

109TH CONGRESS  
1ST SESSION

# S. 1784

To amend the Public Health Service Act to promote a culture of safety within the health care system through the establishment of a National Medical Error Disclosure and Compensation Program.

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## IN THE SENATE OF THE UNITED STATES

SEPTEMBER 28, 2005

Mrs. CLINTON (for herself and Mr. OBAMA) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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## A BILL

To amend the Public Health Service Act to promote a culture of safety within the health care system through the establishment of a National Medical Error Disclosure and Compensation Program.

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

3       **SECTION 1. SHORT TITLE.**

4       This Act may be cited as the “National Medical Error  
5       Disclosure and Compensation Act” or the “National  
6       MEDiC Act”.

7       **SEC. 2. FINDINGS.**

8       Congress makes the following findings:

1           (1) In 1999, the Institute of Medicine released  
2           a report entitled “To Err is Human” that found  
3           medical errors to be the eighth leading cause of  
4           death in the United States, with as many as 98,000  
5           people dying each year as a result of medical errors.

6           (2) To reduce deaths and injuries due to med-  
7           ical errors, the health care system must identify and  
8           learn how to prevent such errors so that health care  
9           quality can be improved.

10          (3) The goals of the liability system are to iden-  
11          tify causes of medical error, remediate those causes  
12          to prevent reoccurrence, and to compensate those in-  
13          jured by medical negligence. Studies have shown,  
14          however, that only one medical malpractice claim is  
15          filed for every 8 medical injuries, and the average  
16          duration of malpractice claim resolution is between  
17          4 and 8 years. Thus, the current health care liability  
18          system has been found to be an inefficient and  
19          sometimes ineffective mechanism for initiating or re-  
20          solving claims of medical error, medical negligence,  
21          or malpractice.

22          (4) The current liability system has also been  
23          shown to be a deterrent to the timely sharing of in-  
24          formation among health care professionals, as well  
25          as between health care professionals and patients,

1 which impedes efforts to improve patient safety and  
2 quality of care.

3 (5) Solutions to the patient safety, litigation,  
4 and medical liability insurance problems have been  
5 elusive. A middle ground solution that meets the  
6 basic needs of all stakeholders including patients,  
7 health care providers, insurers, purchasers, and at-  
8 torneys is desperately needed.

9 (6) Some hospital systems and private medical  
10 liability insurance companies have adopted a policy  
11 of robust disclosure of medical errors, apologies for  
12 such errors, and early compensation for patient in-  
13 jury. For example, a Department of Veterans Affairs  
14 hospital in Lexington, Kentucky, the University of  
15 Michigan Health System, and the private insurer  
16 Copic Insurance Company in Colorado have adopted  
17 such policies and have reported significantly de-  
18 creased legal expenses and smaller claim payouts.  
19 Overall, these policies have resulted in fewer num-  
20 bers of malpractice suits being filed, more patients  
21 being compensated for injuries, greater patient trust  
22 and satisfaction, and significantly reduced adminis-  
23 trative and legal defense costs for providers, insur-  
24 ers, and hospitals where such policies are in place.

1 **SEC. 3. AMENDMENT TO THE PUBLIC HEALTH SERVICE**  
 2 **ACT.**

3 (a) **IN GENERAL.**—Title IX of the Public Health  
 4 Service Act (42 U.S.C. 299 et seq.), as amended by the  
 5 Patient Safety and Quality Improvement Act of 2005  
 6 (Public Law 109–41), is amended—

7 (1) by redesignating part D as part E;

8 (2) by redesignating sections 931 through 938  
 9 as sections 941 through 948, respectively;

10 (3) in section 948(1) (as so redesignated), by  
 11 striking “931” and inserting “941”; and

12 (4) by inserting after part C the following:

13 **“PART D—MEDICAL ERROR DISCLOSURE AND**  
 14 **COMPENSATION**

15 **“SEC. 931. DEFINITIONS.**

16 “In this part:

17 “(1) **DATABASE.**—The term ‘Database’ means  
 18 the National Patient Safety Database established  
 19 under section 934.

20 “(2) **HEALTH CARE PROVIDER.**—The term  
 21 ‘health care provider’ means a person or entity li-  
 22 censed or otherwise authorized under State law to  
 23 provide health care services, including—

24 “(A) a hospital, health plan, community  
 25 clinic, nursing facility, comprehensive rehabili-  
 26 tation facility, home health agency, hospice pro-

1           gram, renal dialysis facility, ambulatory sur-  
2           gical center, pharmacy, doctor’s or health care  
3           practitioner’s office, long-term care facility, be-  
4           havior health residential treatment facility, clin-  
5           ical laboratory, or health center;

6           “(B) a doctor, nurse, physician assistant,  
7           nurse practitioner, clinical nurse specialist, cer-  
8           tified nurse anesthetist, certified nurse midwife,  
9           psychologist, certified social worker, registered  
10          dietitian or nutrition professional, physical or  
11          occupational therapist, pharmacist, or other in-  
12          dividual health care practitioner; and

13          “(C) any other health care professional  
14          specified in regulations promulgated by the Sec-  
15          retary.

16          “(3) IDENTIFIABLE PATIENT SAFETY WORK  
17          PRODUCT.—The term ‘identifiable patient safety  
18          work product’ means patient safety work product  
19          that—

20                 “(A) is presented in a form and manner  
21                 that allows the identification of any provider  
22                 that is a subject of the work product, or any  
23                 providers that participate in activities that are  
24                 a subject of the work product;

1           “(B) constitutes individually identifiable  
2 health information as that term is defined in  
3 the regulations promulgated under section  
4 264(c) of the Health Insurance Portability and  
5 Accountability Act of 1996; or

6           “(C) is presented in a form and manner  
7 that allows the identification of an individual  
8 who reported information in the manner speci-  
9 fied in section 922(e) or 935.

10          “(4) MEDICAL ERROR.—The term ‘medical  
11 error’ means an unexpected occurrence involving  
12 death or serious physical or psychological injury, or  
13 the risk of such injury, including any process vari-  
14 ation of which recurrence may carry significant  
15 chance of a serious adverse outcome.

16          “(5) NONIDENTIFIABLE PATIENT SAFETY WORK  
17 PRODUCT.—The term ‘nonidentifiable patient safety  
18 work product’ has the meaning given such term in  
19 section 921.

20          “(6) OFFICE.—The term ‘Office’ means the Of-  
21 fice of Patient Safety and Health Care Quality es-  
22 tablished under section 933, which shall be a cer-  
23 tified patient safety organization as defined under  
24 part C.

1           “(7) PATIENT SAFETY DATA.—The term ‘pa-  
2           tient safety data’ means information requested by  
3           the Director of the Office to be submitted by the pa-  
4           tient safety officer of a Program participant as de-  
5           scribed in section 935(e).

6           “(8) PATIENT SAFETY EVENT.—The term ‘pa-  
7           tient safety event’ means an occurrence, incident, or  
8           process that either contributes to, or has the poten-  
9           tial to contribute to, a patient injury or degrades the  
10          ability of health care providers to provide the appro-  
11          priate standard of care.

12          “(9) PATIENT SAFETY OFFICER.—The term  
13          ‘patient safety officer’ means the individual des-  
14          ignated by a Program participant as being respon-  
15          sible for ensuring that the conditions for participa-  
16          tion in the Program are met.

17          “(10) PATIENT SAFETY ORGANIZATION.—The  
18          term ‘patient safety organization’ has the meaning  
19          given such term in section 921.

20          “(11) PATIENT SAFETY WORK PRODUCT.—The  
21          term ‘patient safety work product’ has the meaning  
22          given such term in section 921.

23          “(12) PROGRAM.—The term ‘Program’ means  
24          the National Medical Error Disclosure and Com-

1       pensation (MEDiC) Program, established under sec-  
2       tion 935.

3               “(13) PROGRAM PARTICIPANT.—The term ‘Pro-  
4       gram participant’ means a participant that meets  
5       the requirements of section 935(b).

6               “(14) ROOT CAUSE ANALYSIS.—The term ‘root  
7       cause analysis’ means an examination or investiga-  
8       tion of an occurrence, event, or incident to determine  
9       if a preventable medical error took place or the  
10       standard of care was not followed and to identify the  
11       causal factors that led to such occurrence, event, or  
12       incident.

13   **“SEC. 932. PURPOSE AND GOALS.**

14        “It is the purpose of this part to promote a culture  
15       of safety within hospitals, health systems, clinics, and  
16       other sites of health care, through the establishment of  
17       a National Medical Error Disclosure and Compensation  
18       (MEDiC) Program (referred to in this part as the ‘Pro-  
19       gram’). It shall be a goal of the Program to—

20               “(1) improve the quality of health care by en-  
21       couraging open communication between patients and  
22       health care providers about medical errors and other  
23       patient safety events;

24               “(2) reduce rates of preventable medical errors;



1           “(3) ensure patients have access to fair com-  
2           pensation for medical injury due to medical error,  
3           negligence, or malpractice; and

4           “(4) reduce the cost of medical liability insur-  
5           ance for doctors, hospitals, health systems, and  
6           other health care providers.

7   **“SEC. 933. OFFICE OF PATIENT SAFETY AND HEALTH CARE**  
8           **QUALITY.**

9           “(a) IN GENERAL.—The Secretary shall establish  
10          within the Office of the Secretary, an Office of Patient  
11          Safety and Health Care Quality to collaborate with the  
12          Director of the Agency for Health Care Research and  
13          Quality to improve patient safety and reduce medical error  
14          across the health care system. The Office shall be headed  
15          by a Director to be appointed by the Secretary.

16          “(b) ACTIVITIES.—The activities of the Office shall  
17          be deemed patient safety activities, as defined in section  
18          921.

19          “(c) DUTIES.—The Director of the Office shall—

20                  “(1) establish and administer the Program;

21                  “(2) determine who is eligible for participation  
22          in the Program in accordance with section 935;

23                  “(3) develop a standardized application to be  
24          submitted by interested parties for entry into the  
25          Program;

1           “(4) oversee the application process for entry  
2 into the Program under section 935 and provide  
3 technical assistance to Program applicants and Pro-  
4 gram participants;

5           “(5) contract with an independent entity for the  
6 purpose of evaluating the Program at least once  
7 every two years, with the results of such evaluations  
8 being disseminated to Program participants, Con-  
9 gress, and the public;

10           “(6) establish and maintain, in consultation  
11 with patient safety organizations, health care quality  
12 organizations, health care providers, and the health  
13 information technology industry, a National Patient  
14 Safety Database as provided for in section 934 to  
15 receive nonidentifiable patient safety work product  
16 as described in the reporting requirements for Pro-  
17 gram participants under section 935(c)(10);

18           “(7) determine and adopt a standardized pa-  
19 tient safety taxonomy, necessary elements, common  
20 and consistent definitions, and standardized formats  
21 for the electronic reporting of patient safety data to  
22 the Database as described in section 934(e);

23           “(8) survey Federal, State, and local require-  
24 ments for the reporting of patient safety data and

1 work to streamline and reduce duplication of such  
2 requirements;

3 “(9) grant patient safety organizations, re-  
4 searchers, and other qualified individuals and insti-  
5 tutions access to the Database as determined appro-  
6 priate through the evaluation of completed applica-  
7 tions submitted to the Office for such purpose;

8 “(10) analyze, directly or through a contract  
9 with a patient safety organization, all data entered  
10 into the Database and provide Program participants,  
11 Congress, and the public with medical error trend  
12 reports and other analyses as determined appro-  
13 priate by the Director on a quarterly basis;

14 “(11) develop, directly or through a contract  
15 with a patient safety organization, safety and train-  
16 ing recommendations for health care providers that  
17 focus on the reduction of medical errors, improved  
18 patient safety, and increased quality of care on at  
19 least a yearly basis;

20 “(12) maintain a publicly accessible Internet  
21 website to provide patients and health care providers  
22 with information concerning the Program and the  
23 Database;

24 “(13) conduct, directly or through a contract,  
25 the National MEDiC Accountability Study, as de-

1 scribed in section 937, the Medical Liability Insur-  
2 ance Study, as described in section 938, and a study  
3 to reduce the incidence of lawsuits not related to  
4 medical error, as described in section 939; and

5 “(14) perform any other duties for the adminis-  
6 tration of the Program as determined necessary by  
7 the Secretary.

8 “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
9 are authorized to be appropriated, such sums as may be  
10 necessary for each fiscal year to carry out the activities  
11 of the Office.

12 **“SEC. 934. NATIONAL PATIENT SAFETY DATABASE.**

13 “(a) IN GENERAL.—The Director of the Office shall,  
14 in accordance with section 933(c)(6), establish a National  
15 Patient Safety Database that shall—

16 “(1) adopt standardized patient safety tax-  
17 onomy in consultation with the Joint Commission on  
18 Accreditation of the Healthcare Organizations and  
19 other entities with relevant expertise;

20 “(2) include necessary elements, common and  
21 consistent definitions, and a standardized electronic  
22 interface for the entry and processing of the data by  
23 Program participants, as developed by the Director  
24 in consultation with patient safety organizations,

1 health care providers, and the health information  
2 technology industry;

3 “(3) allow for the comprehensive collection and  
4 analysis of the patient safety data required to be  
5 submitted by all Program participants as described  
6 in section 935(e); and

7 “(4) include patient safety data required to be  
8 submitted by Program participants as described in  
9 section 935(e) as nonidentifiable patient safety work  
10 product and privileged and confidential in accord-  
11 ance with section 922.

12 “(b) LIMITATION.—Information submitted to the  
13 Database shall be confidential and protected from disclo-  
14 sure in accordance with the regulations promulgated  
15 under section 264(e) of the Health Insurance Portability  
16 and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

17 “(c) ACCESS.—Access to the patient safety data con-  
18 tained within the Database shall only be provided through  
19 application to and approval by the Director.

20 **“SEC. 935. NATIONAL MEDICAL ERROR DISCLOSURE AND**  
21 **COMPENSATION (MEDIC) PROGRAM.**

22 “(a) ESTABLISHMENT.—The Secretary, acting  
23 through the Director of the Office, shall establish a Na-  
24 tional Medical Error Disclosure and Compensation  
25 (MEDiC) Program to provide for the confidential disclo-

1 sure of medical errors and patient safety events in order  
2 to improve patient safety and health care quality, reduce  
3 rates of preventable medical errors, ensure patient access  
4 to fair compensation for medical injury due to medical  
5 error, negligence, or malpractice, and reduce the cost of  
6 medical liability for doctors, hospitals, health systems, and  
7 other health care providers.

8 “(b) ELIGIBLE PARTICIPANTS.—To be eligible to  
9 participate in the Program an entity shall—

10 “(1)(A) be a health care provider as defined in  
11 section 931(2)(A);

12 “(B)(i) provide, in whole or part, medical mal-  
13 practice insurance for doctors and other designated  
14 health care providers, including—

15 “(I) mutual insurance companies;

16 “(II) privately held or publically traded li-  
17 ability insurance companies;

18 “(III) self-insured hospitals;

19 “(IV) captive insurance companies or pro-  
20 viders covered by captive insurance companies;

21 and

22 “(V) risk-retention groups and any other  
23 alternative malpractice insurance mechanisms;

24 or

1           “(ii) in the case of a Program participant that  
2 is a medical liability insurer, provide to all, or a sub-  
3 set of, the insured of such insurer, an opportunity  
4 to participate in the Program; or

5           “(C) be any other entity determined to be eligi-  
6 ble by the Director;

7           “(2) designate a patient safety officer to ensure  
8 that the conditions of participation described in sub-  
9 section (c) are met;

10           “(3) submit a completed application to the Of-  
11 fice at such time, in such manner, and containing  
12 such information as the Director may require; and

13           “(4) agree to comply with the conditions of par-  
14 ticipation under subsection (c).

15           “(c) CONDITIONS OF PARTICIPATION.—A Program  
16 participant shall, directly or indirectly—

17           “(1) submit a comprehensive plan, as part of  
18 the application for participation in the Program, to  
19 reduce the incidence of medical errors and improve  
20 patient safety;

21           “(2) submit cost analysis statements, in such  
22 manner as determined by the Director, for the 2 fis-  
23 cal years prior to the year of expected entry into the  
24 Program at the time of application and at the end  
25 of every year of participation in the Program, that

1 outline all real and projected costs and savings re-  
2 lated to the liability coverage and legal defense costs  
3 of doctors and other health care providers;

4 “(3) allocate an amount equal to not less than  
5 50 percent of the projected annual savings for the  
6 first year of participation in the Program, not less  
7 than 40 percent of the actual savings reported for  
8 the second year, and not less than 30 percent of the  
9 actual savings reported for the third and each subse-  
10 quent year of participation to—

11 “(A) in the case of a Program participant  
12 that is a medical liability insurer, the reduction  
13 of medical liability premiums for doctors or  
14 other designated health care providers as de-  
15 fined in section 931; or

16 “(B) in the case of a Program participant  
17 that is a health care provider as defined in sec-  
18 tion 931(2)(A), activities that result in the re-  
19 duction of medical errors or that otherwise im-  
20 prove patient safety;

21 “(4) require health care providers included in  
22 the Program by the Program participant and as out-  
23 lined in the Program participant application, to sub-  
24 mit to the patient safety officer a report of—



1           “(A) any incident or occurrence involving a  
2           patient that is thought to either be a medical  
3           error or patient safety event; and

4           “(B) any legal action related to the med-  
5           ical liability of a health care provider;

6           “(5) ensure that the reports filed under para-  
7           graph (4) are submitted to the Database in a stand-  
8           ardized format as designated by the Director;

9           “(6) where appropriate, ensure that a root  
10          cause analysis of any report submitted to the patient  
11          safety officer as described in paragraph (4) is per-  
12          formed within 90 days of the filing of a report under  
13          such paragraph;

14          “(7) ensure that if a patient was harmed or in-  
15          jured as the result of a medical error, or as a result  
16          of the relevant standard of care not being followed,  
17          an account of the incident or occurrence, as de-  
18          scribed in paragraph (4)(A) shall be disclosed to the  
19          patient not later than 5 business days after the com-  
20          pletion of root cause analysis;

21          “(8) disclose information contained in any re-  
22          port submitted to the patient safety officer as de-  
23          scribed in paragraph (4)(A) upon the request of the  
24          patient with respect to whom the report has been  
25          filed;

1           “(9) offer, at the time of disclosure of an inci-  
2 dent or occurrence in which it was determined that  
3 a patient was harmed or injured as a result of med-  
4 ical error or as a result of the relevant standard of  
5 care not being followed, to—

6           “(A) negotiate compensation with the pa-  
7 tient involved in accordance with subsection (d);

8           “(B) provide, at the discretion of the  
9 health care provider involved, an apology or ex-  
10 pression of remorse; and

11           “(C) share, where practicable, any efforts  
12 the health care provider will undertake to pre-  
13 vent reoccurrence; and

14           “(10) prepare and submit entries to the Data-  
15 base as required by the Director of the Office and  
16 in accordance with subsection (e).

17           “(d) NEGOTIATIONS.—

18           “(1) TERMS.—If at the time of the disclosure  
19 of an incident or occurrence in which it was deter-  
20 mined that a patient was harmed or injured as a re-  
21 sult of medical error or as a result of the relevant  
22 standard of care not being followed, a patient elects  
23 to enter into an agreement for negotiations with a  
24 Program participant as provided for in subsection

1 (c)(9), such negotiations shall, at a minimum, pro-  
2 vide for the following:

3 “(A) The confidentiality of the pro-  
4 ceedings.

5 “(B) An agreement that any apology or ex-  
6 pression of remorse by a doctor or other des-  
7 ignated health care provider at any time during  
8 the negotiations shall be kept confidential and  
9 shall not be used in any subsequent legal pro-  
10 ceedings as an admission of guilt if such nego-  
11 tiations end without an offer of compensation  
12 that is acceptable to both parties.

13 “(C) Written notification of a patient’s  
14 right to legal counsel, which shall include an af-  
15 firmative declaration that no coercive or other-  
16 wise inappropriate action was taken to dissuade  
17 a patient from utilizing counsel for the negotia-  
18 tions.

19 “(2) NEUTRAL THIRD PARTY MEDIATOR.—Both  
20 parties may agree to the use of a neutral third party  
21 mediator to facilitate the negotiation of the terms of  
22 the settlement.

23 “(3) TIMEFRAME FOR NEGOTIATIONS.—With  
24 respect to negotiations under paragraph (1), the  
25 parties shall agree that if an agreement on the terms

1 of compensation is not reached within 6 months  
2 from the date of the disclosure required under sub-  
3 section (c)(7) to the patient—

4 “(A) the patient may proceed directly to  
5 the judicial system for a resolution of the issues  
6 involved; or

7 “(B) the parties may sign an extension of  
8 the agreement to provide an additional 3-month  
9 negotiation period.

10 “(4) PAYMENT.—Upon reaching an agreement  
11 under this subsection, the Program participant shall  
12 provide the negotiated compensation to the patient  
13 within an agreed upon timeframe.

14 “(5) FINALITY.—Upon receipt of the final pay-  
15 ment of the accepted settlement as negotiated under  
16 this subsection, the patient shall agree to the final  
17 settlement of the incident described in the report  
18 and findings of the root cause analysis under sub-  
19 section (c)(7), and further litigation with respect to  
20 such matter shall be prohibited in Federal or State  
21 court.

22 “(e) SUBMISSION OF PATIENT SAFETY DATA.—

23 “(1) IN GENERAL.—All entries into the Data-  
24 base shall—

1           “(A) contain only non-identifiable patient  
2 safety work product;

3           “(B) be in a standardized electronic format  
4 to be determined by the Director; and

5           “(C) if related to a single occurrence or in-  
6 cident, be given a common identifier to link en-  
7 tries of related data.

8           “(2) REPORTING REQUIREMENTS.—The patient  
9 safety officer of a Program participant shall be re-  
10 quired to prepare and enter into the Database—

11           “(A) reports, containing only nonidentifi-  
12 able patient safety work product, filed by a  
13 health care provider under subsection (c)(4)  
14 and a summary of the findings of the root  
15 cause analysis with respect to such report with-  
16 in 5 business days of the completion of the root  
17 cause analysis;

18           “(B) the terms of any agreement reached  
19 through negotiations under subsection (d);

20           “(C) any awards given by a Program par-  
21 ticipant to a patient as compensation for harm  
22 or injury whether obtained through negotiations  
23 under subsection (d) or by other means;

24           “(D) any disciplinary actions taken against  
25 a health care provider as a result of involve-

1           ment in any incident or occurrence involving a  
2           patient that is thought to be a medical error or  
3           patient safety event, or legal action for which a  
4           report under subsection (c)(4) was filed; or

5                   “(E) other data as determined appropriate  
6           by the Director.

7           “(3) PRIVILEGE AND CONFIDENTIALITY.—The  
8           provisions of section 922 shall apply to patient safe-  
9           ty data submitted under this subsection.

10 **“SEC. 936. NATIONAL MEDIC GRANT PROGRAM.**

11           “(a) IN GENERAL.—The Director of the Office shall  
12           award grants—

13                   “(1) to Program participants, to enable such  
14           participants to—

15                           “(A) develop and implement communica-  
16                           tion programs to help health care providers dis-  
17                           close medical errors and other patient safety  
18                           events to patients; and

19                           “(B) procure information technology prod-  
20                           ucts, including hardware, software, and support  
21                           services, to facilitate the reporting, collection,  
22                           and analysis of patient safety data as required  
23                           under this part; and

24                   “(2) to patient safety organizations and quali-  
25           fied institutions or individuals, to enable the—

1           “(A) tracking and analysis of local and re-  
2           gional patient safety trends; and

3           “(B) development and dissemination of  
4           training guidelines and other recommendations  
5           for doctors and other designated health care  
6           providers that focus on methods to reduce med-  
7           ical errors and improve patient safety and qual-  
8           ity of care.

9           “(b) APPLICATION.—To be eligible to receive a grant  
10          under this section, a Program participant, patient safety  
11          organization, or qualified institution or individuals shall  
12          submit to the Director of the Office an application at such  
13          time, in such manner, and containing such information as  
14          the Director may require.

15          “(c) AUTHORIZATION OF APPROPRIATIONS.—

16                 “(1) IN GENERAL.—There are authorized to be  
17                 appropriated, such sums as may be necessary to  
18                 carry out this section.

19                 “(2) RESERVES.—The Secretary shall reserve  
20                 20 percent of the funds appropriated under para-  
21                 graph (1) to provide funding to Program partici-  
22                 pants if the Secretary determines that the total costs  
23                 of the cases handled under the Program for the year  
24                 exceed the total costs that would have been incurred

1 if such cases had not been handled under the Pro-  
2 gram.

3 **“SEC. 937. THE NATIONAL MEDIC ACCOUNTABILITY STUDY.**

4 “(a) IN GENERAL.—The Director of the Office shall  
5 conduct, directly or through a contract with patient safety  
6 organizations or qualified individuals or institutions, an  
7 analysis of the patient safety data in the Database and  
8 other available data to determine performance and sys-  
9 tems standards, tools, and best practices (including peer-  
10 review) for doctors and other health care providers nec-  
11 essary to prevent medical errors, improve patient safety,  
12 and increase accountability within the health care system.  
13 Such analysis shall also consider the value of increasing  
14 the transparency of the patient safety data to include the  
15 identity of health care providers and provide recommenda-  
16 tions for improvements to the peer review process.

17 “(b) REPORT AND RECOMMENDATIONS.—Not later  
18 than 2 years after the date of enactment of the National  
19 MEDiC Act, the Director of the Office shall submit to  
20 Congress and make available to States, State medical  
21 boards, and the public a report that describes the results  
22 of the study carried out under subsection (a) and contains  
23 recommendations for Congress based on the findings of  
24 the report.



1 **“SEC. 938. MEDICAL LIABILITY INSURANCE STUDY.**

2 “(a) IN GENERAL.—The Director of the Office shall  
3 conduct, directly or through contract with patient safety  
4 organizations or qualified individuals or institutions, an  
5 analysis of the medical liability insurance market that dis-  
6 tinguishes between types of carriers to determine historic  
7 and current legal costs related to medical liability, factors  
8 leading to increased legal costs related to medical liability,  
9 and which, if any, State medical liability insurance re-  
10 forms have led to stabilization or reduction in medical li-  
11 ability premiums.

12 “(b) REPORT AND RECOMMENDATIONS.—Not later  
13 than 2 years after the date of enactment of the National  
14 MEDiC Act, the Director of the Office shall submit to  
15 Congress and make available to the States, State insur-  
16 ance regulators, and the public a report that describes the  
17 results of the study carried out under subsection (a) and  
18 contains recommendations for Congress based on the find-  
19 ings of the report.

20 **“SEC. 939. STUDY TO REDUCE THE INCIDENCE OF LAW-**  
21 **SUITS NOT RELATED TO MEDICAL ERROR.**

22 “(a) IN GENERAL.—The Director of the Office shall  
23 conduct, directly or through a contract with patient safety  
24 organizations or qualified individuals and institutions, an  
25 analysis of the patient safety data in the Database to ex-  
26 amine cases that were not successfully negotiated through

1 the Program, or of which the parties (including providers  
2 and patients) chose not to participate in the Program and  
3 to determine the reasons, trends, and impact on the Pro-  
4 gram participants and patients.

5 “(b) REPORT AND RECOMMENDATIONS.—

6 “(1) IN GENERAL.—Not later than 5 years  
7 after the date of enactment of the National MEDiC  
8 Act, the Director of the Office shall submit to Con-  
9 gress and make available to the States, and the pub-  
10 lic a report that describes the results of the study  
11 carried out under subsection (a) and contains rec-  
12 ommendations for Congress based on the findings of  
13 the report.

14 “(2) INTERIM REPORTS.—The Director of the  
15 Office shall submit periodic interim reports to Con-  
16 gress (and make such reports available to the States  
17 and the public) before the submission on the report  
18 under paragraph (1) that describes the progress and  
19 findings made in carrying out the study under sub-  
20 section (a).

21 **“SEC. 940. AUTHORIZATION OF APPROPRIATIONS.**

22 “There are authorized to be appropriated, such sums  
23 as may be necessary to carry out this part.”.

24 (b) CONFORMING AMENDMENT.—Section  
25 921(7)(A)(i)(II) is amended by inserting “, including ac-

1 tivities under section 935(e)” after “patient safety activi-  
2 ties”.

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