to consider options for addressing the malpractice issue.

Critics of the proposed federal legislation suggest that:

- The bill may appear self-serving for the medical community because it places a limit on the "non-economic" damages that is considerably below the amount of some awards.

- One of the functions of the current tort law system is that it places a financial penalty on those who fail to meet the standard of care required of them. To the extent that the penalty is being ameliorated, some would argue that there is a need for a different type of assurance that quality care will be rendered. For example, some might suggest that a physician whose practice is found negligent should be required to attend some educational session analogous to a driver education program.

- Insurance is a matter within the jurisdiction of the state governments, not the federal government; therefore, more appropriate reforms could be achieved by working directly with state legislatures to enact reforms.

At the January 21, 1986 meeting of the Executive Council there was discussion of the features of the malpractice problem that were unique to the academic setting, including the mobility of faculty and the use of part-time faculty.

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There was also a discussion of the need for the profession to improve disciplinary procedures. Finally, there was a realization that large awards associated with liability judgments have jeopardized forms of liability insurance beyond medical malpractice.

Although there was general support for the bill, there was some concern about the provisions relating to the attorney fee schedule and some questions about the bill's constitutionality. It was decided that the Association would support the bill in its overall thrust, particularly stressing the areas of concern to academic medical centers, and would work with the AMA to achieve tort reform.

Durenberger Bill (S. 1960)

Recently, Senator Durenberger (R-MN) and Congressman Moore (R-LA) introduced a medical malpractice bill (S. 1960, H.R. 3084) to encourage voluntary settlement of personal injury claims under Medicare, Medicaid, CHAMPUS and other federal programs. The legislation provides a model system to be adopted by the states. If states do not implement it, it would be implemented at a federal level. Key provisions include:

- tender of compensation - if a potentially liable physician provides the injured patient with a written tender to pay compensation benefits for the injury as specified in this bill, the injured individual would be foreclosed from later bringing suit. If a tender is not offered within 180 days, the injured individual may request arbitration and the arbitrator will decide the degree of liability of the doctor.

- amount of compensation - would equal only economic loss as defined in the bill, plus attorneys fees. Non-economic loss, such as pain and suffering, would not be compensated.

- payment schedule - compensation would be paid within 30 days of each legitimate bill to a maximum period of 5 years, but could be paid in equivalent medical services when appropriate. A lump sum payment settlement could be negotiated at any time, but if the economic loss exceeded $5,000, the settlement would require court approval.

- M.D.s could not participate in this alternative liability program without professional malpractice insurance or suitable other indemnity.

The AAMC Executive Council has not yet considered our Association position on the Durenberger bill.

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By Mr. HATCH (for himself, Mr. ABDNOR, and Mr. INOUYE):

S. 1804. A bill to provide for Federal incentive grants to encourage State health care professional liability reform; to the Committee on Labor and Human Resources.

FEDERAL INCENTIVES FOR STATE HEALTH CARE PROFESSIONAL LIABILITY REFORM ACT

Mr. HATCH. Mr. President, I send to the desk the "Federal Incentives for State Health Care Professional Liability Reform Act of 1985." This bill addresses a growing problem in maintaining a wide range of affordable health care services for the American people. I am talking about the problem of soaring medical malpractice costs and the resulting increased expense, and sometime unavailability, of medical professional liability insurance.

Last year, the Labor and Human Resources Committee held hearings which revealed the extent of this problem and the threat it poses to our health care system. In many areas, premiums for professional liability insurance for physicians continue to rise 20, 30, 40 percent a year and more.

The crisis is particularly acute for those rendering obstetrical care. In Florida, 20 percent of obstetricians have reportedly stopped delivering babies and now limit their practice to surgery. In North Carolina, family physicians' malpractice coverage for obstetrics just increased 400 percent, and the majority are reported to be stopping delivering babies.

Nor is the problem confined to physicians. Nurse-midwives, though traditionally at considerable lower risk of suit than physicians, are sometimes categorized with them by insurance companies for premium purposes. In many States, nurse-midwives have recently been unable to obtain insurance, or can obtain it only at exorbitant rates which put it beyond the reach of their incomes. The consequences of such trends among health professionals are obvious—access to health care may be seriously jeopardized unless a prescription is written to treat this malpractice fever.

State governments shoulder the responsibility of defining the judicial or administrative system governing recovery for malpractice injuries, and they are not blind to the medical professional liability insurance crisis. All but one have at least begun reform of their negligence or tort law systems, and many of them are considering further steps. Among these are submission of claims to arbitration panels, limitations on attorney's contingency fees, modification of the collateral source rule, limits on recoverable damages, the establishment of a patient compensation fund, the requirement of periodic payment of large awards, the establishment of pretrial screening panels, and shortening the statute of limitations.

Many of these represent worthwhile improvements. By and large, they respond to perceived failings in the current tort law system, such as the ability of skillful attorneys to obtain exaggerated judgments for pain and suffering, the inducement to unwarranted litigiousness afforded by an escalating contingency fee schedule for attorneys, and the slowness of the legal system in delivering compensation to the injured. Studies have shown that different reforms have different abilities to achieve the overall goals of reducing the total costs of medical malpractice litigation, and thus of liability insurance, and more efficiently delivering compensation.

The legislation I am introducing today sets up monetary incentives to encourage States to adopt further administrative improvements and four tort law reforms, three of which have been found to be among the most effective in holding down litigation costs. This represents a refined version of a proposal drafted by the American Medical Association, and will serve to move the debate on malpractice insurance forward into the consideration of specific legislative solutions.

Briefly, this proposal would fund development grants by which States would design and implement a strategy leading to adoption of these reforms. Additionally, it would grant $2 million the first year and $1 million per year for the next 2 years to any State which adopts all the recommended measures. This money could be used for a broad variety of public health programs, or to conduct studies of the professional liability problem specific to that State.

The reforms named in the bill are: First, periodic payment of damage awards over $100,000; second, elimination of the collateral source rule, thus providing for the reduction of awards by amounts received from other sources for the same injury; third, limitation of non-economic damages (pain and suffering) to $250,000; fourth, limitation of attorney's contingency fees; fifth, allocation of an amount equivalent to that collected from physician licensing fees to the State agency responsible for disciplinary actions; sixth, requirement that hospitals develop risk management programs and require physician participation as a condition to receipt of insurance; seventh, requirement that insurance companies make certain data available to State agencies; and eighth, provision for increased peer review by State medical societies of questionable practice patterns.

I note that some of these proposals strengthen the ability and resources of State boards entrusted with the duty

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of weeding out incompetent health practitioners. I am encouraged that this is part of the AMA's program. The AMA forthrightly admits that malpractice does exist. And I am firmly convinced that much can be done to alleviate the current explosion of liability costs if physicians and other health professionals will police their own ranks conscientiously. Healing the sick is a high calling. It is generally very well paid. And the public has a right to expect that State medical boards will force out of the profession alcoholics, drug abusers, the incompetent, and the unprincipled. To the extent the profession has not done so, it has itself to blame for the current situation.

However, claims are also skyrocketing among health professionals who are skilled and conscientious. Part of this may result from the increase in the variety and complexity of medical technology and services; from higher, sometimes unrealistic, public expectations of what medicine can do; from a new readiness of the ordinary citizen to sue; and from a greater number of patients and attorneys willing to file suits that may be marginal or unfounded, hopeful of huge awards or settlements. It is to address some of these factors that the bill I am introducing was drafted. If adopted by States, the bill's reforms would bring down the cost of medical litigation and would result in a higher level of competence among health professionals.

However, I am well aware of the many problems raised by the bill itself. First, I long have doubted in other contexts the wisdom of using Federal dollars to persuade State governments to alter their laws to reflect some grand Federal design. Those doubts persist here. Further, I note again that many of these reforms have already been considered and some adopted by a number of States. The benefit from these reforms is yet to be realized, but when they have gone into effect, the current "crisis" may be less evident.

This leads to another issue: The most recent information available to me indicates that one or another of the listed provisions has been invalidated under State consitutions in five States. Since it would certainly not be our intention to try to preempt State consitutions, there would be at least five States which, from the start, may have no possibility of participating under this proposal. There are pending constitutional challenges in many other States where reforms have been adopted, as well, and the number of invalidations and ineligible States will likely rise. Finally, the individuals tort law reforms raise not only constitutional issues but issues of equity and policy, which we will want to examine as the debate proceeds.

Regardless, the insurance problem is a serious one. The relentless increase in liability costs and insurance premiums not only threatens access to care in many fields, it leads directly to the practice of defensive medicine, in which health professionals opt for greater frequency of health care testing and services. According to a recent study, costs resulting from professional liability, including premiums and defensive medicine expenses, total an estimate $11 billion to $13 billion of the $75 billion spent on physician's services in 1984. Expected savings if this bill were fully implemented would, by one estimate, exceed $500 million annually, while the total cost of the bill for 3 years would be $224.9 million.

Through the introduction of this bill, I intend to highlight these problems and begin in earnest the search for the appropriate Federal and State roles in malpractice reform. The American Medical Association has provided us with a thoughtful, useful discussion piece. I challenge the best minds in law, medicine, and public policy to concur or to respond with concrete alternatives.

Mr. President, I ask that the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1804

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Incentives for State Health Care Professional Liability Reform Act of 1985".

FINDINGS AND PURPOSE

SEC. 2. (a) The Congress finds that—

(1) there are serious problems with current systems for compensating individuals injured by the malpractice of health care professionals and health care providers;

(2) the increasing costs and unavailability of professional liability insurance are causing competent health care professionals to cease or limit practice in high risk specialties or to totally cease the practice of their profession;

(3) current health care malpractice compensation systems cause substantial numbers of health care professionals and health care providers to engage in defensive health care practices, such as the conduct of tests and procedures primarily to provide protection against legal actions, and such practices result in unnecessary health care costs;

(4) the number of professional liability claims against health care professionals and health care providers is increasing at disproportionate rates, beyond any relationship to the quality of the health care provided;

(5) the increase in the number of liability claims and the size of awards and settlements, and the excessive time and expense devoted to the resolution of such claims, pose threats to State systems for compensating individuals injured through negligence and to continued access by all individuals to health care;

(6) the Federal Government has an interest in State health care malpractice compensation systems because the Federal Government pays health care costs through Medicare, Medicaid, and other Federal health care programs;

(7) experience in States which have enacted reforms in their tort and judicial systems indicates that certain reforms can reduce unnecessary expenditures related to health care liability claims while providing more rapid and more efficient compensation for individuals injured by malpractice; and

(8) Federal incentives to encourage States to adopt reforms to improve State health care malpractice compensation and professional disciplinary systems will result in—

(A) the maintenance of access to quality health care;

(B) a more rational health care malpractice compensation system; and

(C) substantial savings by the Federal Government and State governments.

(b) It is the purpose of this Act to establish a system of Federal incentive grants to States to encourage the adoption of reforms in State health care malpractice compensation systems.

DEFINITIONS

SEC. 3. For purposes of this Act—

(1) the term "injury" shall have the meaning given to such term by each State in its State liability reforms, except that in defining such term, each State shall include in such term injuries arising from the negligent delivery of health care services by a health care professional or health care provider;

(2) the term "health care professional" means any individual who provides health care services in a State and who is required by State law to be licensed or certified by the State to provide such services in the State;

(3) the term "health care provider" means any organization or institution which is engaged in the delivery of health care services in a State and which is required by State law to be licensed or certified by the State to engage in the delivery of such services in the State;

(4) the term "malpractice" shall have the meaning given to such term by each State in its State liability reforms, except that in defining such term, each State shall include in such term malpractice or professional negligence by a health care professional or health care provider in the delivery of health care services;

(5) the term "professional liability" shall have the meaning given to such term by each State in its State liability reforms, except that in defining such term, each State shall include in such term liability arising from the negligent delivery of health care services by a health care professional or health care provider;

(6) the term "Secretary" means the Secretary of Health and Human Services;

(7) the term "State" means each of the several States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands; and

(8) the term "State liability reforms" means the reforms described in section 6.

DEVELOPMENT GRANTS

SEC. 4. (a) A State may submit an application to the Secretary for a grant to develop programs to undertake State liability reforms. Any such application shall—

(1) be submitted to the Secretary within 180 days after the date of enactment of this Act;

(2) contain assurances that the State intends to obtain enactment or adoption of the State liability reforms described in section 6 in order to qualify for incentive grants under section 5; and

(3) contain such other information, and be in such form, as the Secretary may prescribe.

(b)(1) If a State submits an acceptable application under subsection (a), the Secretary shall make a grant to such State.

(2) The amount of a grant under paragraph (1) to a State (other than Puerto Rico, Guam, and the Virgin Islands) shall be

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$250,000, except that if the amount appropriated under section 8(a)(1) is less than $12,000,000, the amount of a grant under paragraph (1) to such a State shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(a)(1), by the number of States (other than Puerto Rico, Guam, and the Virgin Islands) submitting acceptable applications under this section, except that no grant to such a State under this section shall exceed $250,000.

(3) The amount of a grant under paragraph (1) to Puerto Rico, Guam, or the Virgin Islands shall be $125,000, except that if the amount appropriated under section 8(a)(2) is less than $375,000, the amount of a grant under paragraph (1) to Puerto Rico, Guam, or the Virgin Islands shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(a)(2) by 3.

(c) The Secretary may provide technical assistance to States in planning and carrying out activities with grants under this section.

INCENTIVE GRANTS

SEC. 5. (a) A State may submit an application to the Secretary for a grant under subsection (b)(3). Any such application shall—

(1) be submitted to the Secretary within three years after the date of enactment of this Act;

(2) contain a certification by the chief executive officer of the State that, on the date the application is submitted, the State has enacted, adopted, or otherwise has in effect, the State liability reforms described in section 6;

(3) be accompanied by documentation to support the certification required by paragraph (2), including copies of relevant State statutes, rules, procedures, regulations, judicial decisions, and opinions of the State attorney general; and

(4) contain such other information, and be in such form, as the Secretary may prescribe.

(b)(1)(A) Within 60 days after receiving an application under subsection (a), the Secretary shall review the application and determine whether the application demonstrates that the State has enacted, adopted, or otherwise has in effect, the State liability reforms described in section 6. If the Secretary determines that the application makes such a demonstration, the Secretary shall approve the application.

(B) If an application submitted under subsection (a) cites a State statute or other evidence of compliance with the standards for a State liability reform described in section 6, the Secretary shall consider such State to be in conformance with the requirements of such section with respect to such reform if the statute or other evidence of compliance cited in such application is equal to or more stringent than the reform described in such section.

(2) If, after reviewing an application under paragraph (1), the Secretary determines that the application does not make the demonstration required under such paragraph, the Secretary shall, within 15 days after making such determination, provide the State which submitted such application with a written notice which specifies such determination and which contains recommendations for revisions which would bring the State into compliance with this Act.

(3)(A) Within 30 days after approving an application of a State under paragraph (1), the Secretary shall pay to the State a grant in the amount required under subparagraph (B) or (C), as the case may be.

(B) The amount of a grant under subparagraph (A) to a State (other than Puerto Rico, Guam, or the Virgin Islands) shall be $2,000,000, except that if the amount appropriated under section 8(b)(1) is less than $102,000,000, the amount of a grant under subparagraph (A) to such a State shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(b)(1) by 51.

(C) The amount of a grant under subparagraph (A) to Puerto Rico, Guam, or the Virgin Islands shall be $1,000,000, except that if the amount appropriated under section 8(b)(2) is less than $3,000,000, the amount of a grant under subparagraph (A) to Puerto Rico, Guam, or the Virgin Islands shall be an amount equal to the quotient obtained by dividing the total amount appropriated under section 8(b)(2) by 3.

(c)(1)(A) One year after the date on which the Secretary makes payment of a grant to a State (other than Puerto Rico, Guam, or the Virgin Islands) under subsection (b)(3), the Secretary shall pay to such State a grant in an amount equal to $1,000,000, except as provided in paragraph (3)(A) and subsection (d).

(B) One year after the date on which the Secretary makes payment of a grant to Puerto Rico, Guam, or the Virgin Islands under subsection (b)(3), the Secretary shall pay to Puerto Rico, Guam, or the Virgin Islands, as the case may be, a grant in an amount equal to $500,000, except as provided in paragraph (3)(B) and subsection (d).

(2)(A) Two years after the date on which the Secretary makes payment of a grant to a State (other than Puerto Rico, Guam, or the Virgin Islands) under subsection (b)(3), the Secretary shall pay to such State a grant in an amount equal to $1,000,000, except as provided in paragraph (3)(A) and subsection (d).

(B) Two years after the date on which the Secretary makes payment of a grant to Puerto Rico, Guam, or the Virgin Islands under subsection (b)(3), the Secretary shall pay to Puerto Rico, Guam, or the Virgin Islands, as the case may be, a grant in an amount equal to $500,000, except as provided in paragraph (3)(B) and subsection (d).

(3)(A) If the amount appropriated under section 8(c)(1) for grants under paragraph (1)(A) is less than $51,000,000, or if the amount appropriated under section 8(d)(1) for grants under paragraph (2)(A) is less than $51,000,000, the amount of a grant to a State (other than Puerto Rico, Guam, or the Virgin Islands) under paragraph (1)(A) or paragraph (2)(A), as the case may be, shall be an amount equal to the quotient obtained by dividing the amount appropriated under section 8(c)(1) or section 8(d)(1), respectively, by 51.

(B) If the amount appropriated under section 8(c)(2) for grants under paragraph (1)(B) is less than $1,500,000, or if the amount appropriated under section 8(d)(2) for grants under paragraph (2)(B) is less than $1,500,000, the amount of a grant to Puerto Rico, Guam, or the Virgin Islands under paragraph (1)(B) or paragraph (2)(B), as the case may be, shall be an amount equal to the quotient obtained by dividing the amount appropriated under section 8(c)(2) or section 8(d)(2), respectively, by 3.

(d)(1) If, at any time after a State receives a grant under this section, the Secretary determines that the State does not have in effect all of the State liability reforms described in section 6, the Secretary shall provide the State with written notice of such determination. Such notice shall specify—

(A) the reasons for the determination of the Secretary;

(B) that after the date of such determination, the State will not be eligible to receive a grant under paragraph (1) or (2) of subsection (c) unless the State takes such corrective action as may be necessary to ensure that the State liability reforms are in effect in the State, except as provided in paragraph (2) of this subsection; and

(C) that the State may request a hearing before an administrative law judge to appeal the determination of the Secretary.

(2) After making a determination under paragraph (1) of this subsection, the Secretary shall not pay any grant to a State under paragraph (1) or (2) of subsection (c) unless the determination of the Secretary under paragraph (1) of this subsection has been reversed by an administrative or judicial decision.

(e)(1) Any grant received by a State under this section shall be used by the State to—

(A) supplement, and not supplant, funds expended by the State on programs for the provision of health care services, including programs supported with any type of Federal assistance, except as provided in paragraph (2);

(B) support programs of peer review and risk management for health care professionals and health care providers in the State; or

(C) conduct studies of professional liability problems in the State, including studies to determine the impact of the State's malpractice compensation system on health care availability and health care costs in the State.

(2) A grant received by a State under this section may not be used by such State to satisfy any provision of Federal law which requires that, in order to qualify for Federal assistance under such law, the State pay a portion of the costs of the project, program, or activity to be conducted with such Federal assistance.

STATE LIABILITY REFORMS

SEC. 6. (a) The State liability reform which shall be developed with a grant under section 4, which shall be enacted, adopted, or be in effect in a State in order for the State to receive a grant under section 5(b)(3), and which shall be in effect in a State in order for the State to receive grants under section 5(c), are the reforms specified in subsections (b) through (f) of this section.

(b) A State shall require that, in any legal action for damages for malpractice in which a court of the State awards an individual future damages in excess of $100,000—

(1) the payment of such future damages shall be made on an annual or other periodic basis, in such amounts and at such intervals as may be determined by the court;

(2) the court shall determine a schedule for such payments to ensure that damages are paid over the estimated lifetime of such individual or until the total amount of such award is paid to such individual, whichever occurs first, except that—

(A) in any case in which such individual dies prior to the date on which the final payment is to be made under such schedule to such individual, the party obligated to make payments to such individual shall not be required to make any additional payments to the heirs or assigns of such individual unless, after application by the spouse or child of such individual, the court orders such party to make payments to such spouse or child for the support of such spouse or child; and

(B) in any case in which such individual lives beyond the date on which final payment is to be made to such individual under such schedule, such individual may apply to the court for additional payments for economic damages resulting from such malpractice, which shall be calculated at the

annual rate at which such damages were calculated under such schedule; and

(3) the court shall require that such periodic payments be made through the establishment of a trust fund or the purchase of an annuity for the life of such individual or during the continuance of the compensable injury or disability incurred by such individual.

(c)(1) A State shall require that, in any legal action for damages for malpractice in which a court of the State awards damages to an individual, the total amount of such damages shall be reduced by any other payment which has been made or which will be made to such individual to compensate such individual for the injury sustained as a result of such malpractice, including payments under—

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) employer wage continuation programs; and

(D) any other source of payment intended to compensate such individual for such injury.

(2) The amount by which an award of damages to an individual for an injury shall be reduced under paragraph (1) shall be an amount equal to the difference between—

(A) the total amount of any payments (other than such award) which have been made or which will be made to such individual to compensate such individual for such injury, minus

(B) the amount paid by such individual (or by the spouse or parent of such individual) to secure the payments described in subparagraph (A).

(d) A State shall require that, in a legal action for damages for malpractice, the amount of any award of damages for noneconomic losses resulting from such malpractice shall not exceed $250,000. For purposes of this subsection, the term "noneconomic losses" means losses for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary losses.

(e)(1) Except as provided in paragraph (2), a State shall require that in any legal action for damages for malpractice in which an individual receives a settlement or an award of damages, the amount of payments to such individual's attorney shall be in accordance with the following:

If the total settlement or award is:	The attorney's fee shall not exceed:
Not more than $50,000	40% of such amount
More than $50,000 but less than $100,000.	$20,000 plus 33⅓% of the excess over $50,000
More than $100,000 but less than $200,000.	$36,667 plus 25% of the excess over $100,000
$200,000 or more	$61,667 plus 10% of the excess over $200,000.

(2) A State shall require that in any legal action to which paragraph (1) applies, the court may, after receiving a petition from the attorney representing the individual who receives a settlement or an award of damages, permit such attorney to be paid an amount of fees in excess of the amount specified by paragraph (1) if such court determines the petition has adduced evidence justifying such additional fees.

(f)(1) Each State shall provide for the allocation of the total amount of fees paid to the State in each year for the licensing or certification of each type of health care professional, or an amount of State funds equal to such total amount, to the State agency or agencies responsible for the conduct of disciplinary actions with respect to such type of health care professional.

(2) The State shall require each health care provider to have in effect a risk management program which complies with the laws of the State and which is acceptable to the agency responsible for licensing or certifying such health care provider.

(3) The State shall require each company which provides health care professional liability insurance in the State to—

(A) make available, upon the request of any State board or agency responsible for licensing, certifying, or disciplining health care professionals, information concerning any settlement, judgment, or arbitration award for damages for malpractice against any health care professional over which such board or agency has jurisdiction; and

(B) establish, from the data available to such company, programs of risk management for health care professionals, and require each such professional, as a condition of maintaining insurance, to participate in such programs at least once in each three-year period.

(4)(A) The State shall authorize each State agency responsible for the conduct of disciplinary actions for a type of health care professional to enter into agreements with State or county professional societies of such type of health care professional to permit the review by such societies of any malpractice action, complaint, or other information concerning the practice patterns of any such health care professional. Any such agreement shall comply with subparagraph (B).

(B) Any agreement entered into under subparagraph (A) for the review of any malpractice action, complaint, or other information concerning the practice patterns of a health care professional shall—

(i) provide that the health care professional society conduct such review as expeditiously as possible;

(ii) provide that after the completion of such review, such society shall report its findings to the State agency with which it entered into such agreement and shall take such other action as such society considers appropriate; and

(iii) provide that the conduct of such review and the reporting of such findings be conducted in a manner which assures the preservation of confidentiality of medical information and of the review process.

(C) The State shall provide that any activity conducted pursuant to an agreement under this paragraph shall not be grounds for any civil or criminal action under the antitrust laws of the State or for any other civil action under the laws of the State.

(D) Notwithstanding any other provision of Federal law, any activity conducted pursuant to an agreement under this paragraph shall not be grounds for any civil or criminal action under Federal antitrust laws, as defined in the first section of the Clayton Act and in section 4 of the Federal Trade Commission Act.

REPORTS

SEC. 7. (a) Within two years after the date of enactment of this Act, and every two years thereafter, each State which receives a grant under section 5 during any such two-year period shall prepare and transmit to the Secretary a report which describes—

(1) the State liability reforms enacted, adopted, or in effect in the State;

(2) the activities conducted by the State with any grants received under section 4 or 5 during the preceding two-year period; and

(3) any current problems in the State with respect to health care professional liability or health care professional liability insurance.

(b) Within 30 months after the date of enactment of this Act, and every two years thereafter, the Secretary shall prepare and transmit to the Congress a report which summarizes the information submitted to the Secretary in the most recent reports of the States under subsection (a).

AUTHORIZATION OF APPROPRIATIONS

SEC. 8. (a)(1) For grants under section 4(b)(2), there are authorized to be appropriated $12,500,000 for fiscal year 1987.

(2) For grants under section 4(b)(3), there are authorized to be appropriated $375,000 for fiscal year 1987.

(b)(1) For grants under section 5(b)(3)(B), there are authorized to be appropriated $102,000,000 for fiscal year 1987.

(2) For grants under section 5(b)(3)(C), there are authorized to be appropriated $3,000,000 for fiscal year 1987.

(3) Amounts appropriated under this subsection shall remain available from October 1, 1986, to September 30, 1989.

(c)(1) For grants under section 5(c)(1)(A), there are authorized to be appropriated $51,000,000 for fiscal year 1988.

(2) For grants under section 5(c)(1)(B), there are authorized to be appropriated $1,500,000 for fiscal year 1988.

(3) Amounts appropriated under this subsection shall remain available from October 1, 1987, to September 30, 1990.

(d)(1) For grants under section 5(c)(2)(A), there are authorized to be appropriated $51,000,000 for fiscal year 1989.

(2) For grants under section 5(c)(2)(B), there are authorized to be appropriated $1,500,000 for fiscal year 1989.

(3) Amounts appropriated under this subsection shall remain available from October 1, 1988, to September 30, 1991.

By Mr. TRIBLE:

S. 1805. A bill to amend title 5, United States Code, to increase the opportunity to provide a survivor annuity under subchapter III of chapter 83 of such title; and to improve retirement counseling for Federal Government employees; to the Committee on Governmental Affairs.

ELECTION OF SURVIVOR ANNUITY

Mr. TRIBLE. Mr. President, today I am introducing legislation of critical importance to Federal retirees and their spouses. This legislation would ensure that retired Federal employees are provided with a sufficient opportunity to elect a survivor annuity under civil service retirement. My colleague from Virginia, Representative FRANK WOLF, is introducing similar legislation in the House.

Under current law, Federal employees must make a decision regarding the selection of survivor benefits prior to retirement. Once that decision is made it is irrevocable. If a retiree does not elect to provide a survivor annuity, then there is no opportunity to change that decision.

Far too often, this decision is based upon incorrect or incomplete information and advice provided by the Federal employee's personnel retirement counselor. As a result, and in spite of the retiree's wishes, some survivors of Federal retirees are left unprotected and without any source of income upon the death of their spouse.

Mr. President, my legislation will eliminate this unfortunate situation. It would provide Federal retirees with a second opportunity to elect survivor benefits if they have not already done

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By Mr. DURENBERGER (for himself and Mr. DANFORTH):

S. 1960. A bill entitled the "Medical Offer and Recovery Act"; to the Committee on Finance.

MEDICAL OFFER AND RECOVERY ACT

● Mr. DURENBERGER. Mr. President, today I am introducing the Mdicial Offer and Recovery Act along with my distinguished colleague, the Senator from Missouri [Mr. DANFORTH]. I am introducing this bill as a courtesy to my distinguished House colleagues, Representatives MOORE and GEPHARDT. It is a companion bill to H.R. 3084 which would propose to reform this country's medical malpractive system. This measure includes refinements to the proposal which they introduced last year and I am including a summary of the bill after my statement which outlines the provisions and changes from last year's version.

My House colleagues spent considerable time and effort developing this proposal and it is a serious contribution to a much needed national debate. It is the one major measure that provides an alternative to State tort reform, and therefore deserves examination and scrutiny in the Senate along with another important measure, S. 1804, introduced by my distinguished Senate colleague, ORRIN HATCH. His proposal is authored by the American Medical Association.

Mr. President, there is no question that the funding of malpractice insurance is reaching a crisis point. I was reading an article in the Mankato Free Press from my own State of Minnesota, about a young woman named Ann McCall, who was looking forward to having the doctor who had delivered her 21 years before also deliver her new baby. Just 2 weeks before the anticipated delivery date, her doctor informed her that he was turning over his obstetric practice to another doctor because he could no longer afford the escalating cost of his malpractice insurance premiums. Zachary McCall was born to Ann and Pat McCall with the assistance of a physician they had known for only 2 weeks.

This story is repeated every day all over this country. And it's happening because there are major problems with the medical malpractice system in the United States.

Malpractice insurance premium costs are skyrocketing, reaching as high as $100,000 a year for some speciality physicians in certain areas of the country. The number of malpractice claims has tripled over the past decade and million dollar settlements happen on a regular basis. The average settlement has grown from $5,000 to over $300,000 in just 6 years.

Growing numbers of claims have resulted in physicians practicing defensive medicine. The AMA estimates that this may cost Americans at least $15 billion a year in extra costs. Still the number of claims against doctors continues to grow, and the public pays for it through high hospital bills, doctor bills, and health insurance premiums.

Higher malpractice insurance costs force doctors and hospitals to raise their charges and pass these costs on to third party payers and consumers. It is also pricing some physicians out of business. The Minnesota Medical Association estimates that 40 family practice doctors have stopped delivering babies and more are expected to drop the obstetric part of their practice. This could create serious problems for residents in rural Minnesota and similar areas around the country who rely on their community doctor for all their medical care.

The litigation of malpractice cases is unwieldy and expensive. It is also time-consuming and inequitable. A few plaintiffs are awarded large recoveries, but only after a long, drawn out litigation process. But the real tragedy is that the expense of litigation discourages many with valid claims from even prosecuting those claims. And international reinsurance companies are threatening to quit reinsuring American malpractice insurance companies. These reinsurers are concerned that damage awards in the United States have gotten too far out of line from premium revenues.

These problems are not new. In the mid-1970's, in response to increased numbers of claims and sizes of settlements, many liability insurance carriers were left out of the market and others had to raise their premiums by as much as 750 percent. The States responded to this by enacting medical malpractice before legislation. But these reforms have obviously not had much of an effect.

States are now taking even more steps to reform their tort laws. I was in Florida in November and learned about their newly passed law which includes a sliding fee scale for attorneys' contingency fees. States are trying other methods of reform, and the jury is still out on the likely success of these measures. We will watch these changes closely. But it is time to determine whether a Federal role in this area is appropriate.

The crisis may be upon us again. This demands action. We must bring down the cost of malpractice insurance to physicians, insurers, and the public, and at the same time, create a more equitable, efficient system to adjudicate malpractice. At a time when the health care marketplace is becoming more and more cost conscious, we can ill afford this lopsided, ineffective malpractice system that perpetuates an insensitivity to price and unresponsiveness to fairness.

I trust the new year will bring serious debate and resolution of the professional liability crisis. I intend to be at the center of that debate. Mr. President, I ask unanimous consent that the bill and summary of the Medical Offer and Recovery Act be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1960

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medical Offer and Recovery Act".

SEC. 2. ALTERNATIVE LIABILITY SYSTEM FOR MALPRACTICE.

(a) MEDICARE AMENDMENT.—Part A of title XVIII of the Social Security Act is amended—

(1) by inserting after the heading to part A the following new subpart heading:

"Subpart I—Hospital Insurance Program", and

(2) by adding at the end the following new subpart:

"Subpart II—Alternative Liability System for Malpractice

"TENDER OF COMPENSATION BENEFITS IN SETTLEMENT OF MALPRACTICE CLAIMS

"SEC. 1821. (a)(1)(A) In the case of a health care provider (as defined in paragraph (4)(D)) which—

"(i) is participating in an assigned claims plan under section 1826 and

"(ii) is potentially liable for a personal injury (as defined in paragraph (4)(A)) to an injured individual,

if the provider provides the individual not later than the date specified in subparagraph (C) with a written tender to pay compensation benefits with respect to such injury in accordance with this subpart, the individual and any other entity shall (except as provided in paragraph (3)) be foreclosed from bringing any civil action described in paragraph (2) against such provider or other entity joined under subsection (b) based on such personal injury.

"(B) If the provider fails to provide an individual with such a written tender on a timely basis with respect to a personal injury, the individual may, during the 90-day period beginning on the date specified in subparagraph (C), serve on the provider a written request for arbitration on the question of the legal liability for the personal injury and the provisions of this section shall apply as though a tender under subparagraph (A) had been made. If the arbitrator determines that the provider was wholly or partly legally liable for the personal injury—

"(i) the amount of the liability of the provider shall be determined as though the provider had made a timely tender under subparagraph (A), and

"(ii) the provider shall be liable for reasonable attorneys fees incurred by the individual who requested the arbitration.

"(C) The date referred to in subparagraphs (A) and (B) is—

"(i) in the case of a personal injury resulting from a stay as an inpatient in an institution, 180 days after the date of the patient's discharge from the institution,

"(ii) in the case of failure to provide informed consent, erroneous diagnosis, or injury to a new born caused by action or inaction before or at the time of birth, 180 days after the date of the filing of a claim against the provider, or

"(iii) in the case of any other personal injury, 180 days after the date of the action or inaction giving rise to the personal injury,

except that such date may be extended for up to an additional 60 days for purposes of subparagraph (A) if the provider and the patient agree in writing to such extension.

"(D) Nothing in this subpart shall be construed as changing any applicable statute of limitations of any State or of the United States.

"(2)(A) Except as provided in subparagraph (B), civil actions referred to in paragraph (1) include any civil action (whether brought in a Federal or State court) which could have been brought against a compensation obligor (as defined in subsection (d)(1)) for recovery of damages relating to personal injury, whether based on (i) negligence or gross negligence, (ii) strict or absolute liability in tort, (iii) breach of express or implied warranty or contract, (iv) failure to discharge a duty to warn or instruct or to obtain consent, or (v) any other theory that is (or may be) a basis for an award of damages for personal injury.

"(B) Civil actions referred to in subparagraph (1) do not include—

"(i) any action to recover for compensation benefits tendered under this subpart, or

"(ii) any action in the nature of a wrongful death action, but only in the case of such an action for losses accruing to survivors after the death of an injured individual and resulting from the death of the individual.

"(3) In no event shall a civil action be foreclosed under paragraph (1) against any entity which intentionally caused or intended to cause injury, except that this paragraph shall not apply with respect to a personal injury unless the injured individual provides the provider making a tender with a notice of election not later than 90 days after the date the tender of compensation benefits was made.

"(4) As used in this subpart:

"(A) The terms 'injury' and 'personal injury' mean sickness or disease or bodily harm arising in the course of the provision of health care services provided pursuant to (or for which payment may be made under) this title, a State plan approved under title XIX, plans under sections 1079 and 1086 of title 10, United States Code (relating to the CHAMPUS program), section 613 of title 38, United States Code (relating to the CHAMPVA program), a health benefits plan pursuant to a contract with the Office of Personnel Management under chapter 89 of title 5, United States Code (relating to the Federal employees health benefits program), title 10 or title 38 of the United States Code (relating to the Department of Defense and the Veterans' Administration), or any other program established under Federal law.

"(B) The term 'injured individual' means an individual suffering injury in the course of health care provided by an individual or entity.

"(C) An entity intentionally causes or attempts to cause a personal injury when the entity acts or fails to act for the purpose of causing injury or with knowledge that injury is substantially certain to follow; but an entity does not intentionally cause or attempt to cause injury merely because the individual's act or failure to act is intentional or is done with the individual's realization only that it creates a grave risk of causing injury without the purpose of causing injury or if the act or omission is for the purpose of averting bodily harm to the individual or another entity.

"(D) The term 'health care provider' means—

"(i) any institution described in subsection (e)(1), (f)(1), (j)(1) of section 1861 which is a Federal institution or meets the requirement of section 1861(e)(7),

"(ii) an agency or organization described in section 1861(o)(1) which meets the requirement of section 1861(o)(4),

"(iii) any health care professional described in section 1861(r), and

"(iv) a rural health clinic (as defined in section 1861(aa)(2)), a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)), and a hospice program (as defined in section 1861(dd)(2)).

"(E) The term 'entity' includes an individual or person.

"(b)(1)(A) A health care provider which has tendered (or deemed to have tendered) compensation benefits under subsection (a) may, by written notice to the entity, join in the foreclosure provided under subsection (a) any entity which is potentially liable, in whole or in part, for the personal injury and who may benefit from foreclosure of action against the entity under subsection (a). Joinder under this subparagraph may only be by written notice to the entity to be joined and such notice shall not be effective if provided later than the date the provider makes the tender under subsection (a).

"(B) Any entity which would benefit from foreclosure of action against the entity under subsection (a) with respect to a personal injury shall be joined in any tender made (or deemed to have been made) under subsection (a) with respect to that injury if the entity requests such joinder by written notice to the provider making the tender under subsection (a) not later than the date the tender under subsection (a) is made.

"(2) By joinder under this subsection, an entity is deemed to have agreed to pay a share of (A) such compensation benefits and (B) the reasonable costs incurred by the provider in preparing and making such tender and paying compensation benefits. Any disagreement between such entities involved as to any entity's share of the benefits and costs or the amount of such costs shall be submitted to binding arbitration for determination and each entity's share shall be based on the comparative fault of the entities (other than the injured individual) involved.

"(c)(1) Any entity which has tendered (or deemed to have tendered) compensation benefits with respect to an individual under subsection (a) or been joined in the tender under subsection (b) shall be subrogated to any rights of the individual against another entity (other than against another entity joined under subsection (b)) arising from or contributing to the personal injury and shall have a cause of action separate from that of the individual to the extent that (A) elements of damage compensated for by compensation benefits are recoverable and (B) the entity has paid or becomes obligated to pay accrued or future compensation benefits.

"(2) In the case that a foreclosure from liability is effected under subsection (a), no right of subrogation, contribution, or indemnity shall exist against a compensation obligor other than the right of contribution among compensation obligors under subsection (b)(2), nor shall any provision of any contract be enforced that has the effect of limiting or excluding payment under that contract because of the existence or payment of compensation benefits under this subpart.

"(3) The District Courts of the United States shall not have jurisdiction under section 1331 or 1337 of title 28, United States Code, over any civil action arising under this subpart.

"(d) As used in this subpart:

"(1) The term 'compensation obligor'—

"(A) means, with respect to a personal injury, the health care provider that has obligated itself to pay compensation benefits under subsection (a) with respect to that injury, and

"(B) includes—

"(i) any entity that has been joined under subsection (b) with respect to that injury, and

"(ii) any other entity (including an insurance company) which is contractually responsible for payment of the obligations of a compensation obligor under this subpart.

"(2) The term 'initiating compensation obligor' means, with respect to a personal injury, the compensation obligor which (A) first tenders compensation benefits to the injured individual, or (B) agrees to serve as an initiating compensation obligor and has been designated as such by a majority of the compensation obligors for that injury for purposes of this subpart.

"AMOUNT OF, AND ADJUSTMENTS TO, COMPENSATION BENEFITS

"SEC. 1822. (a)(1) The amount of compensation benefits payable with respect to a personal injury is equal to the net economic loss (as defined in subsection (b)(1)) resulting from such injury, plus attorney's fees (as provided under subsection (e)).

"(b) For purposes of this subpart:

"(1) The term 'net economic loss' means—

"(A) economic detriment, consisting only of—

"(i) allowable expense (as defined in paragraph (2)(A)),

"(ii) work loss (as defined in paragraph (2)(B)), and

"(iii) replacement services loss (as defined in paragraph (2)(C)),

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whether caused by pain and suffering or physical impairment, but not including noneconomic loss (as defined in paragraph (3)), less collateral benefits (as defined in paragraph (4)).

"(2)(A) The term 'allowable expense' means reasonable expenses incurred for products, services, and accommodations reasonably needed for medical care, training, and other remedial treatment and care of an injured individual, but includes expenses for rehabilitation treatment and occupational training only in accordance with subsection (d).

"(B) The term 'work loss' means 100 percent of the loss of income from work the injured individual would have performed if the individual had not been injured, reduced by any income from substitute work actually performed by the individual or by income the individual would have earned in available appropriate substitute work the individual was capable of performing but unreasonably failed to undertake.

"(C) The term 'replacement services loss' means reasonable expenses incurred in obtaining ordinary and necessary services in lieu of those the injured individual would have performed, not for income but for the benefit of the individual or the individual's family, if the individual had not been injured.

"(3) The term 'noneconomic detriment' means pain, suffering, inconvenience, physical impairment, mental anguish, emotional pain and suffering, punitive or exemplary damages, and all other general (as opposed to special) damages, including loss of earning capacity and loss of any of the following which would have been provided by an injured individual to another: consortium, society, companionship, comfort, protection, marital care, attention, advice, counsel, training, guidance, and education. Such term does not include pecuniary loss caused by pain and suffering or by physical impairment.

"(4) The term 'collateral benefits' means all benefits and advantages received or entitled to be received (regardless of any right any other entity has or is entitled to assert for recoupment through subrogation, trust agreement, lien, or otherwise) by an injured individual or other entity as reimbursement of loss because of personal injury, payable or required to be paid, under—

"(A) the laws of any State or the Federal government (other than through a claim for breach of an obligation or duty), or

"(B) any health or accident insurance, wage or salary continuation plan; or disability income insurance;

except that no benefits payable with respect to an injury under a State plan approved under title XIX shall be considered to be collateral benefits for purposes of this subparagraph.

"(c)(1) Compensation benefits shall include reasonable expenses incurred by the injured individual in collecting such benefits, including a reasonable attorney's fee. Such expenses may be offset from the amount of compensation benefits otherwise provided, if any significant part of a claim for compensation benefits is fraudulent or so excessive as to have no reasonable foundation.

"(2) A compensation obligor defending a claim for compensation benefits shall be allowed a reasonable attorney's fee, in addition to other reasonable expenses incurred, in defending such a claim or part thereof that is fraudulent or so excessive as to have no reasonable foundation. The fee or expenses may be treated as an offset to any compensation benefits due. The compensation obligor may recover from the claimant any part of the fee or expenses not offset or otherwise paid.

"(d)(1) Allowable expenses under subsection (b)(2)(A) include expenses for a procedure or treatment for rehabilitation and rehabilitative occupational training if the procedure, treatment, or training is reasonable and appropriate for the particular case; the expenses are reasonable in relation to the probable rehabilitative effects and the compensation benefits otherwise payable, and it is likely to contribute substantially to rehabilitation, even though it will not enhance the injured individual's earning capacity.

"(2) Allowable expenses shall not include expenses described in paragraph (1) with respect to a procedure or treatment for rehabilitation or a course of rehabilitative occupational training which exceed $2,000 in any 30-day period unless the injured individual has provided the initiating compensation obligor with notice of such procedure, treatment, or course of training before expenses totaling $2,000 with respect to such procedure, treatment, or course of training during such period have been incurred.

"PAYMENT OF COMPENSATION BENEFITS

"Sec. 1823. (a)(1)(A) Compensation benefits shall be paid not later than 30 days after the date there is submitted to the initiating compensation obligor reasonable proof of the fact and amount of net economic loss incurred, except that payment may be made, for expenses incurred over periods not exceeding 31 days, within 15 days after the end of the period. If reasonable proof is supplied as to only a portion of net economic loss, and the portion totals $100 or more, the compensation benefits with respect to that portion shall be paid without regard to the remainder of the net economic loss. An injured individual to whom a tender of compensation benefits has been made under section 1821 shall be entitled to interest, at the annual rate of interest applied to judgments in the State in which the injury occurred, on such benefits not paid on a timely basis.

"(B) If there elapses a period of five years after a claim for payment of net economic loss incurred is last made with respect to a personal injury, the injured individual is no longer entitled to receive compensation benefits with respect to that injury.

"(2) A compensation obligor who rejects in whole or in part a claim for compensation benefits shall give to the claimant prompt written notice of the rejection and the reasons therefor.

"(3) Compensation benefits with respect to allowable expenses may be paid either to the injured individual or to the entity supplying the products, services, or accomodations to the individual.

"(b) In lieu of payment therefor as a part of allowable expenses and with the consent of the injured individual, a health care provider may provide medical or rehabilitative services needed by the injured individual.

"(c)(1) Except as otherwise provided in this subsection, subsection (d)(2), or section 1822(c)(2), compensation benefits shall be paid without deduction or setoff.

"(2) An assignment or an agreement to assign any right to compensation benefits under this subpart for net economic loss accruing in the future is unenforceable except as to benefits for—

"(A) work loss to secure payment of alimony, maintenance, or child support; or

"(B) allowable expenses to the extent the benefits are for the cost of products, services, or accomodations provided or to be provided by the assignee.

"(3)(A) Compensation benefits for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim, except upon a claim of a creditor who has provided products, services, or accommodations to the extent benefits are for allowable expense for those products, services, or accommodation.

"(B) Compensation benefits other than those for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim to the extent that wages or earnings are exempt under any applicable law exempting wages or earnings from process or claims.

"(4)(i) Except as provided in clause (iii), a claim for compensation benefits shall be paid without deduction or offset for collateral benefits, if the collateral benefits have not been paid to the injured individual before the incurring of expenses included in net economic loss.

"(ii) The compensation obligor is entitled to reimbursement from the entity obligated to make the payments or from the entity which actually receives the payments.

"(iii) A compensation obligor may offset amounts it is entitled to recover under clause (ii) against any compensation benefits otherwise due.

"(d)(1) An entity making payment of compensation benefits under this subpart may bring an action against an entity to recover compensation benefits paid because of an intentional misrepresentation of a material fact by that entity upon which the entity relied, except that such an action may not be brought against the injured individual unless the injured individual made or had knowledge of the making of the misrepresentation.

"(2) If such entity secures judgment in an action under paragraph (1), the entity may offset amounts it is entitled to recover under such judgment against any compensation benefits otherwise due.

"REQUIRING DISCLOSURE OF FACTS ABOUT, AND MENTAL AND PHYSICAL EXAMINATION OF, INJURED INDIVIDUALS

"Sec. 1824. (a)(1) Upon request of an injured individual or compensation obligor, information relevant to payment of compensation benefits shall be disclosed as follows:

"(A) The injured individual shall furnish evidence of the individual's earnings, if self-employed.

"(B) An employer of the individual shall furnish a statement of the work record and earnings of an injured individual who is or was an employee of the employer, for the period specified by the injured individual or obligor making the request, which may include a reasonable period before, and the entire period after, the injury.

"(C) The injured individual shall deliver to the compensation obligor upon request a copy of every written report, not otherwise available to the compensation obligor, previously or thereafter made, available to the individual, concerning any medical treatment or examination of the injured individual and the names and addresses of hospitals, physicians, and other entities, examining, diagnosing, treating, or providing accommodations to the individual in regard to the injury or to a relevant past injury, and the injured individual shall authorize the compensation obligor to inspect and copy all relevant records made by such entities.

"(D) A hospital, physician, or other entity examining, diagnosing, testing, or providing accommodations to an injured individual in connection with a condition alleged to be connected with an injury upon which a claim for compensation benefits is based, upon authorization of the injured individual, shall furnish a written report of the history, condition, diagnosis, medical tests, treatment, and dates and cost of treatment

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of the injured individual in connection with that condition or any previous or other condition which may be relevant to assessing such condition, and permit inspection and copying of all records and reports as to the history, condition, treatment, and dates and cost of treatment.

Any entity (other than the injured individual or a compensation obligor) providing information under this paragraph may charge the entity requesting the information for the reasonable cost of providing it.

"(2) In case of dispute as to the right of an injured individual or compensation obligor to discover information required to be disclosed under this subsection, the individual or obligor may petition a court having jurisdiction over the matter for an order for discovery, including the right to take written or oral depositions. Upon notice to all entities having an interest, the order may be made for good cause shown. It shall specify the time, place, manner, conditions, and scope of the discovery. To protect against oppression, the court may enter an order refusing discovery or specifying conditions of discovery and directing payment of costs and expenses of the proceeding, including reasonable attorney's fees.

"(b)(1) If the mental or physical condition of an injured individual is material and relevant to compensation benefits, a compensation obligor may petition a court having jurisdiction over the matter for an order directing the individual to submit to a mental or physical examination by a physician. Upon notice to the individual to be examined and all entities having an interest, the court may make the order for good cause shown. The order shall specify the time, place, manner, conditions, scope of the examination, and the physician by whom it is to be made.

"(2) If requested by the individual examined, a compensation obligor causing a mental or physical examination to be made shall deliver to the individual examined a copy of the written report of the examining physician, and reports of earlier examinations of the same condition. By requesting and obtaining a report of the examination ordered or by taking the deposition of the physician, the individual examined waives any privilege the individual may have, in relation to the claim for compensation benefits, regarding the testimony of every other person who has examined or may thereafter examine the individual respecting the same condition. This subsection does not preclude discovery of a report of an examining physician, taking a deposition of the physician, or other discovery procedures in accordance with any rule of court or other provision of law. This paragraph applies to examinations made by agreement of the individual examined and a compensation obligor, unless the agreement provides otherwise.

"(3) If any individual refuses to comply with an order entered under this subsection, the court may make any just order as to the refusal, but may not find a individual in contempt for failure to submit to a mental or physical examination.

"(c) If a health care provider tenders compensation benefits with respect to an injured individual under this subpart and there is a dispute between the initiating compensation obligor and the injured individual respecting the determination of the amount of the compensation benefits owing, except as otherwise provided under this subpart, the initiating compensation obligor or the individual may apply to a court with appropriate jurisdiction for a declaration as to the amount of the compensation benefits owed.

"LUMP SUM AND INSTALLMENT SETTLEMENTS AND DECLARATIONS OF BENEFITS

"SEC. 1825. (a) An obligation to pay compensation benefits may be discharged initially or at any time thereafter by a settlement or lump sum payment, except that no such discharge shall be made with respect to an injury with a current value of net economic loss exceeding $5,000 unless a court having jurisdiction over the matter determines that the settlement is fair to the injured individual. A settlement agreement may also provide that the compensation obligor shall pay the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future.

"(b)(1) In an action for payment of unpaid compensation benefits, a judgment may be entered for compensation benefits, other than allowable expense, that would accrue after the date of the award. The court may enter a judgment declaring that the compensation obligor is liable for the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future if it is ascertainable or foreseeable that treatment will be required as a result of the injury for which the claim is made.

"(2) A judgment for compensation benefits, other than with respect to allowable expenses, that will accrue thereafter may be entered only for a period as to which the court can reasonably determine future net economic loss.

"(3) If the injured individual notifies the initiating compensation obligor of a proposed specified procedure or treatment for rehabilitation or specified course of rehabilitation occupational training the expenses of which are an allowable expense and the compensation obligor does not promptly agree to such characterization, the injured individual may move the court in an action to adjudicate the individual's claim, or, if no action is pending, bring an action in a court having jurisdiction over the matter for a determination respecting whether or not such expenses are allowable expenses for which compensation benefits are payable. The initiating compensation obligor may move the court in an action to adjudicate the injured individual's claim, or, if no action is pending, bring an action in a court having jurisdiction over the matter for such a determination as to whether or not expenses for such a procedure, treatment, or course or training which an injured individual has undertaken or proposes to undertake are allowable expenses for which compensation benefits are payable. This subsection does not preclude an action by the initiating compensation obligor or the injured individual for declaratory relief under any other applicable law, nor an action by the injured individual to recover compensation benefits.

"(4) If an injured individual unreasonably fails, either directly or through one legally empowered to act on the individual's behalf, to obtain medical care, rehabilitation, rehabilitative occupational training, or other medical treatment which is reasonable and appropriate, the initiating compensation obligor may move the court in an action to adjudicate the injured individual's claim, or, if no action is pending, may bring an action in a court having jurisdiction over the matter for a determination that future benefits will be reduced or terminated so that they equal the benefits that in reasonable probability would have been due if the injured individual had submitted to the procedure, treatment, or training, and for other reasonable order. In determining whether an injured individual has reasonable ground for refusal to undertake the procedure, treatment, or training, the court shall consider all relevant factors, including the risks to the injured individual, the extent of the probable benefit, the place where the procedure, treatment, or training is offered, the extent to which the procedure, treatment, or training is recognized as standard and customary, and whether the restriction of this paragraph because of the individual's refusal would abridge the individual's right to the free exercise of religion.

"(c)(1) A settlement agreement or judgment under this section may be modified as to amounts to be paid in the future upon a finding that a material and substantial change of circumstances has occurred after the date the agreement or judgment was made, or that there is newly discovered evidence concerning the injured individual's physical condition, loss, or rehabilitation, which would not have been known previously or discovered in the exercise of reasonable diligence prior to such agreement or judgment.

"(2) The court may make appropriate orders concerning the safeguarding and disposing of the proceeds of settlement agreements and funds collected under judgments under this section.

"(3) A settlement agreement or judgment for compensation benefits may be set aside if it is found to have been procured by fraud.

"ASSIGNED CLAIMS PLAN

"SEC. 1826. (a) In order to participate in the alternative liability program under this subpart, a health care provider must participate, directly or through an insurance company which has agreed to be the compensation obligor with respect to that provider, in an assigned claims plan which meets the requirements of this section in order to insure the payment of compensation benefits by compensation obligors.

"(b)(1) Entities (including insurance companies) in a State may organize and maintain, subject to approval and regulation by the regulator of insurance therein, an assigned claims plan and adopt rules for its operation (including designation of assignees) consistent with this section.

"(2) If such a plan is not established or maintained in a State, whether organized by such entities or otherwise under State law, the Secretary shall organize and maintain an assigned claims plan for the State meeting the requirements of this section for purposes of this subpart. The Secretary may not establish an assigned claims plan under this paragraph with respect to health care providers located in a State unless the Secretary determines that no plan under paragraph (1) has been established in the State and the Secretary has provided the State with notice providing the State at least six months in which to establish such a plan.

"(3) Each assigned claims plan shall provide for assessment of costs on a fair and equitable basis consistent with this subpart and providing for assignment of claims in accordance with subsection (c). An assigned claims plan may not permit an entity covered under the plan to withdraw from the plan retrospectively.

"(c)(1) An injured individual entitled to compensation benefits from a compensation obligor pursuant to this subpart may obtain them through the assigned claims plan established pursuant to this section if the initiating compensation obligor obligated therefor is financially unable to fulfill its obligation.

"(2) Where an assigned claims plan finds that a compensation obligor which is associated with such plan reasonably is financially unable to pay the compensation benefits

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it owes, the assigned claims plan shall promptly assign the claims to a member or members of the plan and notify the individual or individuals entitled to receive such benefits of the identity and address of the assignee or assignees. Claims shall be assigned so as to minimize inconvenience to injured individuals. Any such assignee shall have all rights and obligations as if it had lawfully obligated itself to pay such compensation benefits and the plan and assignee may seek payment (including interest) from the compensation obligor or its successor of 120 percent of the costs and expenses incurred in fulfilling the obligor's obligations.

"(d) If an obligation qualifies for assignment under this section, the assigned claims plan or any compensation obligor to whom the claim is assigned is subrogated to all rights of the injured individual against any compensation obligor, its successor in interest or substitute, legally obligated to provide compensation benefits to the injured individual, for compensation benefits provided by the assignee.

"ACTIVITIES TO ENHANCE QUALITY OF CARE

"SEC. 1827. (a)(1) As a condition of participation for an institutional health care provider (as defined in subsection (c)(3)) under this title, if the provider—

"(A) takes an action adversely affecting the clinical privileges of a health care professional (other than a suspension of clinical privileges for a period of 30 days or less), or

"(B) terminates or does not renew a contract with a health care professional,

for reasons relating to the professional incapability (as defined in subsection (c)(7)) of the professional, the provider shall submit a written report detailing the action to the appropriate health care licensing board in the jurisdiction where the provider is located.

"(2)(A) Except as provided in subparagraph (C), no one shall disclose—

"(i) the identity of an entity that provides information to an institutional health care provider (or to a peer review committee) concerning the professional incapability of a health care professional who is or was a member of (or who has applied for membership in) the medical staff of the provider, and

"(ii) the minutes, analyses, findings, deliberations, and reports of a peer review committee.

"(B) Except as provided in subparagraph (C), information described in subparagraph (A) shall not be subject to discovery, and is not admissible into evidence, in any civil, administrative, or criminal proceeding.

"(C) The restrictions of subparagraphs (A)(ii) and (B) shall not apply to the disclosure, upon the request of a health care professional against whom an adverse action is taken by the institutional health care provider, of information relating to that professional, but only if the disclosure is made in a proceeding to determine the lawfulness of the adverse action.

"(b)(1) In the case of a health care professional who is or was a member of (or who has applied for membership in) the medical staff of an institutional health care provider, no one shall be liable to anyone in damages—

"(A) for an institutional health care provider transmitting to a health care licensing board or to another institutional health care provider information respecting the professional, or

"(B) for any entity transmitting to an institutional health care provider (or a peer review committee) information bearing on the professional incapability of the professional,

unless—

"(i) the information transmitted was false, and

"(ii) the entity transmitting the information (I) knew (or had reason to believe) that the information was false, and (II) acted with actual malice in transmitting the information.

"(2) No one shall be liable in damages for any decision (or recommendation of a peer review committee) adversely affecting the clinical privileges of a health care professional or terminating or failing to renew a contract with a health care professional, if the decision (or recommendation) was made in good faith for the purpose of enhancing the quality of care furnished by the provider.

"(c) As used in this section:

"(1) The term 'adversely affecting the clinical privileges' means reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges.

"(2) The term 'health care licensing board' means, with respect to a health care professional, the governmental board, commission, or other authority (if any) responsible for the licensing of a health care professional of that type.

"(3) The term 'institutional health care provider' means a health care provider described in section 1821(a)(4)(D)(i).

"(4) The term 'medical staff' means the professional staff of an institutional health care provider.

"(5) The term 'peer review activity' means any activity engaged in by an institutional health care provider—

"(A) in determining which health care professionals may have clinical privileges at the provider,

"(B) in determining the scope and conditions of these privileges, or

"(C) in changing or modifying these privileges.

"(6) The term 'peer review committee' means—

"(A) the governing body (or any committee thereof) of an institutional health care provider when conducting a peer review activity, and

"(B) any committee of the medical staff of an institutional health care provider assisting the governing body in a peer review activity under the authority of (and with functions delineated by) the governing body.

"(7) The term 'professional incapability' means professional incompetence, mental or physical impairment, or unprofessional or unethical conduct.

"REQUIRING MALPRACTICE INSURANCE FOR PHYSICIANS TO OBTAIN BENEFITS OF SUBPART

"SEC. 1828. A health care professional described in section 1861(r) may not participate in the alternative liability program under this subpart unless the professional has insurance against professional malpractice (or has a suitable bond or other indemnity against liability for professional malpractice) at least in such amount as the Secretary determines to be appropriate, based on the amounts that are consistent with the insurance or bond maintained by professionals in the community and specialty involved.

"EFFECTIVE DATE AND APPLICATION OF ALTERNATIVE STATE MEDICAL LIABILITY LAW

"SEC. 1829. Notwithstanding any other provision of this subpart, the preceding provisions of this subpart shall not apply to any personal injury occurring—

"(1) before January 1, 1988, or

"(2) in a State which has in effect a law that the Secretary determines is designed to bring about prompt payment for loss in the case of damages relating to sickness, disease, or bodily harm arising from the provision of health care services.".

(b) PREVENTING DUPLICATE PAYMENTS.—The first sentence of section 1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)) is amended by inserting before the period at the end the following: "or as compensation benefits under subpart II of part A or under an alternative State liability law meeting the requirements of section 1829(2)".

EXPLANATION OF THE MEDICAL OFFER AND RECOVERY ACT OF 1985 BY CONGRESSMEN W. HENSON MOORE AND RICHARD A. GEPHARDT

RATIONALE

The country again is facing a medical malpractice crisis. Litigation is increasing rapidly. The relationship between physicians and patients has become an adversarial one. Physicians engage in the practice of defensive medicine. They raise their fees to patients to offset increased insurance premiums. In some cases they abandon their practices, making it more difficult for patients to obtain care.

Patients are not being well-served by the current malpractice litigation system. Today's system does not provide a fair, rapid or rational method for compensating victims of medical malpractice. The process requires patients, physicians and hospitals to assume stances diametrically opposed to their best interest. The high cost of malpractice insurance is causing some physicians to abandon their practice, making it more difficult for patients to obtain care.

Today's system for determining and paying compensation for malpractice is unfair and inefficient. A few plaintiffs win large recoveries but only after the long and arduous litigation process, while others equally deserving receive nothing. Most insurance money currently is spent on transactional costs (fees for expert witnesses and lawyers and other costs of litigation) and on payment to a few victims of damages for noneconomic loss (pain and suffering, loss of consortium, etc.)

PROVISIONS OF THE BILL

Model for State Legislation.—The Medical Offer and Recovery Act is designed to serve as model legislation for state legislatures to consider in passing their own mechanism for providing prompt payment of a patient's economic loss. The federal provisions of the Medical Offer and Recovery Act will not apply to states that implement such reforms by January 1, 1988.

Mechanics of Proposal.—1. A health care provider would, within 180 days of an occurrence, have the option of making a commitment to pay the patient's economic loss. Payments from collateral sources such as private health insurance and workers compensation would offset the amount owed by the provider.

2. If the provider makes the commitment to pay the patient's economic loss, a patient's right to sue for malpractice under the conventional tort system would be foreclosed except for cases where the provider intentionally caused the injury or a wrongful death occurred.

3. The *offer must by definition encompass all of the patient's economic loss.* Economic loss includes the cost of continued medical and hospital care, rehabilitation, nursing care, wage loss, the cost of a housekeeper and adapting the patient's house and car, as well as reasonable attorneys' fees in advising the patient. The *payments would occur periodically* as the patient's economic loss accured.

4. The provider making a commitment to pay a patient's economic loss may join to

the settlement other third parties (potential defendants) who may be responsible for the injury. Similarly, other third parties may request to be joined. Any disagreement between the joined parties will be settled by binding arbitration.

Patient Protections.—1. The patient's rights to sue for the enforcement of the commitment are protected should the provider default or breach the commitment.

2. If a provider and patient wish to settle for a lump sum payment instead of periodic payments, they may do so by agreement. However, the agreement would be ineffective (if the patient's net economic loss was in excess of $5,000) without court approval and the provider would be responsible for all of the patients net economic loss.

3.[1] Patients are *assured of payment*. The bill requires physicians to carry sufficient malpractice insurance or post bond in order to participate in the program. This protects patients against judgement proof providers.

4.[1] A patient may demand compensation for economic loss without going to court. In the event that a provider does not choose to voluntarily make a commitment for economic loss, a patient who believed he or she had been a victim of malpractice could request that an expeditious arbitration proceeding be conducted. If the arbitrator determined the provider was at fault, the patient would be awarded compensation for economic loss as if the provider had voluntarily made the commitment. A request for arbitration would foreclose the patient's right to sue for noneconomic damages.

5.[1] A patient is further protected by provisions to reduce malpractice by preventing incompetent physicians and other health care professionals from practicing. Health care institutions must notify state licensing authorities if they terminate the privileges or take other adverse actions with respect to the privileges of a health care professional. It also provides confidentiality and immunity for those who provide information to a hospital or its medical staff that a member of the staff is incompetent or impaired. Finally, it provides immunity from suit for those who review health care professionals' conduct and those who take disciplinary action against them.

● Mr. DANFORTH. Mr. President, I am pleased to join my colleague on the Senate Finance Committee, Senator DURENBERGER, as a cosponsor of the Medical Offer and Recovery Act. This legislation addresses one of the Nation's critical health care problems—the spiraling cost of medical malpractice insurance.

In my own State of Missouri, malpractice insurance rates for family practice physicians rose by 135 percent this year, and hospital insurance costs increased by more than 150 percent. The problem is particularly severe in obstetrics and gynecology, where skyrocketing malpractice insurance rates are discouraging many rural physicians from performing such services and greatly diminishing and availability of care to high-risk maternal patients, who in many cases are poor.

At the Wetzel Clinic in Clinton, MO, which provides care to a wide rural area in the western part of the State, 7 of the 10 doctors who used to deliver babies have been squeezed out of this essential part of their practice by insurance rate increases.

Faced with a tenfold increase in its medical malpractice insurance premiums, Truman Medical Center, a public hospital in Kansas City, was forced to seek a $1.5 million loan from the city to form a self-insurance pool and avoid closing down or operating without insurance. A recent series of medical malpractice jury awards in excess of $10 million has made commercial reinsurance coverage virtually unavailable in western Missouri.

As these examples clearly demonstrate, the medical malpractice insurance crisis is not a problem faced only by doctors and hospitals—it is a problem which affects every one of us. The costs of medical malpractice—which include not only the rising price of insurance, but also the cost of additional tests and procedures ordered by doctors primarily to guard themselves against lawsuits—are paid by employers and individuals in the form of higher health insurance premiums and higher taxes.

This malpractice insurance crisis is but one facet of a much larger problem affecting all purchasers of liability insurance. Accountants, truck drivers, commercial fishermen, municipal governments, and many other groups also are confronting huge increases in the cost of insurance coverage. Indeed, the problem of cost and availability of liability, insurance is so widespread and severe that it is becoming one of the most pressing economic issues the country faces today.

At the heart of the problem is a complicated and expensive civil justice system which consumes more money determining fault than compensating victims. If we are to get at the true cause of our insurance woes—in medical malpractice and other areas—something must be done to provide for more just and predicatable awards to injured parties, while reducing the massive transactions costs associated with litigating disputes.

Although I am not yet certain that the legislation introduced today provides the best proposal for civil justice reform in the medical malpractice area, it is an important beginning. The Medical Offer and Recovery Act would provide for an alternative compensation scheme similar in design to legislation I have sponsored with regard to products liability. The goal is to get people out of the court system and to encourage swift and certain compensation for out-of-pocket losses. The products bill is moving ahead in the Commerce Committee, and I look forward to working on this legislation in the Finance Committee.

While I support the concept of setting up alternatives to formal court litigation of personal injury disputes, I am also aware that tort law reform is an issue within the purview of the States. Many States, including Missouri, have been very active recently in attempting to reform their laws governing personal injury litigation. This legislation is not attempting to discourage these efforts, but rather to complement and support them.

Mr. President, the Medical Offer and Recovery Act is directed at a complex problem, and there are a number of competing interests involved. While the task ahead is a challenging one, I am encouraged by the prospect of real reform that would benefit both the providers and consumers of medical care.●

By Mr. THURMOND (for himself, Mr. DECONCINI, Mr. ANDREWS, Mr. BURDICK, Mr. D'AMATO, Mr. DIXON, Mr. SIMON, and Mr. WARNER) (by request):

S. 1961. A bill to amend title 28 and title 11 of the United States Code to authorize a new U.S. trustee system by providing for the appointment of U.S. trustees to supervise the administration of bankruptcy cases in judicial districts throughout the United States, and for other purposes; to the Committee on the Judiciary.

UNITED STATES TRUSTEES ACT

Mr. THURMOND. Mr. President, on behalf of the administration, I rise to introduce the United States Trustee Act of 1985. This bill would expand and make permanent the U.S. Trustee Pilot Program for Bankruptcy Administration, which was established by title I of the Bankruptcy Act of 1978 (Public Law 95-598). The initial period for the project was 4½ years, but it was extended twice: First until September 30, 1984 (Public Law 98-166), and again until September 30, 1986 (Public Law 98-353).

The U.S. trustees would be charged with overseeing the administration of bankruptcy cases filed under chapters 7, 11, and 13 of the Bankruptcy Code. Under the aegis of the Justice Department, the U.S. trustee system would effect a separation of the administrative and case monitoring functions from the adjudicative functions carried out by the bankruptcy judges and the judiciary. In the nonpilot areas, the bankruptcy judges have continued to adjudicate legal issues and to supervise the administration of bankruptcy cases.

This legislation would expand the pilot program from 10 field offices covering 18 judicial districts to 30 regional offices covering the entire United States. Each region would be headed by a U.S. trustee appointed by the Attorney General for a 4-year term.

Pursuant to the 1976 act, an independent study to compare the pilot and nonpilot programs was undertaken by Abt Associates, Inc. of Cambridge, MA. The findings of that study indicate that the pilot program has resulted in "enhanced honesty and efficiency in bankruptcy administration" in the pilot districts. Certainly this approach deserves careful consideration.

[1] Denotes a new provision added to H.R. 5400 from the 98th Congress.

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1986 CAS FALL MEETING

The 1986 AAMC Annual Meeting will be held October 25-30 in New Orleans. The Council of Academic Societies is scheduled to meet on Sunday, October 26 and Monday, October 27. As in previous years, the Sunday session will be consist of a plenary session devoted to an issue of interest to faculty. The program for this meeting must be decided at this Board meeting so that it may be included in the preliminary program for the Annual Meeting. Possible speakers for the program may be identified at this time.

The Monday afternoon session will include the Council business meeting and a discussion of current issues and directions for the CAS. The program for Monday's meeting will be discussed at a future Board meeting.

GRADUATE MEDICAL EDUCATION COMMITTEE

The Executive Council has authorized the establishment of an ad hoc committee on graduate medical education and the transition from medical school to residency. The AAMC has been concerned about the graduate phase of physicians' education for many years, and in 1981 issued a task force report entitled, "Graduate Medical Education: Proposals for the Eighties." Now, midway through the decade, there are mounting concerns about the disruption of medical students' education by the intensity of competition for residency positions.

In reviewing the positions the Association has taken about graduate medical education during the past 20 years, it appears that a genuine continuum between medical school and graduate medical education has never been attained. Indeed, the continuum concept now appears more tenuous than it did a decade ago. For this reason, the committee has been asked to consider what should be done to alleviate what has been called the "preresidency syndrome," to review the history of the Association's policies about institutional responsibility for graduate medical education, and to recommend to the Executive Council what the AAMC and its constituent institutions and organizations should do to achieve a true continuum of medical education.

AAMC *AD HOC* COMMITTEE ON GRADUATE MEDICAL EDUCATION AND THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY

SPENCER FOREMAN, M.D., *CHAIRMAN*, President, Sinai Hospital, Baltimore
AAMC GME Task Force 1977-1981; AAMC representative to ACGME

D. KAY CLAWSON, M.D., Executive Dean, University of Kansas Medical Center School of Medicine
AAMC GME Task Force 1977-1981; AAMC representative to ACGME; former Chairman, RRC, Orthopedics

ARNOLD L. BROWN, M.D., Dean, University of Wisconsin Medical School

JOSEPH S. GONNELLA, M.D., Dean, Jefferson Medical College, Philadelphia

ROBERT DICKLER, Director, University Hospital, Denver, Colorado

JAMES J. LEONARD, M.D., Chairman, Department of Medicine, Uniformed Services University of the Health Sciences
President, Association of Program Directors in Internal Medicine

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MORTON E. SMITH, M.D., Professor of Ophthalmology, and Assistant Dean, Washington University School of Medicine

MARK L. DYKEN, M.D., Chairman, Department of Neurology, Indiana University School of Medicine

J. ROLAND FOLSE, M.D., Chairman, Department of Surgery, Southern Illinois University School of Medicine

Chairman, RRC, Surgery

THOMAS K. OLIVER, JR., M.D., Chairman, Department of Pediatrics, University of Pittsburgh School of Medicine

Chairman, American Board of Pediatrics

VIVIAN W. PINN, M.D., Chairman, Department of Pathology, Howard University College of Medicine

Former Dean for Student Affairs, Boston University School of Medicine

BERNICE SIGMAN, M.D., Associate Dean for Student Affairs, University of Maryland School of Medicine

GERALD H. ESCOVITZ, M.D., Vice-Dean, Medical College of Pennsylvania

Chairman-Elect, Group on Medical Education

CAROL M. MANGIONE, M.D., Resident, Internal Medicine, University of California, San Francisco School of Medicine

Former member, OSR Administrative Board; Member of Advisory Committee for the Conference on the Clinical Education of Medical Students

Ex-officio Members:

VIRGINIA V. WELDON, M.D., Professor of Pediatrics, and Associate Vice Chancellor for Medical Affairs, Washington University School of Medicine

Chairman, AAMC Assembly

EDWARD J. STEMMLER, M.D., Dean, University of Pennsylvania School of Medicine

Chairman-Elect, AAMC Assembly

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1986 CAS NOMINATING COMMITTEE

The following individuals have agreed to serve on the 1986 CAS Nominating Committee:

Frank G. Moody, chairman
Jo Anne Brasel
David H. Cohen
Rolla Hill
Mary Lou Pardue
Jerry Wiener
Nicholas Zervas

The Committee will meet via conference call in May.